Creating a framework for the remediation of unprofessional behaviour in medical students

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy by Susannah Brockbank

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Abstract – Creating a framework for the remediation of unprofessional behaviour in medical students

Susannah Brockbank

There is a recognised association between professionalism lapses at medical school and later professional misconduct. Medical educators and regulators have increasingly called for professionalism lapses to be identified and addressed at medical school to prevent future problems. Many approaches to remediation have been reported; however, there is a lack of empirical or theoretical basis to many approaches and there are few reports of successful remediation models, particularly over the medium- and long-term. Indeed, in this research, medical schools in the United Kingdom identified that remediation of professionalism lapses is a resource-intensive process but outcomes are uncertain.

One of the challenges of addressing unprofessional behaviour is the lack of a consistent definition of professionalism. Many existing definitions rely on an inequitable perception of a 'professional' doctor that has not evolved to reflect the diversity of the profession. With this in mind, 'unprofessional behaviour' may in fact represent diverse ways of being a medical student that do not align with out-dated professional norms and expectations.

Increasingly, medical students are understood to learn professionalism through a process of identity development. Using a qualitative narrative methodology, this research explored the identities that 'unprofessional' students learn and perform. Analysis of narrative interviews identified common roles and characters within the stories that were told. Combining these findings with existing theoretical frames, particularly identity dissonance theory, a model was created that demonstrates a cycle of identity crisis that 'unprofessional' students seem to experience. Engagement with stakeholders further highlighted the problematic assumptions that limit the possibilities for remediation of professionalism lapses.

The findings of this programme of research led to the creation of a proactive, strategic framework for remediation, founded in principles of equity and inclusion. This framework includes changes necessary in the environment of medical institutions to make space for diverse interpretations of professionalism; intensive faculty development, including the training of 'professional remediators'; and individual remediation through longitudinal coaching relationships. In conclusion, there is a clear mandate for approaching remediation more equitably in order to ensure the medical workforce of the future is equipped to care safely and professionally for patients.

1. Introduction

The purpose of the programme of research reported in this thesis is to create a framework for remediation of unprofessional behaviour in medical students. This is a topic that has been of interest to me for some time, having undertaken professionalism research when I was an undergraduate (Brockbank, David, & Patel, 2011). In undertaking that research, I sought to understand the differences in the attitudes of medical professionals and the public to examples of medical student misconduct. In order to do this, I asked participants to choose the sanctions they deemed most appropriate in response to vignettes describing unprofessional behaviour. During the data collection and analysis, I was surprised by the number of participants – both healthcare professionals and members of the public – who annotated their questionnaires, recommending supportive interventions rather than sanctions. On reflection, I had clearly misjudged attitudes to unprofessional behaviour in medical students: addressing lapses seemed to require a less punitive, more holistic approach.

Over the intervening years, I have become increasingly curious about how medical educators should respond to professionalism lapses. In part, this curiosity is borne out of experiences of conduct in medical students and doctors at all levels that I would deem 'unprofessional'. Witnessing these professionalism lapses often caused me to wonder how these individuals have not had their behaviours addressed before. Furthermore, as I have become more involved in the medical education community, I have witnessed the wide array of stances that medical educators take when discussing examples of unprofessional behaviour. Conversations around professionalism lapses tended to ignite vigorous debate about why these behaviours may have occurred and how seriously they should be taken by faculty. I came to the conclusion that attempts to address professionalism lapses would be similarly diverse, which raised important questions for me about the consistency and fairness of remediation of professionalism lapses. I decided that there was a need for a scaffold that was grounded in robust research to ensure that remediation of unprofessional behaviour in medical students was fit-for-purpose. In this

introductory chapter, I explore the gaps that existed in the literature that further justified the programme of research I undertook as well as the rationale for the scope of my research.

1.1. Search strategy

This introduction is not designed to represent a systematic review of the literature on the topic of remediation. This is in part because, although the existing remediation literature is contextually important, much of the focus of the empirical work in this thesis is more the concepts of professionalism and professional identity formation (see Chapters 2 and 4). Importantly, as much of the literature in the fields of remediation and professionalism are based on small-scale, qualitative research, many contributions would not have met inclusion criteria for a systematic review. Thus this thesis does not contain a formal systematic review as this methodology would not have represented the breadth and depth of the discussion of the existing literature.

I did, however, begin the research process by exploring the relevant literature to identify gaps and potential avenues for my research. Using both Google Scholar and PubMed®, I performed an initial search using the following terms:

- "remediation" AND "medical education"
- "remediation" AND "professionalism"
- "remediation" AND "medical student"
- "remediation" AND "medical student" AND "professionalism"

I then hand-searched the references of any relevant articles to identify further papers. In addition, I searched the key medical education journals – Medical Education, Academic Medicine, Medical Teacher, Perspectives on Medical Education and Advances in Health Sciences Education – to find further articles that were not identified in the database searches. These searches allowed me to gain an overview of the key literature in the field, as well as guiding me to further relevant papers that were referenced. I expanded my reading over the course of my PhD, keeping up to

date with key publications in the field. This approach allowed me to see how my research fitted within the evolving field of remediation of unprofessional behaviour, as I explore over the course of this thesis.

1.2. An overview of key terms

I explore the definition of professionalism in detail in Chapter 2 of this thesis but, in short, it encompasses the behaviours, attitudes, values and identities that are expected of individuals practising or studying medicine (General Medical Council [GMC], 2013; Irby & Hamstra, 2016). The definition is important to consider as unprofessional behaviours, also referred to as professionalism lapses, are events when an individual is perceived to have fallen short of these expectations. Many examples of unprofessional behaviour have been cited and can range from relatively minor difficulties, such as missing assignment deadlines, to more serious matters such as sexual impropriety or breaches of patient confidentiality (Jha, Brockbank, & Roberts, 2016; Mak-van der Vossen *et al.*, 2016).

Remediation is defined as any intervention that intends to set an underperforming learner back on course (Kalet & Chou, 2014). In the field of medical education, remediation most commonly occurs after an episode of academic underperformance, for example a failed examination. In this instance, remediation ordinarily takes the form of a targeted intervention to improve a learner's knowledge and skills so that they may pass the assessment task at a second attempt (Cleland *et al.*, 2013). A similar construct has been applied to professionalism lapses: professionalism is described as a competency that must be achieved in medical education (ACGME, 2019; Frank & Danoff, 2007; GMC, 2018c). Thus, unprofessional behaviour is conceptualised as underperformance that must be corrected.

1.3. The mandate to remediate professionalism lapses

There are a number of arguments that have been used to justify the need to remediate professionalism lapses. In the first instance, professionalism lapses are common, with the existing literature reporting that five to 20% of medical students experience a lapse during their studies (Fargen, Drolet, & Philibert, 2016; Papadakis *et al.*, 2005; Van Mook, Van Luijk, *et al.*, 2010). Some authors have framed the need to address professionalism lapses in terms of an infection that needs to be controlled: in order to prevent spread of unprofessional behaviour, lapses must be dealt with (Van Mook, Gorter, *et al*., 2010). Others viewed the need to deal with lapses in terms of the impact of unprofessional behaviours in clinical practice on patient safety and the quality of patient care (Arnold, Sullivan, & Quaintance, 2016). That said, the evidence that supports the patient safety argument is relatively limited, tending to focus on communication difficulties in practising clinicians leading to increases in errors and litigation.

One of the key drivers for the perceived need to remediate unprofessional behaviour in medical students has been the evidence that links professionalism lapses at medical school with further professionalism problems after graduation (Papadakis, Hodgson, Teherani, & Kohatsu, 2004; Papadakis *et al.*, 2005). Recent work has corroborated the link between professionalism lapses during medical school with further lapses in postgraduate training *(*Krupat *et al.*, 2019). The extant literature correlated even relatively low-level professionalism lapses, such as missing deadlines and persistent lateness, with later disciplinary action (Papadakis *et al.*, 2004; Teherani, Hodgson, Banach, & Papadakis, 2005), creating a perceived mandate to thoroughly address all professionalism lapses at medical school (Papadakis, Paauw, Hafferty, Shapiro, & Byyny, 2012).

The mandate to remediate unprofessional behaviour has been widely adopted, for example by the medical regulator in the United Kingdom (UK) (GMC, 2017). That said, there is little guidance regarding how this should be undertaken. A perceived lack of effective remediation options has previously been identified as a barrier to faculty raising professionalism concerns (Dudek, Marks, & Regehr, 2005). With

these factors in mind, there seems to be a clear drive to offer effective remediation following professionalism lapses; however, there is ongoing uncertainty regarding how this should be delivered.

1.4. Current remediation practices

Remediation of professionalism lapses is perceived as challenging, time-consuming and resource-intensive (Kalet, Guerrasio, & Chou, 2016; Mak-van der Vossen *et al*., 2016; Ziring *et al*., 2015). In spite of the resource implications, there is a lack of consensus regarding how to direct the efforts of learners and educators. Reported remediation techniques vary widely because there is a lack of consistency in how professionalism is conceptualised (Birden *et al*., 2014; Irby & Hamstra, 2016). Furthermore, there is a variation in how lapses are identified and at what level they are deemed to require remediation (A. J. Bennett, Roman, Arnold, Kay, & Goldenhar, 2005; Wilkinson, Wade, & Knock, 2009).

There are different understandings of what unprofessional behaviour represents. Much of the existing remediation literature recommends 'diagnosing' a learner following a professionalism lapse (Boileau, St-Onge, & Audétat, 2017; Hickson, Pichert, Webb, & Gabbe, 2007; Saxena, O'Sullivan, Teherani, Irby, & Hauer, 2009; Winston, Van Der Vleuten, & Scherpbier, 2012), with some educators commonly perceiving professionalism lapses as a symptom of an underlying health problem (Mak-van der Vossen *et al.*, 2019b). Other authors have used different theoretical models to understand professionalism lapses and I explore these in detail in Chapter 3 of this thesis.

The varying understandings and interpretations of professionalism lapses are important in the context of remediation as many of these concepts have been used to underpin reported approaches (Arnold *et al.*, 2016; Barnhoorn *et al.*, 2019; Bebeau & Faber-Langendoen, 2014; Mak-van der Vossen *et al.*, 2019a). Taking a diagnostic approach, for example, focuses remediation interventions on treatment of the underlying health issue rather than an intervention primarily designed to

address the behaviour itself. Some reported remediation programmes lack any theoretically- or empirically-informed structure (Brennan, Price, Archer, & Brett, 2020). In many cases, this leads to a remediation programme that tailors interventions to the lapse or individual in question (Guerrasio & Aagaard, 2018; Hickson *et al*., 2007). For example, if concerns are raised about a student repeatedly missing deadlines or turning up late, this learner would be referred for organisational skills or time management training.

Increasingly, learners are understood not simply to learn the principles of professionalism but to *become* professional over the course of their undergraduate training, thus developing an identity as a doctor (R. L. Cruess, Cruess, & Steinert, 2016a). This has led to a focus in the remediation literature on lapses as problems with identity formation that need to be addressed (Barnhoorn *et al*., 2019; Bebeau & Faber-Langendoen, 2014). That said, reported identity-focused remediation interventions do not necessarily align with the theoretical stances on identity formation (Barnhoorn *et al.*, 2019).

In spite of the proliferation of proposed remediation programmes, there are some key flaws in the extant remediation literature. First and foremost, there is a lack of clear outcomes against which 'successful' remediation can be measured (Chou, Kalet, Costa, Cleland, & Winston, 2019). Furthermore, in a systematic review of remediation practices, Brennan *et al.* highlighted that many authors recommended a combination of approaches without meaningful longitudinal outcomes, leading to ongoing uncertainty regarding which approaches – if any – are truly effective (Brennan *et al.*, 2020). Brennan *et al.* (2020) also identified that remediation for professionalism lapses was often combined with remediation for academic failures, leading to ambiguity regarding which interventions were intended to address professionalism lapses. Overall, there is clearly a lack of understanding of what effective remediation looks like in the face of professionalism lapses. Importantly, this seems to be underpinned by a lack of meaningful understanding of what a professionalism lapse represents in the context of medical education. This thesis aims to address the gaps in the literature regarding the understanding of

unprofessional behaviour and develop an empirically- and theoretically-grounded framework for remediation.

1.5. Scope and boundaries of research

Professionalism lapses are not restricted to undergraduate medical education. Indeed, professionalism problems have been reported across many healthcare student groups (Hinton, 2013; Kaslow *et al.*, 2018; Kenny & Johnson, 2016; Marnocha, Marnocha, & Pilliow, 2015), as well as in practising doctors (Guerrasio *et al*., 2012; Hickson *et al.*, 2007). That said, healthcare professional education – and thus remediation – varies between disciplines and contexts. In order to develop a remediation framework that is operationalisable, it is important for me to make recommendations for the context that I understand and in which my empirical research is embedded. Given my position as an educator in a medical school, as well as my previous research, it follows that I conducted my research in the field of undergraduate medical education. Furthermore, I recognise that medical education, practise and regulation vary around the world. With this in mind, I ground the recommendations I make for remediation in the UK context. I believe that this relatively narrow focus allows me to propose a framework that can be realistically implementable in UK medical schools.

1.6. Questions to address

In order to address the overarching aim of this thesis and create a framework for the remediation of unprofessional behaviour in medical students, there are several key questions that must be answered. Firstly, there is a need to outline in detail what unprofessional behaviour is in the context of UK undergraduate medical education. To this end, the definitions of professionalism and unprofessional behaviour need to be explored using the extant literature. Furthermore, there is a need to understand what the current remediation practices of UK medical schools are in order to map out the existing strengths and limitations. Next, new ways to conceptualise

remediation based on the accounts of individuals who have experienced professionalism lapses need to be articulated. Finally, to create an operationalisable framework, stakeholder engagement and participation is required to translate the findings of research into practice. Only after following these steps is the presentation of an empirically-grounded framework for remediation of unprofessional behaviour in medical students feasible, thus this summarises the road map for the remainder of this thesis.

2. Reviewing the Definition of Professionalism

In order to discuss unprofessional behaviour and its remediation meaningfully, it is vital to be clear about the definition of professionalism. In this chapter, I use the existing literature to define professionalism in the context of my research. I demonstrate the differing historical, social and philosophical concepts that have become intertwined to inform past and current definitions of professionalism in medicine. I then explore the impact that differing definitions of professionalism have on how unprofessional behaviour is understood and interpreted, raising questions about the equity of 'professionalism'.

2.1. Search strategy

As discussed in the introduction to this thesis, I did not undertake a structured systematic review of the literature due to the nature of the body of literature I wished to explore. I did, however, begin the literature search for this chapter in a structured way, using both PubMed® and Google Scholar to identify relevant works. My initial searches included the following terms:

- "professionalism";
- "medical professionalism";
- "professionalism" AND "medical student";
- "professionalism" AND "healthcare".

In addition, I searched for articles about unprofessional behaviour using the following terms:

- "unprofessional behaviour" AND "medic*";
- "unprofessional" AND "medical student";
- "unprofessional behaviour" AND "healthcare";
- "professionalism lapse" AND "medic*";
- "professionalism lapse" AND "medical student;
- "professionalism lapse" AND "healthcare".

I then used a snowballing strategy, hand-searching references and citations for relevant papers to expand my review of the literature. I also searched key medical education journals – as listed in Section 1.1 of this thesis – to capture as much of the pertinent literature in the field as possible.

Over the course of my PhD study, new works emerged that further contributed to this review of the literature. Furthermore, my literature review evolved and became more fluid over the course of my PhD study as I discovered different literatures from disciplines outside of medical education, for example sociological literature regarding the development of professions and professional identity formation. I believe this flexible approach fed into the novelty, breadth and depth of the literature review presented here.

2.2. Medical professionalism

There are many differing ways in which professionalism has been defined in medicine (Birden *et al*., 2014; Van De Camp, Vernooij-Dassen, Grol, & Bottema, 2004; Wynia, Papadakis, Sullivan, & Hafferty, 2014). All definitions of medical professionalism either explicitly feature or tacitly imply common constructs such as competence, altruism and accountability; however, the relative emphasis on, and interpretation of, these concepts depends on the root of the definition, its purpose and its context. Some authors have argued that a unifying definition is impossible (Erde, 2008); however, close interrogation of the extant definitions and their origins is required in order to understand one of the key concepts that underpins this thesis.

Differing paradigms are used to frame the concept of professionalism. Many definitions are based on a description of *values* or *attitudes.* Values are the principles that guide one's behaviour and actions (Arnold & Stern, 2006). Similarly, *attitudes* are pervasive ways of thinking or feeling that affect one's propensity to behave in a particular way (Irby & Hamstra, 2016). Attitudes and values can either be personal or – as is often the case in medical professionalism – collectively held

and governed by a group (Macdonald, 1995; Wynia *et al.*, 2014). Frequently, these attitudes and values are equated with *virtues*: an individual's principles, grounded in high moral standards (Brody & Doukas, 2014; Irby & Hamstra, 2016). In some definitions, these are connected to expected *behaviour*, or the manner in which a virtuous individual should act in accordance with the values of the profession (W. Rogers & Ballantyne, 2010). These aspects often overlap, particularly as it can be difficult to truly separate them. For example, it is difficult to understand a person's values without witnessing them in action, in the way (s)he behaves, hence the terms are often used interchangeably. These different paradigms do, however, have implications for the understanding of professionalism.

2.2.1. Culture and context

One way to understand the differences in definitions of professionalism is the cultural context from which they have emerged. A substantial body of literature exists comparing definitions across regional and national cultures (Al-Rumayyan *et al.*, 2017; Helmich, Yeh, Kalet, & Al-Eraky, 2017; Ho, Yu, Hirsh, Huang, & Yang, 2011; Jha, McLean, Gibbs, & Sandars, 2015; Nishigori, Harrison, Busari, & Dornan, 2014). These analyses highlight contrasts in the interpretations of professionalism that stem from philosophical differences that underpin culture, as well as different models of societal organisation. For example, the pervasive influence of religion on culture in Saudi Arabia is reflected in the definition of professionalism in this context. Professional accountability means not merely being accountable to one's patients and colleagues but also, and perhaps more importantly, to God (Al-Eraky & Chandratilake, 2012). As another example, in a Taiwanese definition, self-respect was felt to be an important aspect of professionalism (Ho *et al.*, 2011), which is at odds with Western definitions that require physicians to universally put patients' interests above their own (ABIM Foundation, 2002; GMC, 2013).

One area where interpretations of professionalism can be seen to differ is in the interpretation of patient confidentiality. In the Arab context, for example, the prevalent family structure has a profound impact: a woman's male guardian may be expected to make decisions on her behalf and thus be included within the circle of

confidence (Jha *et al.*, 2015). This has also been described in other highly paternalistic societies, such as Pakistan (Ho, 2013). Furthermore, in cultures that are community-oriented, such as Uganda, a collective approach to confidentiality has been described, where the whole family is expected to be privy to a patient's medical information (Baingana *et al.*, 2010).

Although regional cultures and practices clearly influence the interpretation of professionalism around the world, this fails to fully account for the variety of definitions of professionalism that exist, as even Western definitions vary (Wynia *et al*., 2014). The majority of current published definitions have been arrived at via a consensus process and use Western definitions of professionalism as a touchstone (Abdel-Razig *et al*., 2016; Al-Eraky, Donkers, Wajid, & van Merrienboer, 2014; Ho *et al*., 2011; Pan, Norris, Liang, Li, & Ho, 2013). One commonly cited definition, the result of the American Board of Internal Medicine (ABIM)'s "Medical Professionalism Project", was borne out of a consensus process involving a number of organisations from North America and Europe (ABIM Foundation, 2002). One could therefore assume that this definition applies across the Western world; however, authors have not unified behind it and debate about the quality and purpose of definitions of professionalism continues (Coulehan, 2005; Irby & Hamstra, 2016). With this in mind, I seek alternative ways of understanding the variety of differences in definitions in order to provide clarity for the purpose of my research.

A seminal paper by Ginsburg *et al.* (2000) introduced key concepts into the debate surrounding professionalism: *conflict* and *context*. The authors recognised that, when faced with a professionalism dilemma, professional values would often conflict with one another. When faced with these conflicts, doctors and medical students must reconcile values against one another to reach a satisfactory conclusion. Furthermore, the environment – *context* – in which a conflict occurs can impact upon how values are interpreted and applied (Ginsburg *et al.*, 2000). For example, a doctor working in an insurance-based healthcare system may have to choose between lying to an insurance company to obtain the treatment that her patient requires and being honest with the insurance company, knowing that this

will result in suboptimal patient care (Werner *et al*., 2004). This phenomenon has been described through empirical study in both medical students and doctors (Borgstrom, Cohn, & Barclay, 2010; Christakis & Feudtner, 1993; Myers & Herb, 2013). Once conflict and context are accounted for, no single aspect of professionalism can be viewed as absolute: all are relative to one another and must be applied with discretion in a given situation. These issues can be aptly demonstrated by looking at an economically resource-poor context, such as Uganda (Baingana *et al.*, 2010). As numbers of medical staff are limited, doctors and students may be required to undertake tasks beyond their sphere of competence when there are no relevantly trained practitioners available. Furthermore, though a professional code of conduct may demand that patients be treated with dignity at all times, a lack of private spaces to examine patients may lead to this dignity being compromised in order to conduct an adequate examination and thus provide safe care and treatment. These examples may seem extreme to a Western audience; however, this highlights that behaving 'professionally' may require a practitioner to sacrifice one professional value to fulfil another. In addition, it serves to emphasise a key point: that the narrative of professionalism is dominated by a Western interpretation.

2.2.2. Dominant discourses

In spite of the heterogeneity in definitions of professionalism and the acknowledgement that definitions are context-specific, there is little accounting for the dominance of some understandings of professionalism over others. Wear and Aultman (2006) published a collection of essays discussing different conceptualisations of professionalism. This volume was published in the context of a call for 'renewed professionalism' that occurred in the latter part of the 20th century. At this time, there were growing concerns that medicine was becoming 'deprofessionalised' (Hafferty, 1988; Reed & Evans, 1987). Authors described a number of factors they believed to have led to a breakdown in the trust between the medical profession and the public. These included: reorganisation of healthcare services for profit; increasing litigation against doctors; scientific and technological

advancements in medicine reducing the importance of humanistic values in healthcare delivery; and increased availability of healthcare information to the public (Blumenthal, 2002; S. R. Cruess & Cruess, 2000; Southon & Braithwaite, 1998). Furthermore, some argued that generational shifts have eroded professionalism, for example with a younger generation expecting more time away from work (Borrero, McGinnis, McNeil, Frank, & Conigliaro, 2008; L. G. Smith, 2005; Wilkinson *et al.*, 2009). Wear and colleagues (Wear & Aultman, 2006; Wear & Castellani, 2000; Wear & Kuczewski, 2004), however, argued that holding onto a former, 'nostalgic' definition of professionalism was unfit for the changing climate of medical practice.

Castellani & Hafferty (2006) used complexity theory to demonstrate that 'nostalgic' definitions of professionalism emerged from a dominant group of individuals and organisations involved in medical education and regulation. Organisations in the United States (US) such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME) had the power to define professionalism for medical students and postgraduate trainees as they were responsible for accrediting training programmes. Furthermore, some authors published prolifically on the topic of medical professionalism for several decades (R. L. Cruess & Cruess, 2008; R. L. Cruess, Cruess, & Steinert, 2016b; S. R. Cruess & Cruess, 1997) and thus definitions of professionalism are dominated by an academic elite (Castellani & Hafferty, 2006; Hafferty & Levinson, 2008). These definitions focused on the physician as a virtuous individual, privileging attributes such as altruism and personal morality. Castellani & Hafferty (2006), however, demonstrated that this was not the only conceptualisation of professionalism adopted and applied by physicians in practice. For example, they identified a group of 'entrepreneurial' physicians, who sought to utilise the free market to drive cost-effectiveness and innovation in patient care, thus improving safety and efficiency. In the debate around 'deprofessionlisation', doctors seeking economic rewards at the expense of medical care was deemed one of the key threats (W. M. Sullivan, 2000b). Thus, the 'entrepreneurial' professionals could be construed as unprofessional for putting commercial interests ahead of individual patients. Castellani and Hafferty

(2006), on the other hand, viewed these 'entrepreneurs' as alternatively professional, using the resources at their disposal to best care for their patients and bring overall benefit to society. In the authors' opinion, the dominant definition of professionalism had become out-dated, failing to reflect the diversifying practice and culture of medicine.

Shirley & Padgett (2006) critiqued the 'nostalgic' definition using discourse theory. According to discourse theory, language is used as a symbol to represent a concept. This symbol, particularly when discussing abstract concepts such as altruism, only has meaning when it is interpreted in a particular context. Linguistic symbols are related to practices, which are reinforced or limited by social, political and cultural institutions. As an example, traditional definitions of professionalism required self-abnegation: a physician must be prepared to put their patients' needs first in all scenarios. Historically, this included being available to patients at all times (Pellegrino, 2002). Some critics of the evolution of medical professionalism implied that a move away from this absolute self-abnegation, towards an expectation of some degree of balance of work life and home life, is unprofessional (S. R. Cruess & Cruess, 2009; L. G. Smith, 2005). Shirley & Padgett (2006) argued, however, that these definitions arose at a time when the vast majority of doctors were men and were not required to be active participants in domestic life. When applied to modern life, this failed to account for increasing numbers of women in medical practice, as well as cultural shifts towards men being more involved in parenting and other traditionally 'feminine' tasks. These shifts in society and medicine required that the professionalism discourse altered to allow balance between professional and personal life – which could actually promote professionalism (West & Shanafelt, 2007) – rather than calling for a return to the past. Shirley and Padgett's (2006) use of discourse theory to develop this understanding suggested that the words used in the definition of professionalism needed to shift to become more congruent with the practices and institutions that give them meaning. This example emphasises a further key issue in definitions of professionalism: they are intrinsically gendered, having been borne out of a medical culture that was dominated by men.

In the previous sections, I have demonstrated that extant definitions of professionalism are not only dominated by a male, Western hegemony but also by an academic elite that conceptualises professionalism based in historical precedents rather than current practice. With this in mind, the literature is unlikely to represent the day-to-day practice of professionalism, though this may help to account for the ongoing diversification in definitions. In order to understand this dominant discourse, I will now explore the sociohistorical context in which medical professionalism emerged and was reinforced.

2.2.3. Sociological definitions of professionalism

Many of the well-cited definitions of medical professionalism were grounded in the sociological understanding of a profession. Cruess & Cruess (2004), for example, explicitly drew on the sociology literature to define professionalism in terms of a contract between the medical profession and society, the terms of which are summarised in Table 2.1. In exchange for certain privileges, such as autonomy, self-regulation and social status, the medical profession makes a collective promise to act with integrity, provide high-quality, safe medical care and not abuse the trust of society (S. R. Cruess & Cruess, 2000). This definition of professionalism, however, relies on the medical profession being distinct from other occupational groups in order to justify the privileges I have outlined. In the following section, I explore the ways in which 'professions' are defined.

Society's expectations of medicine	**Medicine's expectations of society**
The services of the healer	Autonomy
Guaranteed competence	Trust
Altruistic service	Monopoly
Morality and integrity	Status and rewards
Promotion of the public good	Self-regulation
Transparency	Functioning health care system
Accountability	

Table 2.1 – summarising the social contract between medicine and the profession as proposed by Cruess & Cruess (2000)

A number of authors undertook detailed case studies seeking to define the aspects of a profession that are distinct from other occupations (Freidson, 2001; Larson, 1977; Macdonald, 1995). A profession has been described as an occupation whose work is underpinned by knowledge and skills that are acquired via lengthy, specialised and theoretically-grounded training (Larson, 1977). These knowledge and skills are then employed in practices that are necessary to the functioning of society (Macdonald, 1995). Applying this to medicine, healthcare services are required to maintain a healthy workforce and thus support production and a healthy economy. Furthermore, a functioning economy is necessary to support the training of doctors and practice of medicine. In this way, the medical profession and society are co-dependent: each is necessary for the other to function, hence the development of a tacit 'contract'. This 'social contract' is also maintained through control of training and regulation in exchange for providing services to the public, as I explore in the following section.

One particular feature that defines a profession is autonomy and, in particular, self-regulation (Macdonald, 1995). In part this is justified by the nature of professional knowledge: the application of professional knowledge is not governed by formulaic structure but requires the discretion of the individual practitioner. Thus the discretion with which professional knowledge is applied can only be understood by group members (Freidson, 2001). Furthermore, the work of professions is supported by institutions and organisations that control the training, licensing and practice of that profession (Macdonald, 1995). This ensures that professions are autonomous as they are not under direct control of the state. In exchange for the privileges of autonomy and self-regulation, professionals must commit to values to ensure that the public can trust them (Macdonald, 1995). Larson (1977) described members of professions as having a pervasive, often lifelong commitment to their occupation, expressed as both a shared identity and common values. These values are publicly-oriented, with the professional group committing to put the interests of society above their own (Martimianakis, Maniate, & Hodges, 2009). In summary, the 'social contract' is underpinned by complex interplay of trust: professionals are

trusted to act autonomously provided they deliver a public service in a way that justifies this trust.

More recently, scholars recognised that a hard line does not exist between professions and other occupational groups. This is because the extent to which the features described in the previous section applies is not consistent (Evetts, 2003). Even in the response to her own careful conceptualisation of a profession, Larson highlights that the definitional aspects of a profession are inconsistent within and between professions:

> *The most common ideal-type of profession combines heterogeneous elements and links them by implicit though untested propositions – such as the proposition that prestige and autonomy flow "naturally" from the cognitive and normative bases of professional work.* (Larson, 1977, p. xi)

Furthermore, a group's status as a profession is not static but a reflection of an ongoing process of negotiation. This is exemplified by the terminology employed in the sociology literature, with a shift from discussion of a profession as a status quo (Abbott, 1988) towards professionalism (Evetts, 2003) and professionalisation as a process (Timmons, 2010). MacDonald (1995), after Larson, identifies a number of interrelated strategies that are employed by professions as part of a 'professional project'. This 'project' is largely understood to be driven by economic gains, with professions seeking to establish a monopoly, or 'market shelter' (Macdonald, 1995). In this context, a monopoly means a collection of practices that can only be undertaken by the members of the occupational group. A monopoly then secures financial rewards for the group, as the public have no choice but to pay for the services they provide. The profession actively competes with other occupational groups to preserve the monopoly over these services (Abbott, 1988). In order to achieve a closed market in this way, MacDonald (1995) proposed that a profession must negotiate a relationship with the state that allows it to regulate its own practices and define its own standards independent of external scrutiny. The autonomous control of standards, training and accreditation permits members to define who belongs to – and is therefore excluded from – the profession.

Furthermore, by controlling entry into the profession, Starr (1982) believed that the medical profession could also control supply of medical services, thus preserving the economic rewards granted by a competitive market. In order to maintain a self-regulating relationship and thus the monopoly it provides, however, professionals must demonstrate that they can be trusted by governments and societies not to abuse their privileged position. Furthermore, in an attempt to set themselves apart from other occupations, professional groups lay claim to superior moral standards oriented to the public interest (Starr, 1982). In addition, with the financial advantages of a closed market come social power and status. This allows a professional group to reinforce its own legitimacy through privileged discourses (Starr, 1982). In the case of medicine, the profession establishes authority by successfully perpetuating a scientific, biomedical understanding of health and illness, which requires conventional medicine to diagnose and treat, thus establishing that society is dependent upon the medical profession for medical services (Starr, 1982). This authority makes space for continued claims to attributes such as competence, integrity and trustworthiness (Macdonald, 1995). Cynically, perhaps, therein lies the true root of the 'social contract': professionals must promise to behave in a way that is acceptable to the public in order to maintain their authority, social status and economic rewards.

Sociological definitions of professionalism have been criticised for being founded in a masculine, privileged understanding that does not value all forms of work equally (Adams, 2010; Noddings, 1990; Witz, 1992). For example, caring professions such as nursing that are traditionally undertaken by women are often seen as less valuable and thus not truly 'professional'. This reinforces the argument made Shirley & Padgett (2006) outlined in Section 2.1.2, in that the definition of doctors as professionals relies on dominant discourse of doctors as male. In view of the increasing number of women in the medical workforce, arguably the conventional definition of medicine as a profession no longer fully applies.

Even as an often-cited 'ideal-type' (Evetts, 2006), medicine in the United Kingdom (UK) no longer truly fulfils the sociological definition of a profession, thus calling into

question the terms of the 'social contract'. In particular, though the regulatory body, the General Medical Council (GMC), continues to be responsible for the training and accreditation of doctors, it is no longer an autonomous organisation. For example, appointments to the Council are now confirmed externally by a group of Members of Parliament and Peers. Additionally, the medical profession is no longer truly self-regulating. In particular, lay people are involved in every tier and facet of the GMC's processes, meaning that the public play a vital role in regulating doctors (M. Davies, 2014; Samanta & Samanta, 2004). Overall, these social, political and structural changes illustrate that a group's standing as a profession is not static and must shift to accommodate to the prevailing climate.

2.2.4. Normative definitions of professionalism

One way that authors have sought to define professionalism in a way that accounts for social change and context is to anchor the understanding in the day-to-day exercise of professionalism in practice (Campbell *et al*., 2007; Swick, 2000). By relying on social norms – accepted standards or practices within a social group – the professed values should be built from the ground up and therefore apply more directly to physicians 'at the coalface'. Furthermore, understanding professionalism this way is potentially an antidote to the 'nostalgic', inequitable discourses. For this to be the case, however, the norms within the profession need to shift to reflect the reality of the current social climate in a timely fashion. In medical education, empirical study suggests that a dominant male, white, middle class, heteronormative culture continues to prevail (Beagan, 2001; Dickins, Levinson, Smith, & Humphrey, 2013; Murphy, 2016). By employing a normative definition, these inequalities are actually perpetuated rather than addressed, as the existing norms are reinforced by the discourses around professionalism.

Normative definitions of professionalism have been criticised for being too focused on behavioural outcomes and lacking aspiration to excellence (Brody & Doukas, 2014; Coulehan, 2005; Doukas, 2003). Furthermore, an extensive literature exists describing the 'hidden curriculum': the normative behaviours, values and attitudes that are embedded within the culture of medicine and thus pass between

generations of physicians (Gaufberg, Batalden, Sands, & Bell, 2010; Ginsburg, Regehr, & Lingard, 2003; Hafferty, 1998; Karnieli-Miller, Vu, Holtman, Clyman, & Inui, 2010; Mossop, Dennick, Hammond, & Robbé, 2013). This 'hidden curriculum' allows negative attitudes and behaviours to be perpetuated, suggesting that norms may not truly be professional. With this in mind, though a normative definition may reflect a realistic view of professional behaviour in context, it would be unlikely to be acceptable to institutions such as regulatory and accrediting bodies. In simple terms, this iteration of professionalism is a 'tough sell' to the public as well as to governments as it lacks an aspiration to a 'gold standard'. These critiques have led some scholars to call for a conceptualisation of professionalism that is borne out of virtue ethics.

2.2.5. Virtue-based definitions of professionalism

Virtue ethics is grounded in Ancient Greek philosophy and relies upon an individual practising in accordance with her deeply held morals and ethics (Pellegrino, 2002). Proponents of this approach to medical professionalism claim that, if an individual is 'virtuous', (s)he will continually strive to behave in a manner that is congruent with those values and attitudes (Coulehan, 2005) and thus uphold exemplary moral standards. This approach to defining professionalism has, however, been criticised for assuming that only individuals with an appropriate character can become physicians. In the past, this has led to calls for medical schools to select students based on character traits (Adam *et al.*, 2015; Albanese, Snow, Skochelak, Huggett, & Farrell, 2003; Bore, Munro, Kerridge, & Powis, 2005); however, empirically this does not seem to lead to a reduction in professionalism lapses (Siu & Reiter, 2009). Furthermore, this virtue-based concept is based in an understanding of the physician as a "man of character" (Whitehead, Hodges, & Austin, 2013, p. 688), harking back to the Hippocratic definition of a doctor. Firstly, this conceptualisation privileges personality traits over competence and, like the sociological and normative definitions of professionalism, perceives optimal professionalism through the lens of inequitable discourses. Furthermore, virtue-based definitions risk making professionalism an unachievable goal, as highlighted by this quotation:

> *The language often used to define professionalism…is so abstract and idealized that it stigmatizes the word professional such that it becomes a dichotomous idea —either one is a perfect professional 100% of the time, or one fails to be professional even once and is forever after branded as "unprofessional"* (Ginsburg & Stern, 2004, p. 15)

In addition, the abstract nature of virtues makes this difficult to translate into practice, a critique that has led to a call for a behaviour-based definition of professionalism that is transparently teachable and assessable (Parker *et al*., 2008).

2.2.6. Behaviour-based definitions of professionalism

Since the late 1990s, there have been calls for professionalism to be explicitly included in medical curricula (R. L. Cruess, Cruess, & Steinert, 2009; S. R. Cruess & Cruess, 1997). A number of factors seem to have triggered this drive for professionalism curricula, including the concerns regarding 'deprofessionalisation' in medicine (Reed & Evans, 1987) and recognition of the potential damage of the 'hidden curriculum' (Hafferty, 1998). Though it took many years, regulating and accrediting bodies eventually responded by developing standards expected of medical students (GMC, 2018c; Liaison Committee on Medical Education, 2016) and medical educators responded in kind by developing ways to assess professionalism (Stern, 2006). In order to form criteria against which learners could be assessed, these standards draw on virtues, the 'social contract' and professional norms but express these in terms of expected behaviours rather than abstract qualities. These definitions have been described as lacking depth as learners only aim to meet the minimum standard without truly internalising the values and virtues that their behaviour should reflect (Coulehan, 2005). In addition, the regulatory nature of these definitions tends to lead to a perception that they are punitive – that a physician who does not meet the standards will meet with negative consequences (Brody & Doukas, 2014; Finn, Garner, & Sawdon, 2010). That said, in the day-to-day practice of medicine, these definitions are most prominent as they embody the criteria against which medical students and doctors are assessed.

Although I have sought to explore the definitions of professionalism through their differences, they are not mutually exclusive and there has clearly been cross-pollination in the debate over time. Some authors have, in fact, intentionally sought to combine these approaches in order to form a holistic view of professionalism (Helmich *et al.*, 2017; Jha *et al.*, 2016). Regardless of the stance from which a definition has emerged, however, dominant narratives are embedded within it that contain implicit assumptions about a physician's gender, race, sexuality and class. Furthermore, though this has not been demonstrated in the literature, dominant narratives could also perpetuate assumptions regarding other characteristics of a doctor such as disability status and gender expression.

Following consideration of the numerous existing definitions of professionalism, for the purposes of this thesis, I am going to offer two definitions of professionalism. Firstly, I will use a pragmatic definition that applies to the context in which this thesis is being conducted. The GMC's *Outcomes for Graduates* (2016, see Box 2.1) is

Outcomes for Graduates (2016) – Part 3 – The Doctor as a Professional

"The graduate will be able to behave according to ethical and legal principles…
Reflect, learn and teach others…
Learn and work effectively within a multi-professional team…
Protect patients and improve care."

Box 2.1 – an abbreviated form of the GMC guidelines for professionalism in medical students (GMC, 2016, p. 7-10)

the standard against which UK medical students are measured and therefore this is necessarily one way in which I conceptualise professionalism, or the lack thereof. In addition, building upon the elements I have discussed, I posit my own definition of professionalism in medicine – see Box 2.2. The individual's responsibility to the regulatory body requires that she uphold the standards professed by this organisation and thus the public-facing professional collective. In addition, the duty to the public necessitates that the 'social contract', as it evolves to reflect changing culture and climate, is fulfilled. The acknowledgement that one must be

> Professionalism in medicine requires an individual to act knowingly and authentically in a manner that is acceptable to herself, her colleagues, her regulatory body and the public at large.

Box 2.2 – a novel definition of medical professionalism

accountable to one's colleagues ensures that norms are also accounted for. The requirement that the individual *knowingly* engages demands that she takes responsibility for her own professionalism. Finally, the inclusion of authenticity and the need to be accountable to oneself provides a mandate for one's behaviour to be congruent with one's attitudes, values and even identity – not merely a performance of expected behaviour. The focus of this thesis, however, is not a positive concept of professionalism but unprofessional behaviour. It is therefore vital to link the definitions of professionalism to how unprofessional behaviour is understood.

2.3. Unprofessional behaviour

The terminology used in the discussion of unprofessional behaviour varies. The label 'unprofessional' is applied both to the individuals accused of aberrant behaviour and the behaviour itself (Fargen *et al.*, 2016). The individuals concerned are also referred to as 'problem' (Brenner, Mathai, Jain, & Mohl, 2010; Steinert, 2013), 'disruptive' (Harmon & Pomm, 2004) or 'in difficulty' (Christensen *et al.*, 2016). All of these terms, however, imply a behaviour that has occurred in the context of a doctor or student who as 'fallen off the wagon'.

The vocabulary referring to the behaviour itself also varies, with Ginsburg *et al.* (2000) explicitly moving away from the term 'unprofessional' towards discussing professionalism lapses. The rationale for this explicit change in terminology is that labelling a student as 'unprofessional' is unhelpful when making a holistic assessment of the contextual factors that may have led to this behaviour. A similar logic can be applied to the use of the terms such as professionalism 'deficiencies' or 'deficits' (A. J. Bennett *et al.*, 2005; Hauer *et al.*, 2009) – that this vocabulary is

automatically associated with a discourse of failure that may not account for the complexity of the situation. Other authors use the term 'misconduct' (Yates & James, 2010), which aligns with the terminology used by the GMC to refer to significant professionalism lapses. That said, in the regulatory framework used by the Medical Practitioners' Tribunal Service (MPTS), not all lapses in professionalism amount to misconduct (GMC, 2018a), so the use of this term introduces a further question about when a transgression becomes misconduct. 'Unprofessionalism' has also been discussed in the medical education literature (Papadakis *et al.*, 2004); however, there is no explanation of whether this term is interchangeable with unprofessional behaviour or whether it is intended to look more widely and encompass the values, attitudes and norms that may equally be 'unprofessional'. For the purposes of this thesis, I will use both the terms unprofessional behaviour and professionalism lapse. Though my interest spans the behaviours, norms, values and attitudes, it is the behaviour that ordinarily brings 'unprofessional' students to the attention of medical faculty.

One of the key challenges to the discussion of unprofessional behaviour is the lack of coherent definition of professionalism. The threshold at which a behaviour becomes 'unprofessional' is dictated, at least in part, by the professionalism lens through which it is viewed. In a virtue-based definition, for example, any individual that is less than perfect falls short of the professional standard of excellence. In response to this, authors explicitly state that professionalism is "a virtue toward which physicians continually strive" (Arnold & Stern, 2006, p. 20), implying it can never be achieved. By this token, all medical students and doctors fall short and thus behave 'unprofessionally'. In view of the argument that no professional values can be applied absolutely in context but have to be weighed against one another (Ginsburg *et al*., 2000), relative lapses in professionalism must occur. In addition, virtue-based definitions have been criticised for being too abstract, meaning that they are impossible to translate into expectations and standards against which learners can be assessed (Ginsburg, Regehr, & Lingard, 2004; Ginsburg & Stern, 2004).

The call for the inclusion of professionalism in medical curricula has led to a burgeoning literature that regards professionalism as a competency – a collection of knowledge, skills and behaviours that must be achieved and assessed during medical training (Jarvis-Selinger, Pratt, & Regehr, 2012; W. Rogers & Ballantyne, 2010; Stern, 2006). This call to assess professionalism has been exacerbated by the link drawn by Papadakis *et al.* between unprofessional behaviour in medical school and later misconduct as a practising physician (Papadakis *et al*., 2004, 2005; Teherani *et al*., 2005). In spite of the small additional risk identified in these studies (Colliver, Markwell, Verhulst, & Robbs, 2007), a mandate has emerged for unprofessional behaviour to be identified in order that it can be addressed early in a learner's career (A. J. Bennett *et al*., 2005; Mak-van der Vossen *et al.*, 2016; Ziring *et al*., 2015).

A behaviourally-focused and competency-based approach has largely led to attention to behavioural definitions of professionalism, breaking down the concept into piecemeal but assessable fields (Chretien, Greysen, Chretien, & Kind, 2009; Fargen *et al*., 2016; Kitsis *et al.*, 2016; Rennie & Crosby, 2001). Although a behaviour-centric definition of professionalism makes the development of assessment criteria more straightforward (C. Sullivan & Arnold, 2009; Veloski, Fields, Boex, & Blank, 2005), this assumes a particular construct of assessment. Distilling professionalism into tick-box criteria aligns with a style of assessment that is rather simplistic and professionalism becomes a pass-or-fail competency that is achieved – or not – at specific timepoints. This approach has been criticised as not leading to assessment of professionalism but of motivation to comply with expected standards and behaviours, at least for long enough to pass an assessment (Ginsburg *et al*., 2003, 2004). That said, the assessment methods employed often do not align with itemised professionalism outcomes. Written reflection, for example, is frequently used in assessment of professionalism (Wilkinson *et al.*, 2009), a method unsuited to a behavioural definition of professionalism as it requires the learner to examine the cognitive processes and contextual factors that played a role in the outcome. In response to this, scholars have developed narrative definitions that describe professionalism to improve alignment between expectations and assessment

methods (Rawlings *et al.*, 2015; Regehr *et al*., 2012). With this in mind, using a behavioural definition on the basis of an argument that professionalism must be assessed does not hold up to scrutiny. Furthermore, this approach lacks critical evaluation of the lens through which professionalism is being viewed. The assessment of professionalism becomes entangled with the inequitable discourses of professionalism that I have explored above, thus leading to an intrinsically unfair process.

Many studies of unprofessional behaviour have not sought to define professionalism at all but have used reports of observed behaviour by medical students, faculty and doctors as the basis to explore the concept (Baldwin, Daugherty, & Rowley, 1998; Dyrbye *et al*., 2010; Fargen *et al.*, 2016; Ginsburg, Regehr, Stern, & Lingard, 2002; Reddy *et al*., 2007). These observations of professionalism lapses have been further extrapolated into 'profiles', looking to risk-stratify patterns of behaviour among medical students (Cullen *et al.*, 2017; Mak-van der Vossen *et al.*, 2016; Teherani *et al*., 2005). Academic study of unprofessional behaviour in this way assumes that study participants and researchers have a shared understanding of professionalism, meaning that they can identify a lapse when they see it. This has not, however, been borne out by Ginsburg *et al.*'s work in the field of professionalism lapses (Ginsburg & Lingard, 2006; Ginsburg, Lingard, Regehr, & Underwood, 2007; Ginsburg *et al.*, 2003). This research group's extensive study of medical students' and doctors' responses in the face of hypothetical professionalism dilemmas has demonstrated a variety of proposed 'professional' actions. Clearly the interpretation of a professionalism lapse requires an understanding of the immediate contextual factors in order to understand the competing factors that may affect the outcome. Institutional context is also pertinent to examine as institutional culture may facilitate or constrain an individual's choices when faced with a professional dilemma. For example, there may be a 'hidden curriculum' that tacitly promotes unprofessional behaviour (Jha *et al.*, 2016) or an adverse institutional culture may lead to increased stress and thus a higher propensity towards professionalism lapses (Dyrbye *et al*., 2010; West & Shanafelt, 2007).

In spite of the definition of professionalism often being related to the 'social contract', there is little academic study of what the public would perceive as 'unprofessional' or unacceptable behaviour in medical students and doctors (Jha, Bekker, Duffy, & Roberts, 2007). Furthermore, the critique that professional values are being eroded in modern healthcare environments is justified largely by a perceived loss of public trust in the medical profession (W. M. Sullivan, 2000a; van Mook *et al.*, 2009). That said, however, there does not seem to be good evidence to support this, with the medical profession still rated amongst the most trusted occupational groups (Ipsos MORI, 2017). One small-scale study suggested that the public may sanction medical students more harshly than doctors or fellow students following a professionalism lapse (Brockbank *et al*., 2011). In addition, there is evidence to suggest that the public's expectations of appropriate social media use are different to those of medical students (Jain *et al.*, 2014). With this limited evidence in mind, silencing the voice of patients and the wider public potentially leads to a constrained understanding of the acceptability of particular lapses. Given that not only the medical profession but societies more generally are becoming more diverse, the expectations of the public are likely to shift in response to this. This means that basing an interpretation of a behaviour in the absence of a renewed understanding of the sociocultural context is fundamentally restrictive and potentially exclusionary.

In view of the divergence of the professionalism and unprofessional behaviour literatures, it is clear that unprofessional behaviour is not merely the absence of professionalism. Additionally, in order that lapses in professionalism are judged fairly and equitably, it is important that the understanding of unprofessional behaviour is embedded within a fresh understanding of professionalism that is not constrained by historical understandings of what it means to be a physician. There is therefore a need to view professionalism through a new lens. In Chapter 4, I discuss the construct of professional identity formation and how this makes space for lapses in professionalism to be interpreted in the context of individuals, societies, cultures and institutions.

2.4. Summary

In this chapter, I have explored the alternative ways in which medical professionalism is understood from the perspectives of virtues, the 'social contract' and behaviours. I have critiqued these definitions in that they all constrain a definition of professionalism that applies to current medical students and workforces. In particular, I highlighted the potential inequities that may be perpetuated in terms of gender, sexuality, ethnicity and class. In the next chapter, I explore how the definition of professionalism is currently operationalised by medical schools by examining current remediation practices, including the potential impacts of inequitable understandings of professionalism in this context.

3. Remediation of Unprofessional Behaviour in Medical Students: A Survey of Current Practice in the United Kingdom

In this chapter, I present the findings of a questionnaire-based study that was undertaken to establish current practices in remediation of unprofessional behaviour in UK medical schools. In the introduction to this thesis, I explored the lack of robust evidence for remediation strategies. This study was undertaken to understand the variation in remediation practices in the UK and therefore further justify the need for a remediation framework. In the first instance, I discuss the existing literature that demonstrates inconsistent remediation practices in other contexts. I then present the findings of the questionnaire study that uncovered that educators feel uncertain about the practice of remediation and use a high degree of individualisation to design remediation interventions. I go on to discuss my interpretations of these findings, particularly focusing on potential explanations for inconsistency and thus ways in which a remediation framework could support medical educators.

3.1. Background and Context

Remediation of professionalism lapses is a high-stakes exercise. From a student perspective, demonstrating that they have successfully remediated following a professionalism lapse is vital to justify that they are fit to study and practise medicine (GMC, 2016). For faculty, remediation has been shown to be resource-intensive, requiring extensive input from senior faculty (Guerrasio, Garrity, & Aagaard, 2014; Ziring *et al.*, 2015). As discussed in the previous chapters, the work of Papadakis *et al.* (Papadakis *et al.*, 2004, 2005) linked professionalism lapses during medical school with later disciplinary action in clinical practice. This link implies that the investment of faculty resources is justified to protect patients in future (Hauer *et al*., 2009). Furthermore, there seems to be a mandate to ensure that remediation is not merely a series of hoops through which to jump: there is a

need for professionalism lapses in medical students to be effectively addressed for problems to be prevented in the long term.

In the UK, the General Medical Council (GMC) has issued guidance for medical schools, recommending that robust processes should be in place for identifying and addressing professionalism lapses (GMC, 2017; GMC & MSC, 2016). The design and implementation of these processes, however, is left to the discretion of each medical school. As UK medical schools vary significantly in size and structure, it arguably makes sense that each institution tailors their policies and processes accordingly. Leaving space for interpretation could, however, lead to a lack of parity of remediation outcomes for students at different medical schools. As I outlined in the introductory chapter, there is a lack of high-quality evidence in the field of remediation. In combination with relatively loose guidance from the GMC, it follows that UK medical schools are likely to take differing approaches to remediation.

Previous studies in North America (Ziring *et al*., 2015) and Australia (McGurgan, Olson-White, Holgate, & Carmody, 2010) have demonstrated variation in practice between institutions in their approach to addressing professionalism lapses. In particular, Ziring *et al.* (2015) reported that there were differences in the approaches to planning and supervising remediation and a lack of clarity regarding the definition of successful remediation outcomes. That said, the reported content of remediation programmes in this study was similar across the institutions they surveyed.

To date, there has been no study of UK medical schools' remediation practices. There is, however, evidence that demonstrates varying medical school fitness to practise (FtP) processes (David, Bray, Farrell, Allen, & Ellson, 2009). FtP processes are one way in which professionalism lapses might be investigated and addressed, though usually only in cases seen as particularly intractable or egregious. That said, a variation in FtP processes may imply several important things about remediation following professionalism lapses. Firstly, as the medical school must decide at what threshold students are referred for FtP investigation, there may be differences in how professionalism lapses are perceived by different medical schools, with more

'lenient' medical schools referring fewer students. Additionally, there may potentially be differences in efficacy of remediation, with some medical schools remediating more successfully and thus reducing referrals for evaluation of FtP. In either case, the variation in referrals for FtP procedures are likely to reflect a wider variation in identification and management of professionalism lapses.

In the context of this PhD study, there was clearly a need to establish the disparities and areas of need in UK remediation practices before undertaking further study to develop a framework. This study therefore aimed to examine current practices among UK medical schools and common challenges faced whilst attempting remediation for students following professionalism lapses.

3.2. Methods

In order to establish current remediation policies and practices, I designed and conducted an online questionnaire of current remediation practices in UK medical schools. Previous studies have used both written questionnaires and telephone interviews (McGurgan *et al*., 2010; Ziring *et al.*, 2015). There is evidence that suggests participants' responses vary between telephone interviews and online questionnaires, with more positive responses in telephone interviews (Dillman *et al.*, 2009). In the context of this research, participants may have been less willing to share the perceived shortcomings of their remediation practices in telephone encounters. From informal discussions, I was aware that many medical school faculty members were aware of the difficulties with their policies but were often reluctant to identify these limitations in a public forum. With this in mind, managing professionalism lapses could be deemed a relatively sensitive area of questioning: though it is not sensitive to an individual, it may be sensitive from the perspective of institutional reputation.

There is evidence that there is a significant social desirability bias effect in face-to-face surveys on sensitive topics (Krumpal, 2013), thus suggesting that face-to-face encounters were unlikely to offer insights into participants' true perceptions of their

institution's remediation practices. Furthermore, though Ziring *et al.* (2015) used telephone interviews, the undergraduate medical education community is significantly larger in North America and thus relatively anonymous compared to the UK. Overall, I felt that an online questionnaire with a guarantee of anonymity was most likely to yield honest responses. I therefore elected to use an online questionnaire to preserve anonymity, so that participants would feel more able to openly share their institution's approach (Dillman *et al*., 2009). Answers were anonymised by both individual respondent and institution to ensure that participants could not be identified.

The questionnaire (see Appendix 1) included details of the demographics of the institution, followed by questions about their remediation practices. I used the findings of Ziring *et al.* (2015) to inform the design of questions. The questionnaire was piloted at the University of Liverpool to ensure that the questions were fit-for-purpose and the question wording was refined in light of this. The online platform Qualtrics© (Qualtrics, Provo, USA) was then used to disseminate the survey. Ethical approval was granted by the University of Liverpool's Health and Life Sciences Committee on Research Ethics (ID 1008, December 2016; see Appendix 3).

3.2.1. Sampling and recruitment

Participants were identified through personal contacts in the medical education community and via the UK Council on Teachers of Professionalism. Individuals were emailed and asked to nominate one participant in their institution who would be able to provide details of the remediation processes for unprofessional behaviours amongst their students. All 36 UK medical schools currently offering a Primary Medical Qualification (PMQ) were invited to participate. The invitation email contained a link to the anonymous online questionnaire. Fully informed consent was obtained prior to participation. A further prompt email was sent six weeks later to maximise the response rate.

3.2.2. Analysis

Free-text answers were analysed using a combination of inductive and deductive approaches. In the first instance, based on the findings of Ziring *et al.* (2015),

individuals, groups and methods expected to be involved in remediation were identified *a priori*. After a first reading of the data, categories were added in light of the responses and a second reading was undertaken to record each institution's responses (Thomas, 2006).

A deductive approach was then used to code and group together segments of text deemed to have significant meaning. Free-text answers were read again in full, manually highlighted and assigned illustrative codes. These codes were then grouped into descriptive categories as reported below. As the dataset was small and written responses relatively brief, a further iterative process to develop overarching themes was not possible (Braun & Clarke, 2006).

3.3. Results

Of the 36 schools invited to participate, 13 (36%) completed the questionnaire in full. Of these schools, eight were in England, three in Scotland, one in Northern Ireland and one participant declined to declare a location. Twelve of the 13 respondents represented public institutions, with one participant from a private medical school. Of the 12 public institutions, eight took both undergraduate- and graduate-entry students, whilst the remaining four are undergraduate-entry only programmes. This is broadly representative of the medical schools invited to participate.

3.3.1. Variation in practice

A key finding from this survey was the variation in practice that was reported. In the first instance, this was demonstrated by the methods reported for identification of unprofessional behaviour (see Table 3.1). Interestingly, only one quarter of respondents identified a formal reporting system for professionalism lapses, in spite of guidance from the GMC that such a system should exist (GMC & MSC, 2016). That said, at the time this study was conducted, the GMC guidance was relatively recent and thus practice may have changed in the intervening years.

Method of identification	Frequency of reporting
Reporting by academic staff	9
Reporting by peers	6
Reporting by healthcare staff	5
Formal reporting system	3
Academic assessment process (e.g. plagiarism in written work)	3
Fitness to practise proceedings	3
Professionalism committee	2
Attendance monitoring	2
Portfolio process (e.g. 360^{o} feedback)	2
University disciplinary process	1
Reporting by patients	2

Table 3.1 – Reported methods by which professionalism concerns are identified in UK medical schools.

Individual or team	Planning	Supervision
Head of School or equivalent	6	4
Year/divisional lead	5	5
Personal tutor	2	2
Senior management team	2	-
Progress/professionalism committee	2	-
Named professionalism lead	2	1
Support service	2	1
Conduct/FtP[a] committee	1	1
Student	1	-
Specified faculty member	-	2

Table 3.2 – Individuals or teams identified as being involved in planning and supervision of remediation following unprofessional behaviour in UK medical schools.

[a] FtP = Fitness to Practise

In addition, though senior faculty staff were commonly involved in planning and supervision of remediation, the level of seniority and number of individuals involved varied across institutions (see Table 3.2 above). In some schools, the responsibility seemed to fall predominantly to one individual, for example the Head of School, whereas in others, a purpose-built team – such as a professionalism committee – was involved. Notably, only one institution identified a named professionalism lead as responsible for supervising remediation. That said, a number of respondents identified a multi-disciplinary approach to planning and supervision of remediation as a key strength of their institution's process, which may obviate the need for a single named individual.

3.3.2. An individualised approach to remediation

Schools often reported that the individual(s) involved in planning and supervising remediation were defined by the perceived severity of the case:

> [it]*…depends on what has happened, how serious it is, whether it is more academic or personal behaviour. There is a professionalism lead, Dean for students, it might be the year lead in first instance, if more related to personal behaviour may be personal tutor. If serious monitored by SPMC (student progress monitoring committee) chaired by Dean for students.*
>
> SCHOOL 4

This approach to remediation, tailored to the behaviour in question and the individual student, was also reflected in reported approaches to constructing an appropriate remediation plan:

> *Our view is that remediation should be appropriate… A remediation plan is always dependent upon the incident of concern itself, and whether students are already known to us due to previous lapses in professional behaviour.*
>
> SCHOOL 10

In a minority of schools, this individualisation of the remediation strategy was achieved by active involvement of the student concerned, reflecting the GMC's guidance that students should take a lead in their own remediation (GMC, 2017):

> *Usually in partnership with the student… Our philosophy is that learners should actively engage in the construction as well as engagement of remediation.*
>
> SCHOOL 2

In view of the reported individualisation, it is clear to see how uncertainty could arise as to what remediation should look like.

3.3.3. Uncertainty around how best to remediate

Respondents commonly reported uncertainty in their remediation processes. In particular, many respondents expressed a lack of certainty in how to assess a successful outcome:

> *It is often hard to define that someone has adequately improved from their unprofessional behaviour. Professionalism is highly context specific so someone may be able to be professional when being observed or write a reflective piece showing remorse but it is harder to be sure that action will not be repeated.*
>
> SCHOOL 3

Indeed, one participant – in response to a question about ensuring remediation has been successful – identified that only the continuing lack of professionalism lapses can indicate success:

> *Usually that the student has not come to our attention for any further adverse behaviour!*
>
> SCHOOL 10

This indicates that medical schools never feel entirely secure in their remediation as there is no guarantee that professionalism lapses will not occur at some stage during a long postgraduate career. In addition, the implication of this statement is that all professionalism lapses would be perceived as linked. This suggests that, following a professionalism lapse, a student's behaviour must be beyond reproach for the remainder of their medical school career in order to be 'successfully' remediated.

One facet of the remediation process that seemed to cause uncertainty across institutions is whether remediation should be incorporated into, or separated from, a sanctions process. Indeed, as illustrated by this quotation, some schools only employed sanctions in the most severe cases:

> *It's artificial to draw a clear distinction. A sanction is likely only to be applied if the student has been considered under the FtP procedures. The difference is that the sanction would be applied by FtP and the student's progress may be monitored by FtP who may wish to meet with the student again before concluding the case. The student may, however, be supported in the remediation/sanction process by the Year Director and the Head of Student Welfare.*
>
> SCHOOL 13

Approximately one third of schools reported a clear distinction between sanctions and remediation, one third that the two are combined and one third that this depends of the case in question. This arguably indicates that the boundary between 'remediation' and 'sanctions' is blurred and is likely to be open to interpretation by both students and faculty. Furthermore, the interpretation of this intervention is likely to vary between schools, depending on their philosophy regarding the process for addressing professionalism lapses, as I will discuss further below.

In summary, methods for identification of unprofessional behaviour do seem to vary across the UK and medical schools task different individuals with the management of professionalism lapses. Furthermore, institutions seek a proportionate approach, with remediation tailored to the type of lapse and the individual student concerned.

Importantly, there is residual uncertainty about what successful remediation looks like. In addition, there is a suggestion that the language and philosophy surrounding remediation – exemplified by the distinction between sanctions and remediation – varies between institutions, which may have important implications for the approach to the 'unprofessional' medical student.

3.4. Discussion

An important outcome of this study is the confirmation of Ziring *et al.*'s (2015) findings in the UK context: there is indeed variation in the people, teams and structures that underpin remediation following professionalism lapses. The respondents here identified that senior faculty such as the Dean were often involved in both planning and implementing remediation strategies. Furthermore, these senior decision-makers were not alone: institutions mobilised multi-disciplinary teams to address professionalism lapses. This seems to confirm previous claims that remediation is a demanding task for faculty (Guerrasio *et al.*, 2014; Mak-van der Vossen *et al*., 2019a), a finding that does not even begin to account for the cost to the learner. With this in mind, there is clearly a need to ensure that faculty resources are used effectively and remediation is appropriate for the needs of the students.

The involvement of very senior faculty potentially reflects the lack of certainty reported by participants: the responsibility for making these challenging decisions must be taken by a senior member of staff or an experienced team as a means of increasing confidence in decisions. Uncertainty may also be a result of the challenge of understanding whether a student's contrition in response to a professionalism lapse is genuine. Furthermore, senior faculty may be relied upon to make these judgements simply on the basis that they have met the greatest number of learners in this position before and thus have the greatest anecdotal experience in the absence of any structured training. These potential explanations for the reported uncertainty are explored below. Furthermore, a key finding of this study was the individualised approach to remediation of professionalism lapses. In order to

understand the consequences of these findings for this thesis, it is important to explore why this individualised approach has arisen and the impact it may have on remediation practices.

3.4.1. Faculty as a source of inconsistency

As discussed above, this study suggests that – in the UK context – responsibility for addressing professionalism lapses falls to senior faculty. This implies that length of service in medical education confers expertise in the field of remediation of professionalism lapses. Careers in medical education, however, are extremely diverse and an individual could easily become dean of a medical school with little experience of assessing professionalism lapses. Furthermore, according to the responses in this study, few medical schools are making use of a professionalism lead with specific responsibility and skills in the field of professionalism. This is particularly surprising in view of the recruitment method in this study: I invited participants via the UK Council for Teachers of Professionalism. This recruitment method would suggest that professionalism leads would be invited to participate and would therefore be well represented by the findings of this study. Overall, this seems to suggest that there exists a clear separation between the teaching of professionalism and the management of lapses. Furthermore, senior faculty are given responsibility for remediation of lapses, regardless of previous experience or training. There have previously been calls in the literature for faculty development to support remediation of professionalism lapses (Papadakis *et al.*, 2012; Steinert, Cruess, Cruess, & Snell, 2005); however, the concept of a 'professional remediator' does not seem to have developed in response to these calls.

Furthermore, the approach of different educators is likely to differ. In the realm of assessment in medical education, the concept of 'hawks' and 'doves' is often used (McManus, Thompson, & Mollon, 2006). This describes the natural tendency for some assessors to be strict ('hawks'), whilst others are lenient ('doves'). In the context of examinations, statistical methods are often employed to reduce the differences between assessors with the aim of improving consistency of assessment. In the context of evaluating professionalism lapses, however, this study suggests

that few individuals are involved and there may be a lack of checks and balances to ensure consistency and fairness for learners.

In addition, the professionalism lapses that come to the attention of university faculty in the UK are likely to represent the tip of the iceberg. During the clinical years of medical courses, students are ordinarily distributed to a variety of placement sites and central faculty only become aware if lapses are reported, which may not happen consistently. The concept of 'failure to fail' is well described in medical education (Mak-van der Vossen, 2018; Ziring, Frankel, Danoff, Isaacson, & Lochnan, 2018): faculty often express reluctance to report professionalism lapses as they are concerned about the consequences for themselves and learners alike. This is likely to mean that universities only become aware of a relatively small proportion of professionalism lapses amongst clinical medical students. That is not to say that clinical placement sites and individual clinical supervisors are ignoring lapses: they may well be addressed via local, informal processes. A reluctance to escalate professionalism lapses would suggest, however, that the number of individuals involved in remediation is not fully reflected by the findings of this study as it has only captured remediation of lapses of which universities are aware.

One of the key drivers of reporting of lapses may be the perceived severity of the lapse. This implies that there is a qualitative difference between lapses: beyond a certain threshold, educators feel that there is an imperative for lapses to be reported. That said, the threshold for this imperative to report is not clear and is likely to be influenced by factors such as the learner-supervisor relationship and the educator's previous experience of reporting lapses (Ziring *et al*., 2018). The impact of varying thresholds for reporting and addressing lapses is discussed in the following section.

3.4.2. Thresholds as a source of inconsistency

As I have already discussed, in the UK the processes for managing the most severe professionalism lapses fall under the umbrella of FtP proceedings; however, the threshold for referral to FtP varies widely even within a relatively small number of UK institutions (David & Ellson, 2015). Furthermore, the threshold for formal

reporting of lapses is likely to vary between institutions, partly as a result of the structures that are in place to encourage reporting (Ziring *et al.*, 2018). Importantly, these thresholds for reporting have an impact upon remediation practices.

In the first instance, setting a tacit or overt threshold for reporting of professionalism lapses implies that lapses are qualitatively different. In this study, respondents identified differing approaches depending on the perceived severity of the lapses, as reflected by the quotation from School Four above. Mak-van der Vossen and colleagues (2016) have sought to describe types of behaviour that are particularly troubling; however, they suggest that learners who do not demonstrate improvement following professionalism lapses should raise concern. This indicates that the behaviour itself may be of little consequence: instead, a learner's response to it is a more important consideration. This has important implications for reporting and recording of professionalism lapses as it suggests that making judgements about the severity of a lapse may be less important than giving learners a meaningful opportunity to demonstrate change. In order to identify learners that have not adequately addressed lapses, educators must be aware of all lapses and have the opportunity to intervene and follow a learner's progress longitudinally. In this study, one of the key findings was the lack of certainty regarding successful remediation outcomes. This may be explained in part by lack of reporting of low-level lapses as opportunities to develop relationships with learners and track progress over time are likely to be restricted.

In addition, if low-level professionalism lapses are not reported, there may be missed opportunities for early remediation interventions. If only the most severe lapses are reported, a conflict may arise between supportive and punitive actions. This may reflect the difficulties expressed by some institutions in differentiating sanctions from remediation. The current literature recommends separation of remediation from decisions about a student's fitness to progress (Kalet *et al.*, 2016). If medical schools only become aware of students following egregious lapses, however, rapid, high-stakes decisions about a students' progress may have to be made. Under these circumstances, there may then be little opportunity for

supportive remediation interventions. Furthermore, the distinction between support and sanctions may not be entirely possible as educators cannot account for a learner's interpretation of a remediation plan, as I will explore in the following section.

3.4.3. Crime and punishment?

One of the findings of this study was the variation in the degree to which sanctions and remediation are separated. In many ways, the distinction between supportive and punitive interventions is likely to be made by the learner. For example, a learner may be required to repeat an element of the course if poor attendance or engagement has been flagged as a professionalism issue. The university may deem this a remediation intervention: it is intended to ensure that the learner has met the necessary educational outcomes. The learner, however, may view this as unduly punitive as it curtails their holiday time, meaning they miss out on time for work, leisure and travel. This suggests a need for a clear philosophical stance regarding remediation and sanctions that is shared with learners as part of the process.

When analysing medical schools' approaches to remediation, it is possible to draw parallels with the criminal justice system. In the first instance, both professionalism lapses (S. R. Cruess & Cruess, 2004; Samanta & Samanta, 2004) and criminal offences (Rawls, 1999) are viewed as breaches of the terms of a social contract. Furthermore, in both instances, protection of the public is used as the key rationale for addressing the behaviour in question (Kemshall & Wood, 2007; Papadakis *et al*., 2012; Van Mook, Gorter, *et al*., 2010). Additional comparisons can be drawn regarding the intentions of addressing behaviour. In both academic literature and in the mass media, there is an ongoing debate regarding the purpose of the criminal justice system (Daly, 2012): should perpetrators be punished for their crimes or supported to facilitate integration back into society? Similarly, in the wake of professionalism lapses, there is a lack of clarity about whether remediation should be punitive or supportive.

In the UK, the GMC guidance regarding student fitness to practise uses the term 'sanction' to describe potential responses by medical schools to professionalism

lapses (GMC & MSC, 2016). The term 'sanction' certainly implies punitive intent: that the rules have been broken and a penalty must be applied. Though this guidance only refers to cases that potentially meet the threshold for FtP, it sets a tone for medical schools addressing lapses at all levels. Furthermore, the GMC recommends that attempts to demonstrate remediation should be led by the student with support from their medical school (GMC, 2017). This seems to place an onus of guilt on learners and requires them to 'dig themselves out' with little guidance. That said, this does not seem to be the approach taken by the medical schools who responded to the survey: where students were involved, the requirement was for 'active engagement', rather than overall responsibility. In addition, requirement for the student to drive their own remediation is out-of-step with the academic conversation, where the emphasis of remediation is placed on support, particularly early on in the journey (Kalet & Chou, 2014; Mak-van der Vossen *et al*., 2019a).

Fundamentally, in order to delineate the approach that is best suited to professionalism lapses, an understanding of the 'unprofessional' student is required. In the same way that criminals can be seen as either intrinsically bad people or individuals whose behaviour has resulted from a complex interplay of circumstances (Raynor & Robinson, 2005), so too can medical students been seen as fundamentally 'unprofessional' or individuals that have found themselves without the skills and knowledge to negotiate complex professional situations (Ginsburg *et al.*, 2000). Differing philosophies have important implications for remediation strategies and some of the uncertainty reported by participants in this study may reflect a lack of open professional conversations on this topic. Indeed, the difference between 'hawks' and 'doves' in assessment of professionalism may boil down to this: 'hawks' believe that 'unprofessional' students are bad apples whilst 'doves' view them as passive victims of adverse circumstances, with many differing interpretations in between. In order to understand how to approach remediation, it is clearly necessary to interrogate the origins of differing interpretations of professionalism lapses.

3.4.4. Individualisation as a source of (necessary) inconsistency

The data from this study suggest that medical schools are making attempts to address professionalism lapses: medical schools seem to be going to great lengths to design remediation programmes that are appropriate for the student at hand. This reflects much of the recent literature on the topic of remediation that recommends seeking to 'diagnose' a learner following a professionalism lapse (Guerrasio *et al.*, 2014; Kalet & Chou, 2014; Kalet *et al.*, 2016). This process involves drawing up a list of 'deficits', which are then addressed in turn (Guerrasio *et al*., 2014). The aim of this approach is to provide a package of measures that effectively 'treats' the problems that are deemed to have led to the professionalism lapse. There is, however, little guidance about how this 'diagnosis' is made, who should make it and remediation measures that might be used.

Taking a 'diagnosis of deficits' approach necessitates a different remediation plan for each student: it is impossible to have a one-size-fits-all structure as the combination of 'deficits' is likely to be different in each case. This may explain why each new student seems to require a new, individualised approach. Logic should dictate, however, that there is a finite list of 'deficits', which could be matched with one or more effective remediation strategies. Over time, it should be possible to identify strategies that are successful for remediation of a given deficit, which can then be linked together in ways that are eventually predictable. Based on the reports of the participants in this study, however, there does not seem to be a sense of a structure developing over time.

Furthering the medical analogy, this 'diagnosis of deficits' approach is not truly diagnostic: it seeks to identify and address a range of symptoms without formulating a unifying diagnosis and accounting for the complexity of the interactions between the 'deficits'. Individuals are, after all, more than a collection of deficits that need addressing and this approach risks remediation being piecemeal and disjointed (Guerrasio *et al.*, 2014; Kalet & Chou, 2014). Fragmenting an individual into a list of their 'deficits' risks missing the true explanation of the professionalism lapse altogether. For example, a student may be referred for mental health assessment

following a professionalism lapse, diagnosed with anxiety and treated with medication. This does not, however, address the reasons the student did not seek help prior to the lapse; the feelings that she has about the diagnosis and treatment; or her interpretation of the impact of the diagnosis on her professionalism. Although Ziring *et al.* (2015) reported that a mental health assessment was an almost universal tool in planning remediation, this is only one potential contributory factor to professionalism lapses and a mental health problem may have had little or no impact on the lapse in question.

In addition, a 'diagnosis of deficits' approach may be an unhelpful lens through which to assess a learner following a professionalism lapse: seeking a 'diagnosis' implies that the student is diseased or unwell. Ginsburg *et al.* discussed the importance of avoiding labels such as 'unprofessional' as they that this could be stigmatising and unhelpful to learners (Ginsburg *et al.*, 2000; Ginsburg & Stern, 2004). Furthermore, implying that a student is 'sick' and in need of 'treatment' removes the imperative to address contextual factors such as institutional policies that may have contributed to the lapse (Jha *et al.*, 2016), instead making the learner solely responsible. In this study, participants did seem to acknowledge the context in which professionalism lapses have occurred. This may, in part, explain the degree of individualisation that was reported: not only is each learner unique but the interplay with the context is complex and creates myriad possibilities for addressing professionalism lapses.

Overall, a truly holistic approach to remediation that accounts for contextual factors is likely to necessitate a bespoke, case-by-case approach that may seem inconsistent to an external observer. With this in mind, it is important to develop an understanding of the individuals that experience professionalism lapses as this will enable remediation to be truly tailored to their needs, rather than their 'symptoms'.

3.4.5. Performativity as a source of uncertainty

One of the concerns often expressed in informal discussions around addressing professionalism lapses is whether a student has learned to 'play the part' and not fundamentally changed their attitude following remediation. This is alluded to in

the quotation from School Three above: modification of behaviour alone potentially demonstrates that the student has merely learned to 'fake it' more effectively. This raises a key question about the purpose of remediation: is it sufficient for learners to perform the role of 'the professional student' or does remediation need to address something more deep-seated, for example their professional identity. In order to explore whether a performance of professionalism represents effective remediation, there is need to develop a better understanding of professionalism lapses in medical students that goes beyond an attempt to quantify behaviours and looks instead to understand the individual learners' experiences. In the following chapter, I discuss professionalism in terms of identity formation and the opportunity that identity theory presents for increasing understanding of professionalism lapses.

3.4.6. Study limitations

One of the clear limitations of this study that restricts the strength of the conclusions that can be drawn is the low response rate. Though similar response rates have been reported with online survey methodologies (Cook, Heath, & Thompson, 2000), the limited possible sample compounds the effect of the low response rate. That said, when this study is placed in the wider context, it is reassuring that some of the key findings replicate those of previous studies conducted outside the UK.

One of the potential critiques of this study, particularly in view of the low response rate, is that I only sought a single perspective from each institution. This was intended to preserve anonymity: had I sought multiple responses from each institution, identification by institution would have been required to ensure some institutions were not grossly over-represented. As I have discussed above in relation to thresholds, however, there are many different ways in which professionalism lapses may be identified and the myriad methods by which these are addressed may not be fully encompassed by this study. In the majority of cases, the questionnaire was directed to a senior faculty member, such as the programme or professionalism lead. This potentially skews the findings toward more serious cases that would come to the attention of senior faculty. These individuals should

also, however, have a good overview of the institutional policies for professionalism at all levels, giving them the insights required to give in-depth answers.

A further limitation is that this study did not seek to define unprofessional behaviour or set a threshold for the remediation practices in which I was interested. This was a deliberate choice, in that I was interested in the institution's interpretation of professionalism lapses and remediation. In order to understand this more fully, however, I would have needed to ask more questions designed to explore the respondents' interpretations of professionalism lapses and remediation. In spite of these limitations, however, this study has provided useful insights to inform the design of further research areas that may contribute to the creation of a framework for the remediation of unprofessional behaviour.

3.5. Conclusion

This study was designed to explore the landscape of remediation of professionalism lapses in the UK. I have identified important variations in practice across the UK, which seem to be driven in part by a need for educators to design bespoke remediation programmes for each student that experiences a professionalism lapse. Furthermore, there are potential issues with understanding professionalism lapses in medical students: currently behaviours seem to be arbitrarily judged on the basis of severity, in spite of emerging evidence that this may not be a helpful approach. In addition, this judgement of severity may well vary between individual educators, producing inconsistency in reporting of professionalism lapses and limiting medical schools' ability to effectively address them.

I have also discussed the potential impact of individual and institutional perspectives on professionalism lapses: if students are judged to be 'bad' in the wake of professionalism lapses, this implies that capacity for remediation and demonstrating improvement is limited and the only recourse medical schools have is punishment. On the other hand, students may be seen as victims of circumstance in the wake of lapses, which would suggest that there is no meaningful need to address the behaviour with the student. Though these are both likely to represent artificial

extremes, there is clearly a need to understand why such variation in interpretations of professionalism lapses exists.

Overall, this study has provided an outline for the remainder of this thesis. Next, I need to look for new ways of conceptualising professionalism and its development. Using this fresh understanding of professionalism, I can then develop a new holistic understanding of students who experience professionalism lapses to identify a common 'target' for remediation. These understandings can then be translated into a framework to support educators in delivering remediation that is consistent and fair across institutions.

4. A review of the professional identity literature

In Chapter 2, I outlined what *being professional* means through careful evaluation of existing definitions of professionalism. In Chapter 3, I examined how UK medical schools manage professionalism lapses. In particular, I highlighted the ways in which current remediation policies may be problematic for both students and institutions. I identified a need to develop a better understanding of unprofessional behaviour and what it represents. Here, I explore existing theories that have been used to understand how individuals *become professional*. In particular, I critique theories of identity formation that have been applied to medical education and the limitations of these constructs of identity. I highlight the multifaceted, contextual nature of identities. Finally, I discuss how identity formation may shift our understanding of unprofessional behaviour and the implications of identity theories for my research.

4.1. Becoming professional

In spite of the long-standing calls for professionalism to be explicitly taught (S. R. Cruess & Cruess, 1997), how this is done in practice remains uncertain (Goldie, Dowie, Cotton, & Morrison, 2007). Medical curricula now routinely include medical ethics teaching (Birden *et al.*, 2013) and medical schools require that their learners adhere to a code of conduct underpinned by an understanding of professionalism (Ziring *et al.*, 2015). Empirical observation, however, suggests that explicit teaching does not stand up to the challenges of dilemmas faced by learners in clinical environments (Coldicott, Pope, & Roberts, 2003; Feudtner, Christakis, & Christakis, 1994; Myers & Herb, 2013; Satterwhite, Satterwhite, & Enarson, 2000). In particular, the 'hidden curriculum' – as I touched on in Chapter 2 – plays a role in presenting students with experiences that conflict with the values they are taught (Gaufberg *et al.*, 2010; Martimianakis *et al*., 2015). Authors in medical education have shifted towards mandating that students cannot simply learn professionalism but must *become* professional, that is, developing a professional identity (R. L.

Cruess *et al.*, 2016a; Hafferty, 2016). The concept of identifying as a doctor in this manner is not new, as illustrated by this oft-cited quotation on the task of medical education:

> "*…to provide him with a professional identity so that he comes to think, act, and feel like a physician"* (Merton, 1957, p. 5)

Many understandings of identity have been applied to characterise how individuals develop professional identities in medicine. In order to understand the theoretical paradigms that have been used to understand identity formation in medical education, however, first the concept of identity must be understood. Identity is, loosely speaking, an individual's sense of self; however, the exact interpretation of this construct depends on the context of the discussion and the theoretical position of the discussant (Côté, 2006). Many lines have been drawn in the academic debate about identity, including: whether it is a personal or a social phenomenon; whether an individual has a single or multiple identities; and the extent to which one's identity fluctuates (Vignoles, Schwartz, & Luyckx, 2011).

At one end of the spectrum in the identity literature is an understanding borne out of the psychoanalytic and developmental psychology literature. One of the foundational authors in this school of thought, Erikson (1968), drew heavily upon Freud's concept of the self in his understanding of identity formation. Erikson and the subsequent proponents of his work (Schwartz, 2001) see identity as individual, ego-centric and singular. Furthermore, Erikson's (1968) concept of identity development suggests that this is a linear, unified process of self-discovery that happens most rapidly during adolescence and young adulthood and, once completed, is relatively fixed and inflexible.

A competing view of identity is derived from disciplines such as sociology (Chen, Boucher, & Kraus, 2011) and has been translated into methodological approaches such as discourse analysis (De Fina, Schiffrin, & Bamberg, 2006). Using these theoretical frames, identity is seen as a product of the social, political and cultural environment in which an individual exists. Formation of identity occurs through social interactions between an individual and the environment and is facilitated or

constrained by the expectations of others. These expectations may be defined by family, friends, colleagues and other individuals or may be the result of wider socio-political narratives. Furthermore, a socially-constructed identity may apply beyond an individual to members of a collective or group (Vignoles *et al.*, 2011). At this end of the spectrum, identities are often conceptualised as multiple, with an individual negotiating between identities in differing contexts. In addition, as identities are developed within a particular context, these identities evolve as the context shifts over time. This means they are fundamentally fluctuant and constantly being reinterpreted. Relatedly, Goffman (1956) observed that identity is performed in a particular context to meet the expectations of the 'audience'. For example, a junior doctor may give a performance of a kind, patient, caring identity in the presence of a patient and a performance of an impatient, frustrated, under-appreciated doctor with her peers.

Some concepts of identity have evolved to a particular end, for example intersectional identity. Intersectionality theory was developed by Crenshaw in response to her observation of the compound social injustices faced by a black woman (Crenshaw, 1991). In this understanding, identity is necessarily multifaceted but also unified in that one's relative privilege or disadvantage is a product of a complex interplay of factors. I refer specifically to this concept of identity as there has been a call for it to be applied to the study of professional development in medical education (Monrouxe, 2014). Furthermore, in view of the arguments I have highlighted about the potential inequalities inherent in definitions of professionalism, understanding identity through this lens may help to clarify the complex interaction that occurs during professional identity formation.

4.1.1. Applying identity theory to professional development

I have highlighted the dichotomies in the understanding of identity in order to better understand the way in which professional identity formation has been discussed in the medical education literature. Two dominant narratives have emerged in this discussion, each representing one end of the identity spectrum. Firstly, medical education scholars have drawn on the work of Kegan (1982), who rooted his

understanding of identity formation in the work of cognitive psychologist Piaget, as well as drawing on the work of Erikson (1968). In his work, Kegan (1982) developed a six-stage theory of transformative 'meaning-making' that occurs across an individual's lifetime, with a transition between each stage and the next (see Figure 4.1). These transitions were described by Kegan in terms of shifts in an

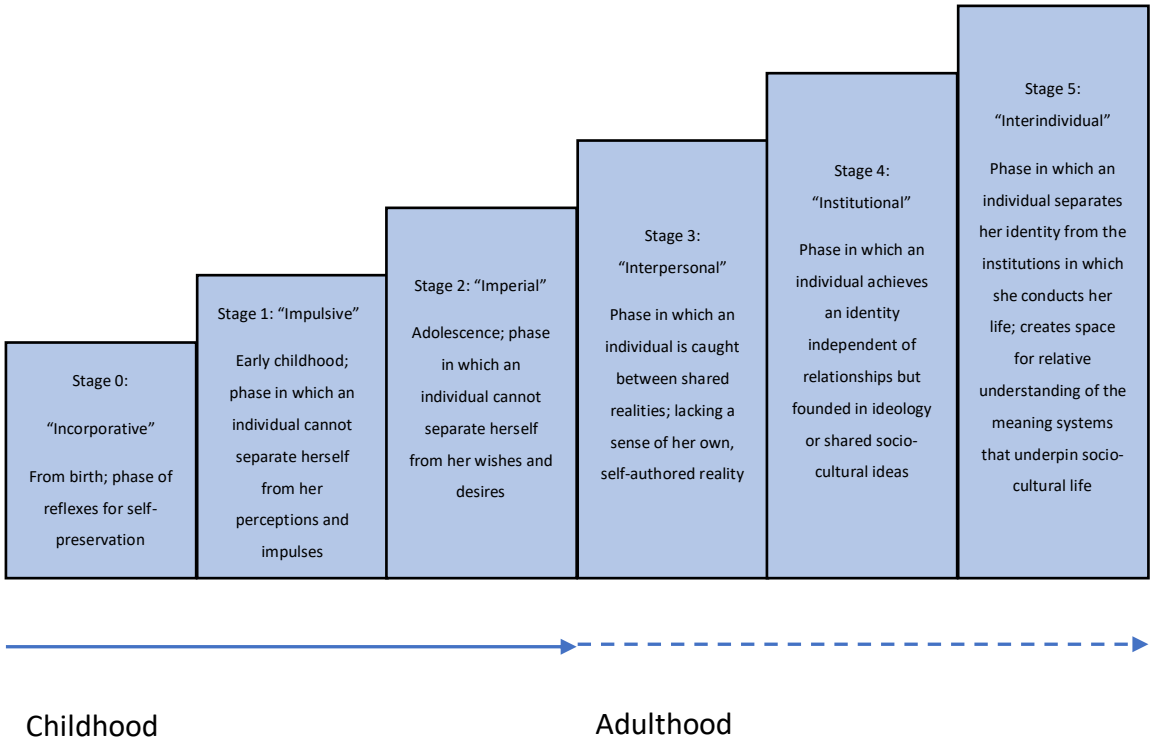

Figure 4.1 – a representation of Kegan's theory of socio-cognitive development (Kegan, 1982)

individual's understanding of their own identity from something they *are* (subjective) to something they *have* (objective). So, for example, in the interpersonal phase of Kegan's model, an individual may view herself as a product of her relationships with others, the transition to the institutional phase is marked by an understanding of these relationships as something she has and thus can exercise autonomy over. In Kegan's understanding, not all individuals achieve the full developmental process, though most reach the interpersonal stage as they become adults.

The implication in the observation that not all adults reach full 'maturity' is that identity is something at which an individual can succeed or fail, with an optimal end-goal. In addition, this one-directional, step-wise process suggests that there is only one route to 'achievement' of a mature identity, without the possibility of

regression. Furthermore, in the final stage of this model, an individual is able to separate her sense of self from both her interpersonal relationships and the wider sociocultural context, implying that defining one's identity in context is actually a form of immaturity. This model has been translated into an understanding of the process of 'moral' identity formation in medical students (Jarvis-Selinger *et al.*, 2012) and has also been advanced as a framework against which identity formation could be assessed (Bebeau & Faber-Langendoen, 2014; Kalet, Buckvar-Keltz, *et al*., 2017). In particular, the use of Kegan's model as an assessment framework reinforces one of my key critiques of this theory, which is that identity formation is a linear process with a clearly defined successful outcome. I would argue that a hegemonic discourse underpins the interpretation of identity formation as 'correct' or 'incorrect', closing down space for alternative cultural understandings that may not perceive identity as individual (Markus & Kitayama, 1991). In addition, the view that identity formation has a fixed end-point has led to an interpretation of professional identity formation as a process that concludes upon the completion of formal training (R. L. Cruess, Cruess, Boudreau, Snell, & Steinert, 2015). Empirical study, however, has led to an appreciation that a doctor does not merely identify herself as 'doctor', but through her subspecialty and role within a given team (Joynes, 2017). Furthermore, a medical student identity – even at completion of training – is not the same as a doctor identity. Hilton and Slotnick (2005) described medical students as 'proto-professionals' in that they had learnt the rudimentary aspects but needed to hone their professionalism in practice. In this way, a medical student leaves medical school with some of the tools to *become professional* but must develop further according to the context in which she finds herself (M. Ryan & Carmichael, 2016). Thus, an individual continues to re-interpret her professional identity depending on her shifting role and the wider context.

At the opposite end of the identity formation spectrum, the concept of 'socialisation' has become popular in the medical education literature (R. L. Cruess *et al*., 2015; Hafferty, 2016). This literature often draws upon empirical studies of medical learner's experiences and the influence upon their identity formation (Becker, Geer, Hughes, & Strauss, 1961; Byszewski, Hendelman, McGuinty, &

Moineau, 2012; Levine, 2015; Merton, 1957; Pitkala & Mantyranta, 2003). 'Socialisation' as a means of professional development relies on learners being 'inculcated' into the culture of medicine. Through observation of, and participation in, the clinical *milieu*, medical students acquire the language and practices of the doctors with whom they associate (R. L. Cruess, Cruess, & Steinert, 2018; Lave & Wenger, 1991). This construction makes space for the collective nature of medical identity – with its rituals and subculture – as well as for the adaptation of an individual's professional identity within changing clinical teams, institutions and wider socio-political narratives. The challenge that this conceptualisation poses, however, is that the learners themselves lack agency, merely being a product of the system in which they train. In order to challenge the 'hidden curriculum', however, learners must engage in a degree of critique of the context in which they find themselves, allowing for shifts in medical culture over time. Furthermore, I argue that 'socialisation' is an attractive concept due to its simplicity. Though socialisation may describe the journey of a 'typical' medical student, it does not allow for the complexity experienced by students from diverse backgrounds whose identities may not neatly fit within the medical *milieu* (Crenshaw, 1991). It is therefore necessary for me to explore further conceptualisations of identity theory that allow for the nuance of lived experience.

One theory that has been applied to the study of medical student identity formation that allows for both identities that are multiple, complex and underpinned by a unified sense of self is that of Figured Worlds (D. Bennett, Solomon, Bergin, Horgan, & Dornan, 2017; Dornan, Pearson, Carson, Helmich, & Bundy, 2015). Figured Worlds theory evolved from Goffman's (1956) understanding of identity performances: not only are identities developed in context but the performance of an identity adapts to the audience at hand. Figured Worlds theory is a complex theoretical construct that was developed from a synthesis of empirical work studying identity across a variety of social and cultural contexts (Holland, Lachicotte Jr., Skinner, & Cain, 1998). Holland *et al.* (*ibid.*) describe identity as formed in social relationships and embedded in cultural practices, with groups developing shared identities through rituals and practices. They also, however, acknowledge that the extent to which an

individual identifies with a given social group or cultural paradigm is self-defined and thus the degree to which the individual adopts the practices and classifies herself as a member of the group cannot be assumed. For example, a medical student that feels alienated from the dominant social practices of medical school due to her prior sociocultural background may elect to resist developing a 'conventional' medical student identity. In this way, Figured Worlds theory seems to make space for aspects of identity, such as race and gender, to be closely-held and thus relatively fixed and seemingly foundational to all other interpretations of the self. In addition, there is potential for identity to be influenced by an individual and the context in which they find themselves, thus allowing for multiple, complex identities that shift over time.

The importance of exploring concepts of identity and its formation is that it highlights the internal inconsistencies in the dialogue within medical education. In spite of the emphasis on the development of a professional identity in the clinical setting and the link drawn between this and professionalism more generally (R. L. Cruess *et al*., 2015), understandings of identity have not been translated into working definitions of professionalism. Returning to the definitions I propose to use in this thesis (see Chapter 2), the GMC's (2016) conduct-based definition certainly does not account for such an adaptive, reflexive process of professionalism learning. In my definition (see Box 2.2, repeated below), however, linking an individual's behaviour to her intrinsic sense of self through authenticity, as well as to the socio-cultural context through the evaluation of peers and members of the public, allows for an identity-based concept of professionalism.

> Professionalism in medicine requires an individual to act knowingly and authentically in a manner that is acceptable to herself, her colleagues, her regulatory body and the public at large.

Box 2.2 – a novel definition of medical professionalism

Finally, despite the popularity of professional identity formation as the basis for professionalism in the medical education literature, few authors draw a link between difficulties with identity formation and lapses in professionalism. This may, in part, be due to the inconsistency with which identity theories are applied. For example, using Kegan's (1982) identity development model, Bebeau & Faber-Langendoen (2014) have proposed that medical student identity development could be 'graded' through analysis of reflective essays. This assumes that a student who does not behave professionally somehow has an 'immature' identity, though in this model the agency to decide not to comply with institutionalised behavioural standards could actually be viewed as a more advanced identity. Furthermore, when viewed in terms of socialisation, an individual loses all agency and thus is no longer accountable for her professionalism lapses. Using Figured Worlds, theory, however, professionalism lapses may be viewed as complex conflicts between an individual's understanding of themselves, interpretation of the expected identity in context and desire to conform to identity norms. In this way, it may be useful to use identity to understand lapses in a new way, in particular creating space for a more equitable analysis of what unprofessional behaviour represents.

4.2. Summary

In Chapter 2, I outlined the inequities inherent in existing concepts of professionalism. One of the ways I proposed that these inequalities could be addressed is to view professionalism through the lens of identity formation, as this makes space for a physician to be both authentically herself and acceptable to her peers, the profession and the public. With this in mind, in this chapter, I analysed the ways in which identity formation has been reconceptualised in the context of the medical professionalism literature. I highlighted the limitations of identity development theories that fail to bring together both individual and social factors, as well as identifying a potential middle ground in the form of Figured Worlds theory. Finally, I identified ways in which identity theory has been employed in the evaluation of professionalism lapses, recognising the limitations of the extant

literature in this field. Overall, identity seems to offer a useful lens through which to understand professional development and thus may provide an opportunity to improve the understanding of professionalism lapses. In the next chapter, I look at methods that can be used to study identity, in order to investigate 'unprofessional' student identities.

5. A Narrative Methodology

In the previous chapter, I outlined the potential utility of identity to understand unprofessional behaviour. I explored identity theories that I believe best conceptualise how identity formation occurs. Having defined identity as the object of study, in this chapter I will explore the philosophical and theoretical underpinnings of my study of identity in 'unprofessional' medical students in order to robustly justify my choice of a narrative methodology.

I begin this chapter by discussing methods that have been used in the past for studying identity and exploring the lessons that can be learned from different approaches. Next, I outline my ontological and epistemological position for the purposes of this programme of research. I then relate this to the concept of identity I have described to ensure that my methodology aligns with the concepts I wish to investigate. I then draw on relevant theoretical perspectives that have shaped the choice of methodology, describing ways in which narratives have been used to study identity in a variety of contexts. In addition, I also explore the 'subjects' of this study – 'unprofessional' medical students – and describe the recruitment and data collection processes, including key ethical and practical considerations. I then conclude by detailing the analytical process, relating this to the relevant narrative theories, as well as drawing distinctions between my approach and alternative qualitative methods.

5.1. Learning lessons from existing research

Identity has been extensively studied in many contexts and for many purposes, including the study of professional identities and their formation in healthcare professionals (Becker *et al.*, 1961; D. Bennett *et al.*, 2017; Joynes, 2017; Monrouxe, 2009; Vivekananda-Schmidt, Crossley, & Murdoch-Eaton, 2015). The discipline of health professions education is extremely heterogeneous and draws on methodological paradigms from other disciplines, such as anthropology, sociology and psychology, as well as the broader field of education (Walsh, 2013). This is in

part due to the diversity of backgrounds represented in medical education: 'medical educators' include doctors, nurses, allied healthcare professionals, social scientists and educationalists (Bleakley, Bligh, & Browne, 2011). It follows that medical educators bring their methodological background with them, creating a panoply of methodological approaches within the field of 'medical education'. Furthermore, education research itself is a broad church as interest in the study of learning and teaching has roots in many different academic fields (Hubball & Clarke, 2010). In the previous chapter, I outlined the different academic disciplines from which understandings of identity have been adopted in medical education. It is therefore necessary to ensure that my chosen methodology to study identity appropriately reflects the construct of identity that I have delineated.

One early way in which identity formation was studied in medical education was using ethnographic methods (Becker *et al.*, 1961), mirroring the approaches used by anthropologists in the early- and mid-Twentieth Century to study cultures (Holland *et al.*, 1998). In the latter part of the Twentieth Century, however, there was increasing critique of traditional ethnography on the basis that these methods uncritically promoted class, racial and gender inequalities by viewing the population that was being studied as 'other', seen through the privileged lens of the white, heterosexual, Western male (Clifford & Marcus, 1986). For this reason, a reiteration of Becker's (1961) traditional ethnographic approach would not align with the understanding of professionalism and identity I have proposed in Chapter 4, however, there are some elements of ethnographic methods that are useful to adopt.

One key way in which ethnographers attempted to address the criticisms levelled at their research practice was by reflecting upon their influence on their research and on the people they are researching (Clifford & Marcus, 1986). Arguably, ethnographic approaches have always been intrinsically subjective as the researcher has always approached the research space with prior experiences, beliefs and biases. That said, the practice – referred to as reflexivity – of openly acknowledging and reflecting on this subjectivity is more recent (Salzman, 2002). Through this

reflexive practice, researchers can explicitly acknowledge the limited, context-bound and subjective nature of their reflections (Hollway & Jefferson, 2000). In the context of my research, reflexivity is a key practice I have adopted from ethnography and is a tool I utilise throughout this thesis to explicitly position myself within the research space.

In spite of criticisms of the patriarchal nature of ethnography, feminist scholars have adapted research practices to study the lived experience of women and other marginalised groups (Davis & Craven, 2011; Visweswaran, 1997). Oakley (1981) made a key contribution to feminist research through her study of the lived experiences of women during pregnancy, childbirth and early motherhood. Oakley (*ibid.*) observed that existing interview practices – a researcher-defined list of questions – reduced the possibilities for an authentic representation of the women in her study and did not appropriately acknowledge their contributions and sacrifices. This led Oakley to advocate an interview technique with a more conversational style, a back-and-forth between researcher and participant. Taking this approach was expressly intended to empower women in the interview space, allowing them to exercise some control over the evolution of the discussion (Oakley, 1981). Importantly, contributions such as this have changed the language used to describe those studied from being passive *subjects* of research to active *participants* in the process – the term that I will use here to describe the students I interviewed. That said, 'participants' in research are rarely allowed to contribute to the design of a study or the interpretation of the findings (McTaggart, 1997). With this in mind, use of this term is perhaps disingenuous as 'participants' are still limited by the relative power of the researcher in the research space. In this way, the 'participants' were restricted in my research; however – as I explore below – I attempted to create an interview space that allowed meaningful participation.

One of the cornerstones of ethnographic research is immersion in the lifeworld of participants over time (O'Reilly, 2009). In the context of this research, I use the term lifeworld to mean the experiences, memories, thoughts and feelings of my participants. Given the purpose of the study was to build an understanding of

'unprofessional' medical students' identities, I explicitly set out to recruit students with identified professionalism lapses. This population was not only likely to be small but also potentially difficult to recruit, given exposition of their 'unprofessional' status was likely to act as a deterrent to participation in the study. With this in mind, a longitudinal ethnographic observation was not a practical way to access these lifeworlds. Thus, my methodological options were narrowed to a one-on-one interview environment so that only I, as the interviewer, need know about their participation in the study. I did, however, adopt methodological tools from ethnography such as observation of body language within the interview space to add further richness to my data (O'Reilly, 2009). In summary, I looked to adopt the reflexive, observational approach from ethnography but sought an alternative paradigm to underpin an interview-based study.

In the late Twentieth Century, researchers within and beyond ethnography became interested in the insights into identity that can be gained from the stories individuals tell about themselves – sometimes referred to as the 'narrative turn' (Bruner, 1990; Lincoln & Denzin, 2003). Various narrative forms, including written and audiodiary, have been used to study identities in medical education (Monrouxe & Rees, 2012; Rees, Monrouxe, & Mcdonald, 2013) and I thus became interested in the use of narrative methods. Narrative methods, broadly speaking, include any study that is concerned with the interpretation of stories (Clandinin & Connelly, 2000). In the following section, I will expand on the rationale for using narratives to study identity.

5.2. Narrative Inquiry

In this section, I explore the merits of using of a narrative methodology to study identity. In order to do this, I explore the extant theoretical frameworks that underpin narrative methods and define the utility of these theories in the context of my research. I then describe how these theoretical positions shaped the design of my study, the conduct of my research and my analytical approach. Throughout, I maintain the reflexive approach that I have described above, positioning myself in relation to the methodological choices I have made.

Narrative methods have been used as an access point for the study of identity as many leading authors have described parallels between our sense of self and the way that we tell about ourselves in stories (De Fina, 2015). One of the key figures in the field of narrative studies, Ricœur, identified two fundamental ways in which individuals could make sense of their identity through telling stories. Firstly, Ricœur (1984, 1985, 1988) argued that telling stories gives human beings a sense of permanence in the world through emplotting our lives in time because the act of storytelling requires a sense of past, present and potential future. Secondly, in order to tell a story about oneself, one must find a way to describe *sameness* between oneself as the teller and oneself as the told (Ricœur, 1992). Indeed, some later authors have developed these ideas, suggesting that telling stories is an important way in which humans make sense of themselves in the world, as Bruner states:

> *In the end, we become the autobiographical narratives by which we "tell about" our lives.* (Bruner 2004, p. 694)

This quotation suggests that narrative goes beyond an expression of an internal identity to a process by which identity is further developed in the act of storytelling. This understanding requires storytelling to be understood not as a monologic, one-sided act but as a negotiated process that requires an audience and has a social purpose (De Fina, 2015). In order to justify this understanding of narrative identity, it is important to explore understandings of the nature of truth and knowledge and how these principles relate to the use of narratives as a vehicle to study identity.

5.2.1. Epistemology and Ontology

Different approaches to social sciences research are often framed in terms of ontology – the researcher's understanding of the nature of truth – and their epistemology – how they understand that truth can be known (Crotty, 1998). In relation to narrative methods, interpretations of the nature of truth are an important consideration. Reflecting on my own experience in designing this study, I was often faced with the question 'but how will you know what they tell you is true?'. Underlying this question is an assumption that there is a singular, objective

truth and uncovering this truth should be the purpose of any academic pursuit. In the context of my medical practice, this understanding of the world is common and often uncritically accepted: in spite of the subjective nature of many aspects of medicine, such as diagnosis, research is framed by claims of absolute truth. In philosophy, however, many divergent theories exist to explain the nature of truth in the human world. A full exploration of these theoretical positions is not possible here; however, I will seek to explain some key principles relevant to this study.

A fundamental shift in the understanding of truth occurred in the late Nineteenth and early Twentieth Centuries with the emergence of philosophers such as Nietzsche. Key antecedents of Nietzsche believed in a truth that existed beyond the realms of human experience, so called transcendental truth (Chouraqui, 2014); however, Nietzsche wrote extensively to deconstruct this notion. In simple terms, Nietzsche posited that there was no way to describe an experience of truth beyond the human world as all human experience is preceded by language: in order for anything to have meaning, we must be able to communicate about it (Nietzsche, 2012). This ontological shift, whilst not dismissing truth altogether, led to myriad ideas regarding truth as a subjective experience, also called subjectivism (Crotty, 1998). In medicine, subjectivism is to some extent employed to describe experiences that cannot be perceived by an observer, such as pain. The primary way in which clinicians can understand their patient's experience of pain is through a patient's description of the sensation. Though in large part pain cannot be objectively measured, most clinicians would agree that it does exist through the accounts of their patients.

The challenge that arises with taking a subjectivist stance is that truth can seemingly cease to exist at all – a criticism that was often levelled at Nietzsche's work (Finnigan, 2000). For many, however, the idea that there is no truth fails to represent their experience of the world as, to some extent, predictable and persistent, not influenced by human experience. As study of the sociocultural world – for example through the emergence of disciplines such as anthropology and sociology – increased in popularity, so too did ideas around the socially constructed

nature of truth (Berger & Luckmann, 1966). Instead of truth being conceptualised as either completely objective and removed from human interpretation or, conversely, so totally tied to an individual's subjective experiences as to become inconsequential beyond this, truth was conceptualised as *intersubjective.* An intersubjective understanding of truth is one that acknowledges that truths are co-constructed by people and societies through sharing lived experiences (Blumer, 1980; Snow, 2011). In an intersubjective paradigm, meanings are based on an individual's interpretations of the world around them and are negotiated with others through interactions, leading to an understanding of the world that these individuals believe to be true (Denzin, 2004). This allows for individuals to have differing interpretations of the world that are not necessarily 'right' or 'wrong', whilst also accounting for shared understandings that persist over time and become 'true' (Davidson, 2001).

Defining truth as intersubjective is important in the context of this study for several reasons. Firstly, the stories told and interpretations that I make of them will be underpinned by assumptions of a common understanding of the world, thus allowing space for meaningful communication of ideas between my participants and I. In addition, I do not believe that an objective understanding of identity is possible as any understanding will be bound by the lived experience of both myself, as the researcher, and my participant. With this in mind, the intention of this study is not to uncover an objective, universally applicable truth but instead to describe a potential interpretation of the world that I have formed through the study of my participants' stories.

The lack of a universal objective truth is also important when considering questions of 'validity'. Some qualitative researchers have attempted to translate the construct of validity from a quantitative paradigm, for example through presenting data to members of an academic community (Altheide *et al.*, 2002; Golafshani, 2003; Kvale, 1995). A process of validation, however, assumes that lived experiences described by participants, or my interpretations of them, can be 'invalid' if not accepted by the academic community. If truth is intersubjective and understandings of the world are

negotiated in interaction between individuals, then all findings are valid providing they have emerged from methodologically robust research. In an intersubjective paradigm, it is useful to consider 'resonance' rather than validity. Resonance is the extent to which research findings ring true with an audience, such as an academic community (Given, 2008), and has been cited as a marker of excellence in qualitative research (Tracy, 2010). In seeking resonance, there is space for 'dissonant' findings that do not comfortably chime with the experience of the audience, without these findings being dismissed as invalid or untrue. Importantly, taking an intersubjective ontological stance also raises questions regarding how truth can be explored in the context of my research, as I will now discuss.

As I discussed above, one of the key points in Nietzsche's writing is that all human meaning is preceded by language (Chouraqui, 2014). Extrapolating from this, it is logical to conclude that it is through the study of language that understandings of the world can be developed. This epistemological approach became popular in the latter part of the of the Twentieth Century, particularly in France, amongst a group of scholars who are now often referred to as 'structuralists' (Sturrock, 1979). Foucault, for example, undertook detailed textual analyses to form new interpretations of society and its structure. Fundamental to Foucault's analyses were ideas about the nature of language and thus the possibilities and limitations of his work. He understood language as a social practice embedded in time and place and thus constrained his interpretations within this context (Foucault, 1969). Again, this is an important rationale for my methodological approach as I did not seek an interpretation that would apply across contexts. As I discussed in the previous chapter, it is my understanding that identity is fluctuant in time and place and therefore any study of it will be context-bound and transient.

Key critics of Foucault highlighted his analytical approach – using historical written texts – as a fundamental flaw in his interpretations of the world. Contemporaries in other academic fields, such as anthropologist Lévi-Strauss, believed that the primary unit of language was the spoken word and that writing was a secondary phenomenon, designed as a representation of speech (Sperber, 1979). This leads to

a further epistemological consideration in my study: that the spoken, rather than written, word is a useful unit of analysis. In the context of my research, this understanding is based upon a belief that identity is a social practice and the performance of identity is undertaken for a particular social purpose (Giddens, 1991). Though texts are also produced for an audience, written stories are arguably less spontaneous and potentially carefully curated for social or political purposes (Fernandes, 2017). With this in mind, I felt that a face-to-face interaction would give a more authentic representation of the identities of my participants for the purposes of my research.

A key idea that ties these methodological considerations together is that language is a social practice; it exists so that we may communicate with one another (De Fina & Georgakopoulou, 2012). Blumer (1969), developing the work of Mead (1934), used the term 'symbolic interactionism' for the process by which knowledge is developed and shared in the social *milieu*. Blumer's conceptualisation of knowledge building has three key components:

- that individuals attribute meaning to things they experience in everyday life and act towards them according to this meaning;
- that this meaning is derived from social interactions;
- that meanings are constantly shaped and re-formed through experience.

This allows meanings that have been formed through lived experience to be shared and reinterpreted. It follows then that, if language is fundamental to the way humans understand the world, all understandings of the world are formed in interaction with others and shaped not only by their experiences but the stories that are told about these experiences (Blumer, 1969). This approach to understanding truth is referred to as a *social constructivist* epistemology (Crotty, 1998). A social constructivist epistemology aligns with an intersubjective ontology as language and shared understandings in the social world are common features. Relating this to my own study, I was aware from the outset that my prior experiences would potentially shape both the stories I was told and my interpretations of them. A social constructivist approach reinforces the importance of working reflexively at all times

to be aware of my own influence as a researcher in this project and the potential impact of this on any findings (Finlay, 2002).

When taking a position that knowledge is developed through social interactions, it is important to consider how those social interactions are constructed. In the wake of Marx's discussions of power in industrialised society (Crotty, 1998), a number of divergent schools of thought have developed that consider societal structures as profound influences of power dynamics. In Foucault's study of psychiatric practice, he described the power structures that were produced and reinforced by the medical profession to perpetuate the social discourse of 'madness' (Foucault, 2001). The discourse that related 'madness' to danger permitted the institutionalisation of those deemed 'mad', their segregation from wider society and the deprivation of their freedom (Foucault, 1973). Furthermore, the heroism of the medical profession in protecting society from the 'mad' created a space for these practices to continue and thus propagated the institutional power dynamic between the medical institution and patients (Foucault, 1973). Foucault's work has been criticised for failing to acknowledge individuals' capacity to challenge dominant institutions (McLaren, 2002). That said, as I explored in the previous chapters, there are ongoing institutional hegemonies that individuals cannot resist. One of the ways in which these power structures have been analysed – building on Foucault's work – is through poststructuralism, as I explore below.

In the latter part of the Twentieth Century, a school of thought emerged known as poststructuralist feminism. In contrast with structuralist or conventional feminist approaches, the object of poststructuralist study is not simply to understand and criticise power structures in societies but to deconstruct the paradoxes, embodied in language and practice, that perpetuate these discourses and power relations (Derrida, 2016). Furthermore, the researcher is not beyond the reach of these power structures and must therefore be self-critical about her place within them (Leavy, 2007). As a consequence of this critique and deconstruction, the intention is to make space for all potential subjectivities and thus to break away from the discourses that maintain inequities in society (Butler, 2004). This is important in

relation to my work as I self-identify as a feminist and am therefore sensitised to gender issues that may arise in interaction with my participants, particularly due to the gender inequities currently perpetuated within medicine that I discussed in Chapter 2 (Wear & Kuczewski, 2004). Furthermore, given that I believe that knowledge is constructed in social interaction, I am aware that any research findings will be subject to the power dynamics and subjectivities of both my participants and myself (Hesse-Biber & Leavy, 2007). That said, by taking a reflexive stance as I have done, I am seeking to create a space in which norms can be acknowledged but not necessarily perpetuated in the research environment to allow new insights to emerge.

In summary, the methodological choices that I outline in the following sections are underpinned by an intersubjective ontology and by social constructivist and poststructuralist feminist epistemologies. These philosophical positions relate closely to my understanding of identity as constructed in social interaction for a purpose in a particular time and space, as an act of sense-making embedded within an individual's wider lived experience and influenced by sociocultural norms. Bearing these considerations in mind, I will now explore the field of narrative research in more detail in order to align with these positions and justify this methodological approach.

5.2.2. Narrative methods – a background

The challenge with any exploration of narrative methods is that this field is extremely heterogeneous (Andrews, Squire, & Tamboukou, 2013). Having attended a number of 'narrative methods' conferences and symposia, I was struck by the variety encompassed by this umbrella term and the number of disciplines that have adopted narrative inquiry (Hyvärinen, 2006). In the broadest sense, narrative research is concerned with stories. This is, however, a heterogeneous term that includes fiction and non-fiction, as well as analytical approaches derived from literary criticism, linguistic analysis, sociology, anthropology, psychology and politics (De Fina & Georgakopoulou, 2015). Furthermore, there is still debate about the fundamental components of a story and, indeed, whether all 'narratives' even fit

within the 'story' frame (Riessman, 2008). In an attempt to combat this lack of clarity, the concept of prototypical narrative has been proposed (M.-L. Ryan, 2007), the definition of which centres on:

- a world populated by characters with agency and thus the potential to influence events;
- events that are causally-linked and cause a shift in circumstances of the characters;
- and is intended to communicate something meaningful to an audience.

In this description, one of the key elements of a story can be summarised by the statement 'and then this happened': something must occur that influences the world that the characters inhabit, necessitating some reaction. Though this definition has emerged largely from careful analysis of fictional texts (M.-L. Ryan, 2007), independent analysis of real-life spoken narratives has yielded similar conclusions (De Fina & Georgakopoulou, 2012).

In the seminal work conducted by Labov and colleagues (Labov, 1972; Labov & Waletsky, 1997), a detailed analysis of stories was undertaken as part of a study of Black English in New York. This study not only yielded a definition of story as "a sequence of two clauses which are temporally ordered" (Labov 1972, p. 360) but also a six-part structure of a typical story, as described in Table 5.1 (Labov, 1972; Patterson, 2013).

Though this framework has been extensively used to analyse personal stories (Riessman, 2008), it has been criticised for providing too narrow and Anglo-centric a definition of narrative, requiring past events told in a temporally-ordered fashion that is not typical in all storytelling traditions (Patterson, 2013). In particular, authors concerned with the analysis of stories in conversation found that this structure did not apply to the 'narratives' that were their object of study (Georgakopoulou, 2007). Even in the context of a single storyteller, an individual does not organise events in accordance with a strict timeline: it is natural to digress and follow tangents before returning to the core story. With this in mind, stories conforming to this structure can be described as 'canonical', making space for

Story element	Description
Abstract	A brief introduction to the story about to be told.
Orientation	An explanation of the circumstances of the story, for example, time or location.
Complicating action	An event that acts as a disruption.
Evaluation	A commentary on the internal thoughts or feelings of the teller.
Result	The conclusion of story events.
Coda	A synopsis, bringing the audience back to the present day.

Table 5.1 – a synopsis of Labov's (1972) story elements

alternative forms of storytelling (De Fina & Georgakopoulou, 2015). Mishler (1986) highlighted an interesting dichotomy between narratives invited in the context of a research interview and those naturally occurring in conversation, suggesting that the Labovian framework may apply less well to spontaneous narrative acts. Though the analytical utility of either definition of narrative may be limited, this is a useful point of departure from which to explore narrative methods in more detail.

5.2.3. Narratives as social acts

As outlined above, narratives can be considered as a social act for the purpose of expressing something about oneself and one's place in the world (De Fina, 2015). With this in mind, it is important to consider not merely the components of a story but *the purpose* for which it is told. Bamberg has written extensively on the topic of positioning within narratives (Bamberg, 1997; Bamberg, De Fina, & Schiffrin, 2011; De Fina *et al.*, 2006). In this context, the term positioning relates to Foucauldian ideas about 'subject positions', namely the concept that individuals are not agentic and purposeful but that their actions and possibilities are intrinsically shaped and constrained by their relations to institutional power structures and societal discourses (Foucault, 1969). This concept has been developed and connected to identity narratives, meaning that the identities we can tell about ourselves are limited by discourses (B. Davies & Harre, 1990). Though positioning theory in narratives does not reject human agency to the same extent as Foucault, scholars in

the field see the identities that individuals can tell about themselves as intrinsically moulded by their understanding of the world and their place within it (Deppermann, 2015; Hollway, 1984).

Bamberg's approach, as well as those that have developed from it (Deppermann, 2015; Slocum-Bradley, 2010), offers the opportunity to evaluate stories from two different perspectives. Firstly, the way a story is told can provide insights into the intended social actions – *what do I want my audience to think of me?* In addition, analysis of a narrative can give ideas about how the teller views herself in relation to societal discourses, also known as 'master narratives', and the expectations that ensue (Hollway, 1984). With De Fina, Bamberg conceptualised a framework of how an individual positions herself within a personal narrative, as demonstrated in Figure 5.1 (Bamberg, 1997; Bamberg & Georgakopoulou, 2008; De Fina, 2013).

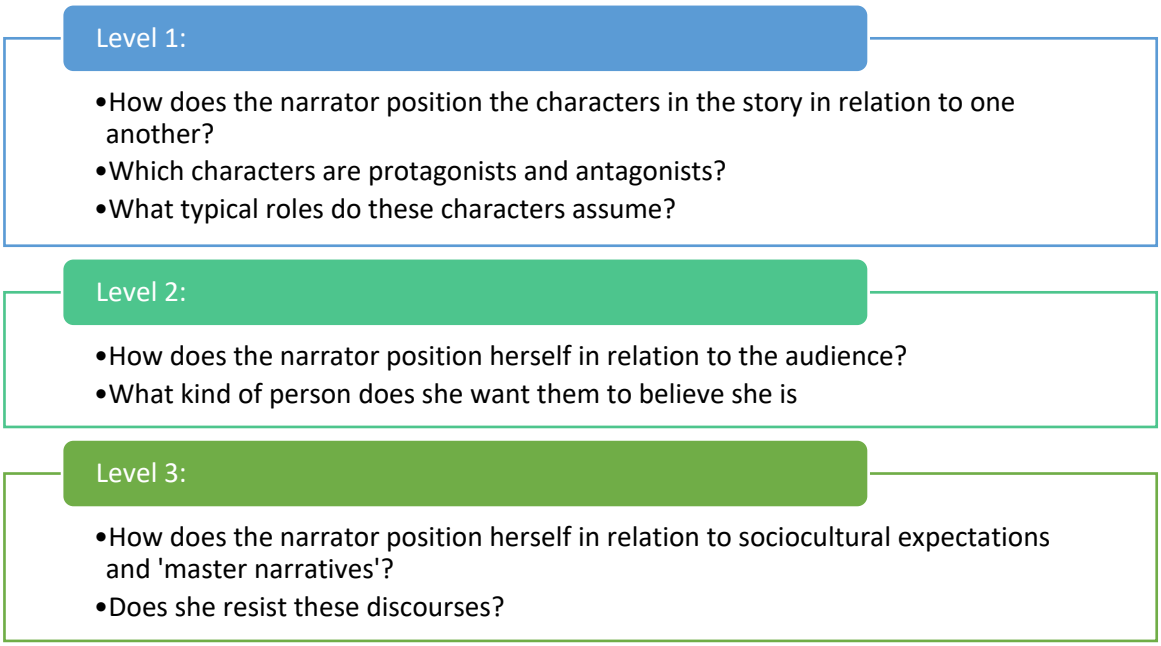

Figure 5.1 – A summary of Bamberg's (1997) narrative positioning framework

This positioning framework has been developed into a rather more complex model, connecting these layers as they interact with one another (Deppermann, 2013). For example, in an autobiographical narrative, the narrator tells about her current self in relation to herself as a character in the story, thus implying sameness or difference between past and current perceptions of self.

There have been number of empirical studies that demonstrate how individuals position themselves within their narratives. Cain (1991), in her study of people attending Alcoholics Anonymous, observed a number of elements of the stories told in that space that can be described in terms of narrative positioning (Bamberg, 1997). Cain observed that longstanding members told stories of their former selves using typical characterisations such as 'desperate' and 'irresponsible', positioning themselves in counterpoint to their current selves as assuming responsibility for their actions. Furthermore, these stories took a prototypical form involving drinking, a downward spiral, hitting 'rock bottom', remorse, abstinence and restitution, allowing members to position themselves as 'recovering' and thus as legitimate members of the Alcoholics Anonymous community (*ibid.*). Cain (*ibid.*) also observed that this pattern became more evident in long-term members, indicating this prototypical narrative was the dominant social practice within the space of Alcoholics Anonymous.

It is useful to consider the influence of structural analyses of fictional stories, as folktales and fairy stories can easily form a prototype for the construction of life stories. One of the seminal authors in this field, Propp (1968), for example, undertook an analysis of Russian folktales with the intention of uncovering common story forms. Analyses such as these describe archetypal characters and plots, such as the 'romantic hero' or the 'damsel in distress'. Though these prototypical characters arguably lack nuance, their familiarity can influence the way in which we tell real-life stories and characterise ourselves within them (De Fina & Georgakopoulou, 2015).

Prototypical narrative performances such as this are seen in a variety of social environments. My personal experience has demonstrated the power of the medical history as a narrative device, with patients assuming roles within their stories designed to evoke agency or victimhood; telling stories that are more or less shaped by the rhythms of a medical consultation; and aligning themselves – or not – with societal expectations of 'patienthood' (Greenhalgh & Hurwitz, 1999; Shapiro, 1993). Importantly, the narratives that patients produce affect the way in which they are

perceived by the medical profession (Sointu, 2017; Street, Gordon, & Haidet, 2007). When considering narrative as a social action, it is important for me to be sensitised to the prototypical stories that participants may tell and, in particular, the power dynamics that their narrative positions imply, as this will fundamentally influence the story that is told, the one that I hear and the outcome of any analysis of this narrative.

In this study, I am interested in not only how identities are storied but also how these relate to master narratives in medicine and society more broadly. With this in mind, positioning theory provides a useful analytical structure that aligns with the social constructivist, poststructuralist feminist epistemological position I have described. With this theoretical background in mind, I will go on to consider the study design that emerged from my interest in narrative methods.

5.2.4. Narrative interviewing

Mishler (1986) drew a stark distinction between spontaneous stories and those elicited in an interview setting, criticising the latter for influencing the resulting narratives and rendering them artificial. In her analysis of the interview environment for the production of narratives, De Fina (2015) drew a dichotomy between biographical and interactional narratives. In this comparison, De Fina (2015) extrapolated from an understanding of identity as interactional to conclude that narrative research must be interactional – between participants or between researcher and participant – in order to yield useful data for identity analysis. Other authors, however, privileged extended periods of talk and the reflections that these produce, believing these give a better sense of an individual's coherent sense of self (Freeman, 2006).

Given that I have expressly rejected the concept of identity as coherent and unitary, it follows that I would select an interactional methodology for the study of identity in my participant group. That said, it would have been natural for me to construct an interview based around stories of professionalism lapses that would not only have limited the stories my participants told about themselves but may also have caused them distress (Monrouxe, Shaw, & Rees, 2017). In order to avoid distress, I

was keen to pursue an unstructured interview technique, allowing participants to define the content of the stories that they wanted to tell. Wengraf (2001) advocated the use of a 'single question aimed at inducing narrative' in an autobiographical interview environment, to allow participants to tell about themselves in their own terms. Though this approach is seemingly entirely without structure, Wengraf (2001) explained that the interaction with a participant outside the interview environment, as well as the careful construction of the single narrative question, play a vital role in the ensuing narrative. For example, a single narrative question can be as open as 'tell me your life story' or as narrow as 'tell me the story of your journey here today' (Wengraf, 2001). Importantly, this question is open to the interpretation of the participant and she should be encouraged to include anything she feels is of relevance.

De Fina (2015) criticised Wengraf's approach for lacking interaction and thus yielding data of limited utility in narrative identity research. There are, however, two important counter-arguments to be made. Firstly, De Fina's (2015) argument assumed that all interaction happens within the interview itself, which is clearly not the case. From the moment a participant is first approached to take part in a research study, an interactional process has begun that positions both the researcher and the participant in particular roles (Ballinger & Payne, 2000; Finlay, 2002; Hesse-Biber, 2007). This interaction is not necessarily explicit; for example, Ballinger & Payne (2000) reflected on the impact of attire on patient's willingness to participate in research. In their example, they commented on the overlap between a smartly attired researcher wearing an identification badge and a member of clinical staff in the clinical environment. In my study, I was aware that there were a number of roles that could be assumed by my participants and myself, for example senior doctor/medical student, faculty member/student, not to mention interested researcher/'good' participant. Each of these positions could potentially lead to particular social actions, such as choice of vocabulary, style and content of the resulting narrative.

One appealing aspect of Wengraf's (2001) biographical interview approach is that he endorsed actively resisting the urge to transform the research interview into a pedagogic or therapeutic one. In denying the assumption of conventional roles, the interview can then make space for alternative identity narratives and performances. That said, it is vitally important to remain aware of the power dynamics, both within the interview environment and upon later analysis of the resulting data as the expectations of both interviewer and interviewee cannot be eliminated altogether. I took several reflexive steps to remain aware of the social actions required of both my participants and myself, which I will outline later in this chapter.

The second counter-argument to De Fina's (2015) critique is that Wengraf's interview style is not purely monologic. Firstly, by being physically present as an interviewer – rather than using, for example, audiodiaries – my non-verbal cues would potentially influence the narrative. As an example, the moments at which I choose to begin recording the interview, or the junctures at which I furiously take notes, would likely have given participants ideas about the pertinence or interest of particular topics (King, Horrocks, & Brooks, 2019). This could shape the resulting narrative and again requires careful and timely reflection, both during and following the interview encounter, to attempt to capture as much data for analysis as possible (Hollway & Jefferson, 2000; Tessier, 2012).

Furthermore, following Wengraf's (2001) schema, the entire interview is not monologic. Though the first section of the interview follows a single narrative question format, he recommends at least one follow-up section, in which the interviewer should select topics from the initial monologue and ask further questions aimed to elicit further narratives (Wengraf, 2001). Given that I was seeking an interview environment that would avoid distress, this approach allowed me to tailor my questioning to the topics that each participant had already felt comfortable to share. That said, the selection of topics upon which to expand was not a neutral process, as Hesse-Biber (2007) highlights in her feminist approach to unstructured interviewing: my participants would likely form further impressions about the 'right' stories to tell based on the topics I did and did not pursue. This

again potentially leads to the identity performance within the interview being shaped by the anticipated social actions (De Fina, 2015; Goffman, 1956). With these considerations in mind, I believe that using Wengraf's (2001) interview framework was a useful toolkit for designing an ethical interview format that permitted sufficient interaction to allow for identities to be explored. Having now justified this approach, I will explore the practicalities of study design, participant recruitment and data analysis built upon it.

5.3. Study design

This study was designed to develop an understanding of the identities of 'unprofessional' medical students. The research question for this purpose was framed as follows: "how do 'unprofessional' medical students story their medical school experience?". This question was developed in light of both the literature described in Chapter 4 and the literature on the nature and practice of narrative research. Here I will outline the key practical considerations that were made to address this question. This study was approved by the University of Liverpool's Health and Life Sciences Committee on Research Ethics (approval ID 1909, September 2017; see Appendix 3).

5.3.1. Participant selection and recruitment

In previous studies of unprofessional behaviour among medical students, researchers recruited from an entire cohort of medical students, asking them to report professionalism lapses that they have observed or in which they have engaged (Fargen *et al.*, 2016; Ginsburg *et al.*, 2003). Given that this study was specifically designed to study the identity of students that had behaved 'unprofessionally', a purposive sampling technique was required (King *et al.*, 2019). In view of the unclear definition of unprofessional behaviour, as discussed in Chapters 2 and 3, delineating the parameters for the population of interest was challenging. Though medical schools vary in their methods for identifying and recording unprofessional behaviour, I decided the clearest parameter to set was any

student that had come to the attention of their medical school due to that school's own definition of unprofessional behaviour. I did not seek to further define the behaviours I would deem 'unprofessional' as the nature of the behaviour was not the object of study. Instead, as I was interested in the identity of students who had behaved 'unprofessionally', the label attached by the medical school and the student themselves was the focus of my interest. I was aware from the outset that this study population was likely to be small and challenging to recruit. With that in mind, I approached eleven medical schools across the UK, concentrated in England. Two schools reported that they had no students who would be suitable for this study and four schools declined to participate; however, the following universities agreed to recruit students: Kings' College London, University of Leeds, University of Liverpool, University of Manchester and University of Sheffield.

In order to gain access to the 'unprofessional' student population, I required a gatekeeper at each participating medical school who was able to identify potential participants (Hennink, Hutter, & Bailey, 2011). This gatekeeper was an individual who was involved in managing professionalism issues at the medical school and therefore was already aware of students' professionalism lapses. This was important as it did not require disclosure of sensitive information. In addition, the use of a gatekeeper – as opposed to me accessing student records – meant that it was not necessary for the nature of the professionalism lapse to be disclosed to me. Given the issues that I have discussed regarding the power dynamics of the research environment, I felt that this was an important consideration as it limited the extent to which I could unconsciously form a judgement in advance of the research encounter (Hollway & Jefferson, 2000).

Each potentially eligible participant was contacted directly by the gatekeeper at their medical school, inviting them to contact me if they were interested in participating. This was a further strength of using a gatekeeper as it meant that I did not need to be aware of the identity of any students that would be eligible but did not wish to participate. That said, I was aware of the potential limitations of using a gatekeeper, in particular that (s)he may selectively invite participants (Hennink *et*

al., 2011). The reasons for selective invitations, however, may be valid – for example, to avoid distress in a student during a difficult period – and therefore I accepted this limitation as necessary.

Following the invitation email, I was approached via email by potential participants. I responded with further details of the study, including an electronic copy of the participant information sheet, inviting them to respond with further questions or to arrange an interview date. The participant information sheet provided not only details of the study but also information about confidentiality, data management and institutional ethical approval in order for valid consent to be gained in advance of the interview.

5.3.2. The interview environment

In view of the importance of preserving participants' confidentiality, it was important that interviews took place in a private room. In order to protect myself as a lone researcher, however, it was also important that this was in a public place and that my whereabouts was known, in line with University of Liverpool policies (University of Liverpool 2012). With these considerations in mind, I chose to conduct interviews on the premises of participating medical schools. Appropriate rooms were recommended and, where necessary, booked by the relevant gatekeeper. The participating student's identity was not disclosed to the gatekeeper so that (s)he could feel confident that participation would not affect their studies. I was aware that the use of medical school premises could potentially impact upon the interview, as these interactions could easily feel like meetings with faculty and thus prompt justification of, or apologies for, professionalism lapses. As there was no practical alternative, however, I chose to take steps to make the interview environment feel comfortable.

In view of the reflexivity literature already highlighted (Ballinger & Payne, 2000), I was aware of the importance of my influence on the interview environment. Before beginning the interview, I introduced myself, offering some biographical details including my academic and clinical background. In doing this, I was attempting to make each participant feel more comfortable to share their story (Hesse-Biber,

2007), rejecting the typical researcher/informant relationship by offering some information about myself. I began each interview by giving the participant an opportunity to re-read the information sheet and ask any questions before signing a consent form. I then reiterated that I did not know any details about them prior to the interview and explained the style of the interview – that I would ask the participant to tell their story from their perspective. This was designed to prime the participant as far as possible to share their autobiographical narrative (Wengraf, 2001). Following this introduction, I began the formal interview with the following narrative-inducing statement:

> *"Tell me your story of becoming a doctor, all the events and experiences that you feel are relevant. You can start wherever you like and take all the time you need. I won't interrupt but I will take a few notes for later."*

This question was designed after Wengraf's (2001) framework and was intended to be both open to the interpretation of the participant but also focused toward storytelling. I allowed each participant to talk until their story came to a natural conclusion and then took a brief break, in which some participants chose to leave the interview room and others stayed and often asked me questions about myself. Again, I shared some information about myself willingly to make space for participants to position themselves in relation to me in different ways within the interview environment.

Following the break, I asked further, focused questions designed to induce narrative on topics and themes included in their spontaneous story. Wengraf (2001) refers to these as topic questions aimed at inducing narrative (TQUINs). Examples of these narrative-inducing questions include:

- "You mentioned your mother a few times early on – would you tell me a story about her?"
- "You told me that you really enjoy spending time on the wards. Can you tell me a story of an experience when you've enjoyed being on the ward?"

I selected these topics based on notes taken during the participant's spontaneous narrative, trying to focus on areas that had seemed less well storied or glossed over in their initial narrative. I began framing TQUINs according to the order in which the original narrative was recounted; however, I also framed further TQUINS during the second interview phase to allow me to follow narrative threads. For example, if a participant told a story in response to a question about their mother that mentioned an incident at school, I may have asked a further question such as "can you tell me a story about that time at school?". Once these topics were exhausted, I drew the interview to a close.

Wengraf (2001) also recommends a third interview, separated in time, to allow for semi-structured questions that clarify details from the initial interview. Though I had included this possibility in my original study protocol, I did not pursue it as I was less concerned with the logical details of the story and with ensuring clarity of telling but was more interested in the positions taken within the initial spontaneous narrative (Deppermann, 2013). Furthermore, following initial data analysis, I did not feel that there was a need to return to interview the same participants.

5.3.3. Data recording

From the inception of the study, I kept a reflective log, documenting the recruitment and interview process. I was aware that the all interactions with my participants, whether in writing or in person, would potentially influence the story that I was able to tell about them (Clandinin & Connelly, 2000). With this in mind, I felt it was vital to attempt to consciously evaluate my own emotional reaction and place this alongside the interview data itself during the analytical process (Finlay, 2002).

As I have already mentioned, I chose to take notes during the interview in order to shape the questioning in the second part. I was aware that note taking would potentially impact upon the stories told, as this activity could be interpreted by participants, implying that some topics were of more interest than others (Hollway & Jefferson, 2000; Tessier, 2012). In order to combat this, I kept my notes to key words only to minimise this activity during the interview itself.

In agreement with my participants, I elected to audio record the interview, starting the recording when introducing the narrative-inducing question described above. Again, I was aware that what I chose to record – or not – would affect my participants' perceptions of the interactions that were 'important' to me as a researcher but, pragmatically speaking, audio recording allowed me to maintain a record of the interview with a degree of permanence. Immediately following the interview, I took detailed reflective notes about the content of the interview and my reaction to the interviewee (Wengraf, 2001). This was important not only as a reflexive tool but also an analytical one, as I will explore further in the following section (L. Richardson & St. Pierre, 2005).

Following the interview, I transcribed the interaction in full from the audio recording. I chose to do this myself as it allowed me to immerse myself within the interview and therefore add to my reflective notes about each participant. Some authors have advocated working directly from audio recordings (Crichton & Childs, 2005); however, the ease with which transcripts can be annotated and coded during the analytical process led me to use them as an adjunct to, not a replacement for, the audio recordings (Tessier, 2012). As the transcription process can profoundly influence interpretation (Riessman, 2008), I used a combination of reflective field notes, audio recordings and transcripts as the basis for my analysis, moving between them to interrogate and refine my own interpretations.

All written data – transcripts and field notes – were anonymised to protect participant confidentiality. Field notes were stored in a secure location and electronic media – transcripts and recordings – were encrypted and stored securely, following the University of Liverpool's Code of Practice (University of Liverpool, 2011). These were important ethical considerations as preserving the anonymity and confidentiality of participants was fundamental to their involvement in the study, particularly in view of the detailed and potentially sensitive information contained in their stories.

5.4. Analytical Process

The analysis in this study took several forms, contingent on the narrative theories that I have explored in this chapter. Firstly, I was interested in the themes that were talked about, particularly during the spontaneous narrative section of the interview. I was keen, however, not to take a conventional thematic analytic approach, as this has been criticised for distancing what is told from its context (Riessman, 2008). With this in mind, I adopted Riessman's approach that she employed in her study of divorce (Riessman, 1990) that allows themes to be interpreted within narratives (Riessman, 2005, 2008). This approach involves a detailed reading and interpretive coding of the interview data, followed by grouping codes into representative themes (Braun & Clarke, 2006). Taking these themes, I went back to the data to see how these themes were acting within the narrative, using Labov's narrative framework to assist in describing these narrative actions (Labov & Waletsky, 1997). This allowed me to interpret what kind of stories were being told by my participants. The process is demonstrated by some examples in Appendix 4.

Data saturation – the point at which no new interpretive codes emerge – is often considered the endpoint for thematic analysis (Braun & Clarke, 2006). Given my small sample size, however, I was aware that this was unlikely. Furthermore, data saturation implies that there is no further truth to be gained from the analysis, which is at odds with my ontological and epistemological position – that my analysis is contextual and profoundly influenced by my individual interpretation. With this in mind, I did not see saturation as a required or desirable outcome. Using a blended analytical approach, however, acknowledges that emergent themes are not homogeneous as each theme may be employed differently in similar narratives (Riessman, 2008). Taking a rather crude example, one participant may tell of a professionalism lapse as a *complicating action* that put her medical career at risk, whereas another may tell of a lapse as an inevitable result of the events that had preceded it. Using a narrative structure to guide my thematic analysis therefore allowed me to understand how participants storied the events in relation to their evolving identities.

The second layer of analysis involved using De Fina's interpretation of Bamberg's positioning framework (De Fina, 2013). The purpose of this analysis was to infer the social actions and positions invoked by participants both during the interview itself and also during the wider interview interaction. I did this by listening to the all the audio recordings in full and making detailed notes regarding characters, roles, positions and discourses employed by the participants. I used these notes to develop summaries of each participant's positions. Using these characterisations, identities and discourses, I then went back to the entire dataset to identify any further examples of similar positions to allow me to map these occurrences across my participant population. Importantly, this process was informed by the narrative theory that I have described in this chapter. Some qualitative methodological approaches, particularly phenomenological ones (J. A. Smith, Flowers, & Larkin, 2009), encourage researchers to 'bracket' their former knowledge, with the intention to permit new understandings to emerge (Fischer, 2009). This approach is grounded in the phenomenology of authors such as Husserl (1931) and Heidegger (1962), who believed that a researcher must consciously set aside their previous knowledge and social constructions in order to see the truth of an experience. In my mind, however, this is an unrealistic endeavour; as a researcher in the field, I am already immersed in experiences and theories that will shape my interpretations. With this in mind, I sought to use theory as a touchstone for my analysis – going back and forth between extant theoretical interpretations and my emergent findings.

In Section 5.2.1, I reflected on being asked 'but how will you know what they tell you is true?'. Although I addressed this in terms of my intersubjective understanding of truth, it is also important to consider in relation to the analytical frameworks I have described. Both the narrative-focused thematic analysis and the positioning analysis are not primarily concerned with *what* is told but *how* and *for what purpose.* Having taken the ethically-driven decision to be unaware of my participants' professionalism lapses, I was never going to be able to corroborate the stories that I had been told. With this in mind, I intentionally focused my analysis away from the told events and towards the act of telling. Furthermore, as the act of telling involves

participants reinterpreting the events they describe (Bruner, 2004), the boundary between truth and lies becomes blurred. The resulting narrative may be an honest account of the participant's recollection of events, but this does not necessarily render it 'true' from all perspectives. Focusing on the act of telling also aligns with both my context-bound, socially constructed understanding of knowledge and the object of the study – identity. How a participant chooses to tell their story, be it fact, fiction or somewhere in between, gives insight into their perception of themselves and how they choose to present themselves to the world.

5.4.1. Quality assuring the analysis

The nature of the analytical approach I took placed me as the sole analyst in this programme of research. This was necessary as only I had been embedded in the interview environments and had thus experienced the entire interaction with each participant. This placed me in a unique position to reflexively analyse the interview audio and transcripts, alongside my recollections and field notes, to produce the findings that I present in this thesis. With this in mind, it was vital that I took steps to ensure that the analysis was high quality and underpinned by robust methodological understandings.

First and foremost, I not only read extensively about different approaches to narrative inquiry, I also attended formal training in narrative analysis that was provided by the University of Liverpool. I undertook this training prior to design of the study, which ensured that the programme of research was expressly designed around a narrative inquiry approach. This short course specifically included coding excerpts of narrative interviews with group discussion of the coding process. In addition, at the beginning of analytical phase, I attended the Summer Course in Narrative Studies provided by the University of Aarhus, Denmark. This summer school was an opportunity to present my data and discuss my analytical approach with a number of academics from different branches of narrative studies.

During the analytical phase, I shared segments of coding with my supervisors allowing me to discuss and refine my approach to the narrative thematic coding. I also discussed and justified the emerging narrative positions, using example

quotations. These supervisory discussions challenged me to explain each identity position and how it was performed by different participants in different interview contexts. Finally, my supervisors reviewed the iterations of the findings chapters (Chapters 6 and 7), as well as the collective stories described below, included in this thesis to ensure that these expressed the discussions and interpretations that we had had along the way.

5.4.2. Communicating findings

The final layer of the analytical approach in this study involved finding a way to communicate the commonality and difference in the deeply personal stories shared by my participants, whilst ensuring that their anonymity was preserved. One of the key aspects of narrative research, highlighted by the work of Clandinin and Connelly is that working with narratives creates stories (Clandinin, Cave, & Berendonk, 2017; Clandinin & Connelly, 2000; Connelly & Clandinin, 1990). In their work, Clandinin and Connelly (1990) often seek to embed the stories of their research participants within their own narrative of conducting the research, promoting a self-reflexive approach (Finlay, 2002). I was, however, keen to ensure the centrality of my participants in the reporting of the findings allowing exemplars of their positions and prototypical stories to speak for themselves, thus maintaining the feminist stance that I have claimed. Richardson encourages researchers to think reflexively about how they write as the interpretive actions of this aspect of the research process are often unacknowledged (L. Richardson, 1990). In particular, she criticised conventional sociological writing for failing to represent subjugated individuals or communities, thus perpetuating social power structures, and saw telling the stories of these people as one way to combat these inequities (L. Richardson, 1988). In order to do this, she formed 'collective stories' to communicate the common plotlines of her research participants. I adopted this method as a way of communicating my findings, as I explore in detail in Chapter 9. This writing method allowed me to bring together both themes and positions that my participants shared in a way that is authentic to my experience of having conducted the research, permitting me to retell their stories without compromising their anonymity. This

approach has also allowed me to maintain my reflexive stance to the last, presenting their stories from my perspective as the audience and interpreter (see Appendix 2). Furthermore, this aligns with my poststructuralist theoretical position as I seek to go beyond uncovering the power structures upon which these stories are predicated and move to deconstruct them through the telling of human stories. These stories were used to explore the resonance of my data within the medical education community, as I describe in Chapter 9 of this thesis.

5.5. Summary

In this chapter, I have undertaken a wide-ranging exploration of the philosophy and existing theory that has informed the design of the study at hand. I have taken an explicitly intersubjective ontological position, relating this to my social constructivist and feminist poststructuralist epistemology. Using this backdrop, I have then justified the use of narrative methods to understand identity as this approach allows co-construction of knowledge based in social interactions, uncovering individuals' characterisations of themselves and the way they see themselves in society. I have then used narrative theory to explain the way in which the study was designed and conducted, as well as the modes of analysis I employed. Finally, I concluded the chapter with a justification of how my findings will be communicated in the chapters to follow. Throughout, I have sought to communicate reflectively about my position within the study and the methodological choices I have taken, as I will continue to do in the communication of my findings.

6. Findings 1: The Told Stories

In the previous chapter, I outlined the key methodological considerations that informed this narrative study of 'unprofessional' medical student identity. In the following two chapters, I describe the outcomes of the narrative-focused analysis that I undertook. I draw a distinction between the explicitly 'told' stories, presented in this chapter, and the 'untold' stories presented in the following chapter. Throughout, I use illustrative quotations to represent the lifeworlds described by my participants in as authentic a manner as possible.

6.1. Participants

In the previous chapter, I described the process for recruiting my participants and the medical schools from which they were recruited. In Table 6.1 below, I present a brief summary of the seven participants who agreed to be interviewed for this study. This summary gives a very coarse-grained overview of my participant group. Importantly, I do not state which school they were recruited from as this has the potential to compromise their anonymity. I have also given each participant a pseudonym, all of which are common English names. As I will explore in these findings chapters, a number of my participants were not White British: indeed, my sample represented a range of ethnic and national identities. Three of my participants, however, expressly asked that their ethnicity not be disclosed. With this in mind, I have used ethnically homogeneous pseudonyms to honour their requests. I have, however, chosen pseudonyms consistent with participants' gender expression in the interview environment. These broad-brush descriptions are based on the information participants shared, not on any information provided by their medical school.

Participant	Brief summary
Sarah	Fourth year student. Resitting fourth year for academic reasons. Previously repeated first year due to ill health.
David	Fifth year student. Suspended awaiting an FtP hearing. Multiple previous interruptions in studies due to ill health.
Hannah	Third year student. Previously started medical school at a different university but discontinued her studies for health and social reasons.
Laura	Third year graduate-entry student (five year medical programme). Previously applied to medical school directly from school but was unable to take up a place due to grades. Pursued an alternative career prior to medicine.
Pete	Second year student. Applied to medicine directly from school but did not get a place. Retook exams to improve grades and reapplied during 'gap' year.
Victoria	Fourth year graduate-entry student (five year programme). Previously applied to medical school directly from school but did not get a place. Undertook undergraduate and Master's degrees prior to medicine. Previous interruption in year two due to social problems.
Henry	Fourth year graduate-entry student (four year programme). Undertook an undergraduate degree prior to medical school.

Table 6.1 – a summary of the participants in this study

6.2. Overview

First and foremost, I wanted to highlight an important aspect of the narratives presented here. Whilst the participants in this study were all recruited due to their experiences of professionalism lapses, I am not seeking to diagnose them as a group. The purpose of this analysis is not to determine the pathology of professionalism

problems. Indeed, I appreciate that there is a very fine line between students that do and do not experience concerns about their professionalism. As discussed in Chapter 3, the threshold at which a student becomes 'unprofessional' is variable. There is therefore an extent to which any student labelled as 'unprofessional' may have behaved in a similar way to their peers but they suffered the misfortune of their behaviour being flagged as a lapse. With this in mind, I am not seeking to set these lived experiences totally apart from a 'normal' medical student. Instead, I wish to use the lifeworlds that were opened up in the interview space to add depth to our understanding of the lived experience of professionalism lapses and the complex factors that may be at play in this space.

In addition, I wanted to continue my reflexive stance by stating how difficult it has been to summarise my findings in these chapters. Based on my experience of conducting these interviews, students such as these do not come with small, self-contained stories. The interview methodology that I adopted encouraged them to tell me rich, undulating stories of their lives and findings ways to effectively communicate this complexity is challenging.

Furthermore, this is not my only experience of dealing with medical students' stories of professionalism lapses. In my experience, even relatively low-level concerns can be met with elaborate narratives rich with apparent reflections, apologies, reasons and excuses. By the time participants in this study reached the interview stage, their stories may have been well rehearsed, though perhaps not in their entirety: they have told the story of their road to medical school many times in response to the question 'so why do you want to be a doctor?'; they have told the tale of their professionalism lapse to multiple senior faculty members and committees; they have told the stories of their successes and struggles to their friends and family. At each telling, the tapestry of the story becomes richer with new retrospective details or evaluations of events. Furthermore, bringing these different stories together into one cohesive telling for the purposes of the interview potentially requires additional sense-making, some of which seemed *ad hoc* and incomplete in the interview space – something that I will explore further in these findings chapters. With this in mind,

seeking to distil the pertinent details to illustrate my analytical stance has been challenging. Any attempt to convey the multi-faceted narratives seems two-dimensional and these chapters can only include the chapter titles in the book of stories I have collected.

In order to convey the complex stories as authentically as possible, I have also written 'collective stories' based on the narratives my participants shared (see Appendix 2). The purpose of these narratives was primarily to communicate with stakeholders in an accessible way, as I will explore in Chapter 9. In the process of writing these 'collective stories', I have sought to maintain three-dimensional, true-to-life narratives whilst focusing on the elements that I believe to be useful in furthering the understanding of the 'unprofessional' medical student.

In the following chapters, I explore the results of both the thematic and positioning analyses. As discussed in Chapter 5, this is a blend of different approaches to narrative analysis. The positioning analysis highlights the *positions* – the roles and characters – that participants assume in their stories (Bamberg, 1997). The thematic analysis concentrates on the content of the stories themselves, developing the narrative *themes* that participants discussed (Riessman, 2008). It is not possible to entirely separate a story's content from the characters a narrator uses to tell it, so there are overlaps and blurred lines between these layers of analysis. In table 6.2 below, I have blurred the gridlines to demonstrate the blurred boundaries between the different elements of the analysis. Furthermore, in the following chapters, I have deliberately intertwined the positions and themes to demonstrate the ways in which they complement and overlap with one another.

The analyses yielded six cross-cutting identity positions and five narrative themes, as summarised in Table 6.2. I repeat this table at regular intervals throughout the following two chapters for reference. Broadly speaking, I have divided this into two chapters along the lines of my interpretation of the participants' intentions and the social actions of their narratives. As discussed in Chapter 5, telling stories is a social phenomenon that has a purpose for the narrator: tellers wish to convey something to their audience about themselves, their experiences and their place in the social

	Positions	Themes
The Told Stories	'The Medic' 'Explicitly at Odds'	'I think being a doctor is what I am supposed to be' • 'I will get there eventually' 'I am not sure where I fit' • 'I am not sure if I can do it' • 'I cannot make sense of myself' 'I am not like the rest of them' • '…because I do not want to be' • '…because it has been harder for me'
The Untold Stories	'The Victim of Fate' 'The Self-made (Wo)man' 'The Maverick' 'The Lucky One'	'It feels like the world is against me' 'It is not what it looks like' • '…but I will play along'

Table 6.2 – Summary of identity positions and themes

world. In this chapter, I explore the stories that my study participants seemed to want me to hear – the 'told' stories. This involves the positions they seemed to deliberately assume in their tale and the themes that were superficially apparent in the stories that they told. In the following chapter, I detail my interpretation of the unintentional or 'untold' stories. This includes the inconsistencies and contradictions, including my interpretations from my positions as a doctor and a teacher, adding an understanding of the medical and educational worlds they narrate. Furthermore, I explore what was left unsaid and the positions that my participants may have unintentionally assumed during their narratives. Again, the boundaries between the 'told' and the 'untold' are not sharp: the division presented here is based on my reading of the stories that were told and the context in which

they occurred. The differences between the 'told' and the 'untold' are therefore based on my interpretation of the extent to which I felt the stories achieved their intended social actions in the interview space.

6.3. Identity positions and emergent themes

The stories described here serve to highlight two of the key identity positions that were a feature across many of the participant narratives: those of being 'The Medic' and of being explicitly at odds with their peers. I also relate these positions to relevant emergent themes – 'I think being a doctor is what I am supposed to be', 'I am not sure where I fit' and 'I am not like the rest of them'. In my discussion of the narrative themes, I will refer to Labov's (1972) six story elements (see Table 5.1) to contextualise these themes within the wider narratives. For reference, these six elements are: abstract, orientation, complicating action, evaluation, resolution and coda (*ibid.*).

6.3.1. The Medic

One of the positions that all participants assumed, to a greater or lesser extent, was that of 'The Medic'. This was expressed in a variety of ways, from explicit identity claims – 'as a medic…' – to more subtle references. The students I interviewed commonly gave illustrative examples of interactions with patients, used medical terminology, referred to assumed shared medical knowledge and even made reference to medical professional values.

Importantly, I had introduced myself to each of them, both via email and also in person, explaining my combined roles as both a PhD researcher involved in medical education and a practising clinician. Some participants explicitly referred back to this *shared* identity to contextualise a point during their narrative, for example one made reference to my chosen specialty of rheumatology to occupy a shared professional space:

> *I seem to like the more general specialities, you know, like things like rheumatology's much more interesting to me than cardiology, for example.*
>
> DAVID

Similarly, Victoria positioned herself as 'The Medic' by speaking of her future career choices. By using the example of General Practice (GP), she is demonstrating that she understands the medical world and can see her place within in:

> *And then I think I decided that I'd like to be a GP? Just because of the fact that it's quite…varied. Like, you see a lot of diseases and there's more patient contact. Like, you know your patients.*
>
> VICTORIA

Another way in which participants assumed the identity position of 'The Medic' was by reinforcing how hard they worked and how difficult life as a medical student is. The dominant societal perception of medicine as a career is that it requires not only intellect but also sacrifice and dedication. I was told stories of difficulties getting into medical school. For example, as table 6.1 demonstrates, several participants had not got into a medical course directly from school but had undertaken alternative undergraduate degrees and then returned to medicine as a postgraduate. Participants told me of the demands of the course, with most positioning themselves as hard-working, diligent students. Participants also told me of the elements of student life that had been missed out on to study and the fatigue caused by the demands of clinical placement. Here, for example, Hannah refers to the long days required of her during clinical placement time.

> *I'm in placement at, sometimes eight thirty in the morning all the way to five. It's just really tiring.*
>
> HANNAH

At times, they even critiqued their peers for not putting in the requisite time and effort, for example:

> *…sometimes we know who the people are that…are never in. Or sometimes, like, my friends'll be on their placements and like 'oh, I'm with so-and-so but I've literally not seen them since day one.'*
>
> LAURA

A further way in which participants assumed 'The Medic' identity position was by discussing the academic difficulty of a medical degree. Hannah, for example, refers to "not [being able] to know everything" due to the sheer quantity of content in the curriculum. Several participant narratives included stories of academic failure that were contextualised by the challenging nature of the course, for example the amount of information there was to learn and the difficulties balancing personal study with being on placement.

In addition, participants positioned themselves as 'The Medic' by using medical ethics and values as a means of defending their actions when professionalism concerns arose. By employing medical discourses in this way, participants implied a sense of belonging to the medical community that contrasts with the professionalism lapse that might seem to position them as outsiders. In this quotation, for example, David explains the principle of consent to me to ensure his position of morality in the context of a complaint made about this incident by a fellow student.

> *I go and see this woman. She's a little bit confused but she's, but she is able to consent. She's able to retain and…er, hold the information…*
>
> DAVID

Some participants even positioned themselves alongside doctors, citing examples of being as skilled, knowledgeable or dedicated as the practicing clinicians. David, for example, told a story of a patient he had assessed mistakenly not being seen by a qualified doctor. As part of this story, however, he allays any concerns about the patient's care by emphasising his competence and experience:

> *I would say I'm quite confident with doing back pain as a, as a presenting symptom.* […] *having done electives at the* [specialist centre]. *So I've done quite a lot of assessments like this.*
>
> DAVID

In the quotation below, Hannah goes further, taking a position of superior medical knowledge in her criticism of junior doctors not undertaking a practical procedure the 'right' way.

> *…in terms of the procedures that they do. I feel like…not all the rules are being followed. Like, what we're taught* […] *and what they do.*
>
> HANNAH

When assuming this position of belonging, or even superiority, a number of participants made errors which, to me as a practicing physician, were glaring. For example, they misused medical terminology or told stories about patients that did not logically hang together in medical terms. This perhaps belies the fact that these students are still learning and striving for this identity, a point to which I will return in section 6.3.3, as well as in Chapter 7.

Another aspect of the medical identity position assumed by participants was that of acting as the doctor to themselves, their friends and their family. Even participants at an early stage in their medical career told me stories of diagnosing themselves or the people around them. In the quotation below, for example, Victoria speaks about a change in her Mother's behaviour and her immediate suspicion of a diagnosis of dementia. Later in her narrative, Victoria returns to this topic and suggests that she suspected dementia even when her mother's doctors and the other members of the family did not, thus positioning herself as 'The Medic' within the family unit as well as within the wider medical context.

> *I started seeing change in her behaviour and stuff and I instantly knew there was something wrong with her but it took a bit of time*

> *to kind of know exactly what was wrong with her. I suspected it was dementia but I was hoping it would not be dementia?*
>
> VICTORIA

The participants' propensity for self-diagnosis was also illustrated by the following quotation from Pete, a second-year student, who discussed his experiences of seeking to find an explanation for his symptoms of low mood.

> *…in hindsight, I found out only this year why I was feeling…depressed and anxious. And it's, that's because, er…I have Seasonal Affective Disorder. So* [I] *can't say that I've, like, totally diagnosed it. It's just that, like, when I read up about it, it sounds exactly what I have.*
>
> PETE

Using self-diagnosis and treatment also serves to illustrate one of the emergent themes – *I think being a doctor is what I am supposed to be* – in that participants wove stories of medical aptitude into many of their narratives, giving a sense that the medical world is one in which they naturally belong. This theme extends beyond the identity position of 'The Medic' to express a sense of purpose and vocation, telling the story of how these individuals have come to incorporate 'The Medic' as an aspect of their identity.

6.3.2. I think being a doctor is what I am supposed to be

The theme 'I think being a doctor is what I am supposed to be' relates to participants' narratives conveying a sense of destiny to their medical career thus far. Aspects of participants' narratives often reiterated societal norms about medicine as a career, including giving the sense of a calling to the profession. Indeed, in Pete's orientation to his story of becoming a doctor, he described medicine as "a vocation". These tropes may be common in medical students in general; however, in this section, I discuss how the participants in this study employed these narratives of purpose and destiny to offset their professional or academic difficulties.

The first aspect of this theme is that individuals identified an early desire to pursue a career in medicine. Here, for example, David speaks of wanting to be a doctor for as long as he can remember:

> *Ever since I was five years old, I've just wanted to be a doctor. And everything I've done to do with medicine has concerned that.*
>
> DAVID

Similarly, Victoria described medicine as "the only thing that [she] wanted to do" from a very young age. Some participants described being recognised as "potential doctors" at school, largely due to academic capability. Participants used this early aptitude as a form of orientation in their narratives of becoming a doctor, in that this was often storied as one of the first experiences that indicated that medicine might be the right career for them. In his narrative, Pete explained that he had been directed towards medicine during secondary education, as demonstrated by this quotation:

> *If you wanna end up doing science in university or in, like, GCSEs or 'A' levels, you kinda go onto, like, a science stream* […] *I was kind of, like, going in the science stream* […] *I knew, like, medicine was the final goal.*
>
> PETE

Similarly, Laura storied her educational experience as an aspect of her journey that had channelled her towards a career in medicine:

> *…you were in sets for…science, maths* […] *So…very early on, you sort of knew if you were…one of those potential…doctors, vets, dentists, the lawyers*
>
> LAURA

Participants' stories of being identified at a young age seemed to imbue their stories with a sense of pre-determination that reflected the dominant social narrative that medicine is a 'calling'. These stories of destiny stood in counterpoint to the

interrupted journeys that many of the participants had experienced, as exemplified by the summaries in table 6.1, as I explore later in sections 6.3.4 and 6.3.5.

Using the narratives of early identification of medicine as their future career also gave a sense of persistence to participants' stories of wanting to be a doctor that was sometimes recapitulated later in their narrative as part of a coda. For example, when summing up a story about the academic or professional challenges, participants returned to the refrain of 'this is what I have always wanted' to highlight the sense that medicine has always been their purpose. In David's interview, for example, he concluded his spontaneous story with a coda section about the point he was at, waiting for a decision about his fitness to practise, with this statement:

> *And I'm…just trudging along, desperately wanting to become a doctor because it was the last thing in my life. But it was also like the first thing for me. I always wanted to be a doctor.*
>
> DAVID

Similarly, Victoria summed up her story of "trials and tribulations" – as I will explore further in section 6.3.5 – with this statement:

> *And all I want to do is just get through my degree and…get through passing medicine.*
>
> VICTORIA

Overall, these narratives of medicine being the first and only thing that they wanted to do gave a strong sense that these participants continued to feel that medicine was their calling, in spite of difficulties they had faced along the way.

In several instances, participants incorporated the voices of other characters in their story to corroborate that medicine is the right career for them. One way in which this occurred in participants' narratives was through other healthcare professionals identifiying their potential. Victoria, for example, told a story about working with a psychiatrist, who told her she would make a good doctor. In this quotation, she

highlights the reasons she can recall this individual giving, thus reinforcing that he believed that a career in medicine is what she should pursue:

> *…he said to me: 'there's something about you, you know? I think you shouldn't be a psychologist. You'll be a good doctor.' And I said 'why do you say that?'. He said: 'you've got the skills. You've got the attributes. You've got the right attitude…'*
>
> VICTORIA

In a similar vein, Sarah used her experience of working as a healthcare assistant to add power to her narrative of medicine as her vocation. Here, for example, she employs the voices of the nursing staff who encouraged her to reinforce that they believed it was the right path for her to take:

> *…they would always encourage me and when they knew I was applying for medicine, they'd always root for me and say, you know, 'you can come back here as an F1'…*
>
> SARAH

In addition, Sarah went on to use the voices of patients who "really related to" her to reinforce the qualities that made medicine a good fit for her. A number of other participants used the voices of patients to corroborate their stories of being a good fit for a career in medicine. In this excerpt, for example, Henry uses a story of a patient feeling willing to share new information with him in a wider evaluation of the quality of his interactions with patients:

> *…she said that nobody had ever…that she never felt comfortable saying, sharing that stuff with anyone before. That she felt that no one had ever listened to her like that before.*
>
> HENRY

In this quotation, Henry also plays into another prototypical medical narrative to highlight his sense of purpose in medicine: that of being a saviour or a hero. Here, Henry implies that, if not for him, this patient would never have been able to share

her full story and thus he was her saviour from the failings of the other healthcare practitioners. My perception is that a hero identity is common in medicine: many doctors believe that they exist to 'save' their patients from the danger that has befallen them. There is little extant literature describing this identity but this tacit belief is perhaps best represented by the persistence of paternalism in medicine (Drolet & White, 2012). Indeed, recent discourses during the COVID-19 pandemic have once again brought the 'hero' narrative to the fore (Frangou, 2020). This sense of heroism was important in terms of the theme 'I think being a doctor is what I am supposed to be' as participants conveyed a sense of individual purpose and responsibility: if it were not for their individual actions, people may have come to harm. Perhaps the most obvious example of this was a story that Pete told of successfully resuscitating a refugee on the beach of a Greek island. In this narrative, Pete uses the voice of the survivor's Grandmother as part of the evaluation in his story of his heroism:

> *And she was super thankful to me. Er…crying and everything…*
>
> PETE

A further aspect of participants' narratives that conveyed the sense that it was participants' destiny to become a doctor was the story of getting into medical school. In some cases, this formed a narrative in itself, preceding the overarching story of their journey through medical school. Organising their narratives with these stories in the foreground seemed to suggest the significance that getting into medical school held for these participants: it was a vital step on their journey towards a medical student identity. Laura, for example, told a lengthy story about applying to medicine at 18, falling short of the grades, pursuing an alternative degree and applying to medicine on two separate occasions as a graduate before getting in. This effortful journey gives a strong sense that Laura believed that a career in medicine was truly the right path for her. On the other hand, Henry explained that he had only applied for a single medical course:

> *I only applied for [university], because of the [research institute]. Er…and got onto it. Which was very fortunate.*
>
> HENRY

In taking this rather bold step, Henry imbues his story with a sense of fate: that he got into the only programme that he applied to means his future in medicine is 'meant to be'.

In addition to the overarching theme, a subtheme emerged, which I have named 'I will get there eventually'. Earlier in this section, I described participants using their narratives of destiny to project themselves into the future, perhaps even conveying a sense of desperation to reach their goal of becoming a doctor. This subtheme describes a more concrete sense of participants having a future in medicine. Also earlier in this section, I highlighted how participants described their attributes and skills to reinforce their place in the medical world. Here, participants use further evaluative sections to describe how similar attributes will help them achieve their goal of becoming a doctor in spite of the adverse circumstances that they describe in their stories. Victoria, for example, focused much of her narrative on the challenging situations that she had found herself in and the uncertainty regarding her future due to academic failure. As I have highlighted in the quotation above, she clearly described medicine being 'all I want'. Here, however, she gives a more concrete sense of a future that allows her to use her aptitude for medicine to benefit the city in which she lives:

> *I feel as though I've been given this gift but…to, like, serve humanity, serve community, serve my people, serve people in the* [city], *the city that I belong.*
>
> VICTORIA

A further way in which participants imbued their narratives with a concrete sense of an achievable future was to discuss their choice of specialty. Here, for example, Henry explains how he struggles to focus on many parts of the medical course as his eyes are fixed on his future in psychiatry:

> *Almost all of…medicine…interests me but doesn't move me? Erm. I've got my sights so firmly set on psychiatry…*
>
> HENRY

Participants also projected themselves into a successful future by discussing the skills that they were developing during their time at medical school. One of the key events in Laura's story, for example, was the difficulty she had with examinations early on in her time at medical school. Here, however, she gives an example of success in a practical exam to highlight how adeptly she can now apply her knowledge to clinical scenarios:

> *…I remembered a question that I should've asked.* […] *And I just sort of went 'oh! And one more question before we finish.' And when I asked it, I just remember, he winked 'cos he was like, he knew then that I'd got it.*
>
> LAURA

In summary, the theme 'I think being a doctor is what I am supposed to be' brings together participant's narratives of past experiences and future possibilities that demonstrate their belief that medicine is their purpose or vocation. This, however, seems to sit at odds with the knowledge that these participants have experienced professionalism lapses. This contradiction between claims of natural aptitude and struggling to conform to the expectations of the medical world is highlighted in the exploration of the following theme 'I am not sure where I fit'.

6.3.3. I am not sure where I fit: uncertainty and conflict

In contrast to the previous theme, this section describes participants' expressions of discomfort with becoming a doctor. This is theme perhaps best introduced by the following quotation from Sarah, in which she reflects on a moment of near hysteria at the thought of herself and one of her colleagues being doctors in the future:

> *I just cracked up, because, I thought, 'this is ridiculous', like the idea of me and him being doctors in the future* […] *It just…seemed so absurd, that I just started laughing…*

SARAH

When taken out of context, this might not seem to convey a sense of doubt or discomfort. When this quotation is embedded in a story of desire to become a doctor and the sense of purpose described in the previous section, however, it communicates a tension between where these participants found themselves and where they wanted to be. I have divided 'I am not sure where I fit' into two subthemes – 'I am not sure I can do it' and 'I cannot make sense of myself'. The first of these subthemes describes expressions of uncertainty about their ability to progress from their present position, whereas the latter focuses on a sense of doubt about whether they can meet the expectations of a medical identity in the future.

The first subtheme here – 'I am not sure I can do it' – describes feelings of doubt and insecurity about being able to complete a medical degree. This relates primarily to uncertainty regarding having adequate intellect, skills and resources to make it through the medical course. A number of participants told me of occasions when they struggled in pressurised circumstances, particularly in clinical or examination settings. In her story, Victoria spoke at length about an experience of repeatedly failing a paediatric clinical assessment, which had become a stumbling block as she could not progress without passing this element of the course. As part of her narrative, Victoria evaluated the experience of this assessment, explaining her perception of why she struggled to pass under the conditions of the assessment. In particular, as demonstrated by this quotation she told me about her reaction to being questioned by senior doctors and how the repeated failure had led to a lack of confidence that she would be able to produce a correct answer under pressure:

> *I think I just panic. Just because of the experiences that I've had or, like, I've been put in a position to quickly name a disease and I know that's what medicine's about…erm, I just get jumbled and I would say something else…*
>
> VICTORIA

Whilst the experience of 'getting jumbled' when under pressurised circumstances might be normal, the cumulative nature of these experiences seems to have become associated for Victoria with her experience of failing. In particular, by acknowledging that 'that's what medicine's about', Victoria demonstrates an awareness that coping under pressure is a skill she needs to develop but she did not seem sure how she could go about this and thus find a way to succeed. In this way, she sets her inability to produce coherent answers under pressure apart as a problem that is preventing her from finding a way to 'fit' the expectations of the medical environment. In addition, experiences of academic failure leading participants to doubt their own capability were not confined to Victoria's extreme example of repeated failure of a single element of the course. Instead, many expressions of doubt in their ability to progress followed a single episode of failure. Some of these stories of failure were contextualised in a wider narrative of multiple obstacles, which led to the failure being evaluated as a 'final straw' that had damaged their belief in their future. Here, for example, Sarah is discussing a recent OSCE (objective structured clinical examination) failure that had led to her having to repeat a year of the medical course:

> *…resitting, at first it does feel horrible and you feel like a failure and your self-esteem takes a major hit. I wouldn't come out of my room for a good few weeks.*
>
> SARAH

Again, Sarah's distress might be perceived as a normal reaction of a medical student in the wake of such a significant academic shortfall. Later in her narrative, however, Sarah projects her doubts about her OSCE failure into her future career as a junior doctor:

> *So, I started feeling like 'oh, well if I can't even accept and get over this hurdle, how am I going to deal with sometimes the daily grilling from your consultant?'*
>
> SARAH

This further complicating action suggests that, even if Sarah can successfully complete the academic requirements of the course, she doubts that she can withstand the challenges that will face her at the next stage of her career. Overall, these narratives offer a sense that participants were struggling to find meaning in their current situation: they were both desperately trying to overcome immediate obstacles, whilst simultaneously being unsure that they could find a way to comfortably cope with the challenges the medical environment would pose in the future.

The subtheme 'I'm not sure I can do it' was not only expressed by participants in the wake of academic failure. Indeed, the sense of uncertainty about their progression also came through in participants' narratives of professionalism lapses. Here, for example, Henry discusses the difficulties he had with engagement in the medical course, particularly describing his struggle to discipline himself to do something that might be necessary but that does not excite him:

> […if] *it's the choice between…I dunno, going to wards?* […] *or…thoroughly seeing where a certain train of thought will go that feels…worth indulging? Then, erm…I'm not very good at going with the boring option.*
>
> HENRY

Interestingly, Henry openly described this being an ongoing difficulty that he did not know how to overcome, despite a lack of engagement in the course potentially being perceived negatively by medical faculty. This openness gives Henry's difficulty with engagement a sense of permanence, implying it will continue to be a problem until such a time that Henry's career is purely focussed on a specialty or interest of his own choosing. Furthermore, his frankness about these difficulties seem to imply that he is not particularly concerned about this – as though he knows he does not fit and does not really wish to – a theme to which I will return in section 6.3.4.

In each of the above examples, Victoria, Sarah and Henry clearly attribute their sense that they are 'not sure they can do it' to their own personal failings, thus

internalising the source of the problem. None of them seem to imply that they 'cannot do it' because the expectations are too onerous or unrealistic. Instead, they are internalising their failure and expressing their lack of 'fit' due to their own shortcomings. In other examples, however, participants expressed a sense of doubt that they could complete a medical degree due to failings on the part of the medical school. Much of David's narrative focussed around a series of professionalism concerns that had occurred during his time in medical training. In an evaluative section of talk, David recognised that his behaviour did not 'fit' the expectations of the clinical environment but he was not entirely sure that he understood these expectations and therefore did not know how to resolve this lack of 'fit'. In this quotation, however, he places the onus for the lack of fit on the medical school:

> *It'd also be nice if there was more specific teaching, I think, on things like ward etiquette. 'Cos they spoke about breaking ward etiquette, all that, how you were speaking to people…and you're never actually taught it.*
>
> DAVID

In this way, David implies that he is both uncertain about the future due to his lack of 'fit' with the ward environment, whilst also externalising responsibility for resolving the problem. A further example of this comes from Pete's story about a series of professionalism concerns. He told a story of a having to attend a progress panel to justify these professionalism problems. In the run up to this hearing about his professionalism, Pete had been unsure whether he would be permitted to take his exams and was therefore in a state of flux, having to study but being unsure whether this was futile. Following his hearing, the panel mandated that Pete attended the student support service; however, he missed his appointment, reporting that he "didn't get the text" reminding him to attend. As a result of this, further concerns were raised about his professionalism, which he tried to reject, as demonstrated by this quotation:

> *And then I tried emailing them and tried to, er, to tell the person that gave me the professionalism form to not: 'please don't give me a professionalism form, I beg you.'*
>
> PETE

This story demonstrates two layers of uncertainty about Pete's progress. Firstly, in the wake of his further professionalism lapse, he was once again thrown into a state of flux about whether he would be allowed to take his exams. Pete therefore found himself unsure if he could progress with his degree. Furthermore, and perhaps more significantly, Pete's blame of the appointment system and desire to convince the faculty member not to issue a further professionalism concern demonstrated that he – like David – was externalising the responsibility for what had happened: the medical school had failed him, not the other way around. In this way, Pete's narrative is *demonstrating* that he 'cannot do it', as he could meet the expectations set by the medical school that would have permitted him to progress. Overall, the stories encompassed by the subtheme 'I am not sure I can do it' seemed to tell of a persistent sense of unease: the next academic failure or professionalism lapse was just around the corner and participants did not know how to avoid it.

As I stated at the beginning of this section, a second subtheme also emerged, which expressed participants' tensions between the different roles and expectations they were trying to fulfil, which I have named 'I cannot make sense of myself'. At this stage, it is useful to reflect back to the literature discussed in Chapters 4 and 5 to frame the interpretations I have made. In particular, Goffman (1956) described that all individuals give different identity performances, depending on the context in which they find themselves and the expectations of that environment. So when we are thinking about medical students 'making sense of themselves', it is important to bear their perceptions of the expected identity performance in mind. As I explored in sections 6.3.1 and 6.3.2, many participant narratives aligned with common tropes and stereotypes about what it means to be a doctor. In this section, however, I highlight the ways in which participants real-life experiences came into conflict with

their perception of the 'ideal' doctor, leading to the interpretation that they 'cannot make sense of themselves' in the medical *milieu.*

As I have alluded to when discussing 'The Medic' identity position, a number of my participants told stories of diagnosing themselves. In addition, a number of students with health problems were concerned about disclosing the extent of these to both the medical school and their healthcare provider. Though anxiety about disclosure, particularly of mental health problems, is well described in terms of the associated stigma (Sayburn, 2015), there seemed to be an additional facet here. Participants also seemed to have an unrealistic perception that all doctors are healthy, leading to a difficulty understanding that it was possible to be both a doctor and a patient. This added to participants failing to 'make sense of themselves', as they could not reconcile their roles as both patient and healthcare provider and how the two could co-exist, for example:

> *I feel like, as a doctor you need to be in good health to take care of your patients. And you're also kind of a role model to them.* […]*so hopefully I with get in-, get everything under control.*
>
> HANNAH

In addition to personal health problems, participants also described the challenge that arose when members of their family became unwell. When discussing 'The Medic' identity position, I highlighted the way in which participants positioned themselves as the diagnostician for their family members. When family members required care, however, it seemed to rapidly become apparent that being 'The Medic' conflicted with this role. Victoria, for example, talks about the onus for her mother's care falling to her as "the medic in the family" and the negative impact this had on her ability to keep up with her medical course:

> *I was one of her carers, so, erm…I was under extreme stress. And pressure. But I still ploughed through: I went through my placements. I wasn't very with it…*
>
> VICTORIA

This formed the orientation to Victoria's story about the paediatric placement that had caused her difficulty with repeated failure, as I discussed in section 6.3.2. So, Victoria makes a direct connection between the new role as 'carer' and a challenge to her future role as 'doctor'. Where Hannah doubts her ability to be a doctor due the perceived failings in her own health, Victoria cannot make sense of how she moves forward in medicine with this new responsibility for her mother. Similarly, Sarah told a story of her sister coming to stay with her and it rapidly becoming apparent that she was mentally unwell. This meant Sarah had to shift into a position of parental-type responsibility, which had a subsequent negative impact on her studies. In particular, she described a clinical case in her OSCE that was reminiscent of her sister's illness, as described here:

> *…there was one station…the mental health station. It was…it was a female with mania who, the situation was, like, practically identical and I just froze and I just couldn't.*
>
> SARAH

This aptly demonstrates how, in that moment, Sarah could not make sense of how to separate the experience of caring for her sister from her need to perform the role of a medical student. Indeed, the tension between these came to the fore very viscerally in the pressurised situation of an examination.

Another way in which these identity tensions seemed to be played out in participants' narratives was in their attempts to balance being a 'normal' student and being a medical student. As I explored in section 6.3.1 about 'The Medic' identity position, one of the tropes that participants discussed in their narratives was how difficult medicine could be and the amount of hard work that a medical course required. This was juxtaposed, however, with interviewees telling stories of wanting to be like other students, having time to go out and have fun in spite of the demands and expectations of university life. Hannah, for example, talked about the difficulties of trying to balance everything, particularly against the increasing burden of clinical placement time:

> *…this year, it's just, you don't know what to sacrifice: your study time, like, exercising, meeting friends…*
>
> HANNAH

Hannah further expanded on this, talking about the "pressure" that she felt to be sociable and the things she had to miss out on because she was studying medicine:

> *…mainly just the…clubbing and nights out and stuff. If you're doing a different degree, maybe it's…feasible…*
>
> HANNAH

These quotations demonstrate Hannah's seeming disappointment at not being able to be a 'normal' student and the tensions that arose for her as a result of her choice to study medicine. A further expression of participants failing to make sense of their choice between 'normality' and the expectations of medicine included romantic relationships. David, for example, described his desire to pursue a new, long-distance relationship, which came into conflict with the demands of his medical course. Indeed, he described the travel back and forth that led him to feel dislocated:

> *At this time, I-, I'd just got with my girlfriend, who I'm with now. So my life got more chaotic. Erm…erm, because she lived in* [distant city]. *So I was commuting. A lot.*
>
> DAVID

This part of David's narrative was an evaluative section that he seemed to use to explain why he was missing clinical placement time. He seems to connect his lack of "a home base" with wider disorganisation and therefore a sense that his relationship was interfering with the demands of his medical programme. Though experiences such as building new relationships are not exclusive to medical students, let alone specifically medical students who have experienced professionalism issues, both David's and Hannah's examples serve to demonstrate

that these individuals are going through a process of renegotiating their place in the world, trying to make sense of competing priorities and multiple social roles. This renegotiation is happening at a potentially complex time in these individuals' lives as they are transitioning from adolescence to young adulthood. Both David's and Hannah's stories suggest that events that would perhaps be perceived as a 'normal' aspect of growing up were storied as difficult due to their position as medical students. This gives a sense that these participants could not understand how to balance societal expectations of young adulthood with the expectations of being 'The Medic'.

Reflecting on 'The Medic' identity, the expectation seems to be that medicine requires unquestioning commitment and thus this identity does not allow space for any others. In his narrative, however, David is unable to offer this commitment to the role of 'medical student', whilst simultaneously being devoted to the role of 'boyfriend'. Unlike Hannah's story, however, there was no sense of reconciliation between the identities in David's narrative: he did not seem to have resigned himself to sacrifice something nor had he reached an understanding that he could be both. He did not seem able to conceptualise an identity that could meet the expectations of both roles. The unresolved tensions described by David seemed to have an ongoing impact of his sense of belonging and 'fit' within the medical *milieu.*

The final aspect of this subtheme pertained to participants not being able to make sense of themselves in a clinical environment that was not what they had expected. In particular, they told stories of experiences during their medical education that made them doubt their chosen path, disavowing them of their beliefs about medicine or their intended specialty. For example, Henry described his experience of meeting a psychiatrist with "the closest thing to a psychopathic personality" and the impact that experience had on his perception of professionalism in psychiatry:

> *I feel as if some of these elements of professionalism…aren't enacted as readily as perhaps they should be.*
>
> HENRY

When thinking about the wider context of this narrative, Henry describes psychiatry as the only aspect of medicine that he is truly inspired by. With this in mind, his encounter with an imperfect individual seems to shake his belief in his 'fit' within this specialty. Other participants told similar stories of coming across flawed individuals and the impact that this had on their understanding of their 'fit' within the system. Laura, for example, described meeting junior doctors who were rude and dismissive:

> *…even just basic manners, 'cos that's what it comes down to. I'm like 'it doesn't matter that I'm a medical student* […] *if I was a consultant, I bet you'd reply.'*
>
> LAURA

Laura contextualised this experience in terms of her previous role: having had an alternative career before beginning medical school, she felt like her 'fit' within the medical hierarchy was not comfortable. She went on in her narrative to discuss the difficulties making sense of the medical student position as this did not feel natural given the experiences she had had prior to medical school:

> *…like, I think if I was still working…I wouldn't have put up with that. But then it's, like, weird, because I'm now back into that role of being a student and…that, sort of, makes me feel…lower.*
>
> LAURA

As shown in Table 6.1, most of my participants had taken a path that could be perceived in some way as 'unconventional'. Though I am not suggesting that individuals who have a more challenging journey to medicine are necessarily at increased risk of professionalism lapses as this was by no means the intention of this study, it is noteworthy that these 'unconventional' journeys were a significant part of the stories they told. Overall, this theme demonstrates that the participants in this study were struggling to find a comfortable space for themselves in the medical *milieu*, as well as negotiating multiple roles and identities that seemed to conflict with their perception of what being a doctor requires. This sense of not fitting in

was also communicated by an identity position that was prevalent in many of the narratives: that of being explicitly at odds.

	Positions	Themes
The Told Stories	'The Medic' 'Explicitly at Odds'	'I think being a doctor is what I am supposed to be' • 'I will get there eventually' 'I am not sure where I fit' • 'I am not sure if I can do it' • 'I cannot make sense of myself' 'I am not like the rest of them' • '…because I do not want to be' • '…because it has been harder for me'
The Untold Stories	'The Victim of Fate' 'The Self-made (Wo)man' 'The Maverick' 'The Lucky One'	'It feels like the world is against me' 'It is not what it looks like' • '…but I will play along'

Table 6.2 – Summary of identity positions and themes

6.3.4. Explicitly at odds: deliberate tales of difference

In contrast to 'The Medic' position, where participants embedded themselves within medical traditions, participants also used their narratives to set themselves apart from the medical establishment and their peers. In one way or another, each of my participants storied themselves as different from their peers, though the source of perceived differences varied. As I have suggested in the preceding section, one way in which students assumed this narrative stance was by telling stories of the alternative paths that they had taken to this point. For example, only one of my

participants had entered medical school directly from school; three of the seven were graduates from non-medical courses; and two had started other degree programmes but had dropped out. Interestingly, this was often where participants' narratives started – with the story of (not) getting into medical school.

The position of being 'explicitly at odds', however, did not only pertain to their medical career but to a wider sense of not being a 'typical medic'. For some students, the differences began in their early lives, positioning themselves as 'other' on the basis of their sociocultural background. This included a girl who had grown up in an Arab household and was not expected to succeed academically and an individual who was the first in a white, working class family to attend university. These early differences, however, were not resolved upon entry to medical school and this position related to stories of having to work harder than 'typical' students to progress through medical school, as demonstrated here:

> *Like, I've had to work every step of the way to be here. Probably harder than a lot of people, who hasn't-,haven't come from my background.*
>
> SARAH

> *And…I know I'll have to try…a lot more harder but I'm willing to do that.*
>
> VICTORIA

Additionally, the position of being at odds with their peers when entering medical school was perpetuated by stories of continuing to feel at odds due to a perceived difference in life experience. One way in which this was evident in participants' narratives was through identification of differences in age and thus perceived different life stage at entry to medical school. In this quotation, for example, Laura talks about the alienation she felt starting medicine as a graduate:

> *…there were certain things where you just thought 'oh…okay. You are 18. I'm…not 18 anymore. We're at…we're at different stages.'*

> *Erm…and I think I just felt a bit, sort of, lonely at that point.* […]
> *And it just made me doubt…*
>
> LAURA

This was not, however, the only way in which participants storied differing lived experiences. Two of my participants, for example, were born abroad and lived in several countries prior to settling in the UK, whilst others told stories of having travelled extensively. This led to them taking a position of being different due to a heightened cultural awareness borne out of these experiences, reflecting on shifting cultural expectations and the challenges of adapting to the context at hand.

In addition to the differences at entry into medical school, for some participants circumstances emerged during their time there that led to a perceived divergence from the perceived conventional medical path. In my participant group, this took two main forms: academic failure and disruptions due to illness. The circumstances leading to this position are well described by the discussion of the theme 'I am not sure where I fit'; however, the resulting identity position is subtly different. Not only did these individuals express a sense of alienation, their alienation seemed to be exacerbated by the circumstances described in their narratives. Overall, this gave their character in the story a sense that they were being forced further and further apart from their peers. When combined with a story of having started on the back foot, this led in some cases to a sense of almost complete dissociation from other medical students, as demonstrated by Victoria discussing her peers as the anonymous 'them':

> *If I wasn't* [sic] *a student…who had, erm…a lovely family background. Who had no problems in her daily life. I can bet you 100% that I would be capable enough to…pass just like them.*
>
> VICTORIA

The sense of being 'other' did not necessarily – as demonstrated by Victoria's quotation above – lead to participants positioning themselves as less capable or deserving of a career in medicine. In fact, some participants seemed to deliberately

assume this position of 'otherness' in order to position themselves as more capable or insightful. Some participants positioned themselves as more worldly than their peers with awareness of aspects of medicine, academic scholarship and society that extend beyond the norm. This is aptly demonstrated by the quotation below, in which Henry is trying to explain his relationship with the performative aspects of medical professionalism, such as smart dress. In questioning the dominant paradigm – that smart dress is necessary for medical students – Henry claims a position of 'otherness' compared to his uncritical peers:

> *…from a…anthropological understanding, with an appreciation of ritual and so forth, I understand why I have to dress smart and do my…shirt up and all the rest of it, because that has therapeutic power.*
>
> HENRY

Henry was not the only participant to take the role of 'expert' in his narrative. Several participants used their experience of different cultures and practices to assume a position of superior knowledge within their story, discussing the problems with the UK healthcare system and how things could be done better. In the quotation below, David – slightly sarcastically – highlights one of the differences he has witnessed between doctors in the UK and in Brazil: in Brazil, though they work longer hours, they make time their day to have lunch. Indeed, later in his narrative, David spoke about how important he perceives this to be as the Brazilian doctors eat together, visiting local restaurants and thus engaging with one another and the wider community.

> *…working there they do eight in the morning 'til eight at night. But they do have, er, lunch, which is quite nice. Quite nice invention: this meal between starting work and finishing work. It's a rare thing.*
>
> DAVID

In the following example, however, Hannah takes a patient perspective to draw a comparison between her experience of the Indian and UK healthcare systems. In this part of her narrative, she is telling a story of having tests for "stomach pains" in India, drawing a comparison with the situation she was in at the time of our interview, when she was having difficulty getting an appointment with her General Practitioner.

> *I do remember how much faster it is to get things done there. Compared to here. It is a charge that you do have to pay for it, but…the actual payment is…quite affordable…*
>
> HANNAH

Hannah's story aptly demonstrates an intentional position of difference: as a medical student in the UK, it would be natural to assume that the healthcare system here is better given the relative resources of the two countries and Hannah chooses to contradict this assumption.

Participants also seemed to assume this position of being 'explicitly at odds' when discussing their professionalism lapses. They positioned themselves as having some unique insight into the meaning of 'professional' that, at least in part, acted as a justification of their deviation from these norms. Here, for example, Pete is discussing his understanding of professionalism in the UK that he contrasts with his prior experience of work experience in an African nation. In discussing professionalism in this way, Pete implies that professionalism is a luxury of Western healthcare systems rather than essential aspect of medical practice around the world.

> …[the] *reason professionalism exists is because…it's efficient. That's, y'know…it's efficient and it treats people right* […] *I've been to, like,* [African country] *and stuff where, like, doctors are, like…they're professional to a certain extent but, y'know, like…a doctor can make a mistake and kill someone and…no, who cares?*
>
> PETE

Furthermore, in this section, Pete implies that he has gained a greater understanding of professionalism than his peers due to his African experiences. This enhanced insight perhaps allows him to 'play along' with professional expectations, which I will discuss further in section 6.3.5. Though both of these examples imply a degree of superiority over their peers, the effect on me as an interlocutor was quite different. In the first case, for example, I was left with a sense that Hannah was naïve to the world around her: though paying for efficient medical care may be of little consequence to her, to many people, this is clearly an insurmountable obstacle to accessing basic healthcare services. In Pete's example, I felt that he had not quite grasped the purpose of professionalism; it is not a means to prevent medical error or as a way of punishing doctors who make mistakes but as a way to ensure trust between patients and healthcare practitioners. Though the 'truth' of these matters is of little consequence to the narrative, this space between the identity work being undertaken by participants and what is achieved is something to which I will return in more detail in the next chapter.

Overall, the identity position of being 'explicitly at odds' conveys the idea that these participants storied themselves as unlike their peers. This identity position seemed to be an intentional social action to set themselves apart from the individuals around them, as well as the dominant discourses and structures in which they exist. Their 'otherness' largely emerged in stories of their lived experience outside of medicine, which allowed participants to consciously put themselves in a position of insight into their difference. This contrasts with the previous theme – 'I am not sure where I fit' – in which participants told stories about mismatches between their sense of self and their perceived expectations of a doctor identity. Instead, this identity position describes participants' choice to narrate themselves as 'explicitly at odds', which relates closely to the following emergent theme – 'I am not like the rest of them'.

6.3.5. I am not like the rest of them: not a 'typical' medic as a narrative device

In section 6.3.3, I described the elements of participant's stories that belied an internal struggle between their ideas about what it takes to be a doctor and their

own sense of self. In their narratives, participants also told stories of the objective, external factors that made them different from their peers. Some of these factors have been highlighted in the 'explicitly at odds' identity position, in that objective differences were used as a way of distancing themselves from dominant ideas about medicine and what a medical student looks like. Participants also used their differences as elements of their narrative, either as a prologue to or an explanation for their additional challenges, in particular professionalism lapses. This theme describes how perceived differences from the 'typical' medic were deployed in plot as justifications and explanations for events.

This theme – 'I am not like the rest of them' – is divided into two distinct subthemes: 'because I do not want to be' and 'because this has been harder for me'. The first of these subthemes – 'because I do not want to be' – relates to participants' stories of choosing an alternative path. In a number of cases, this was expressed in terms of a distaste for the hierarchical structure of the medical system in the UK, which participants told me was something they were unable to make peace with. Here, for example, Henry uses a discussion of hierarchy and authority in his orientation to his own story of a professionalism lapse that involved him being disciplined for taking his shoes off during a meeting.

> [I] *don't…tend to get particularly intimidated by authority, because I don't really respect…authority.* […] *Erm, but, y'know, assumed authority, simply by virtue of one's accidental position in a hierarchy in whatever context you find yourself, doesn't have…any power at all, really, in my mind.*
>
> HENRY

In giving this prelude to contextualise his professionalism lapse, Henry made it clear that he was indifferent to the professionalism concern that had been levelled at him: the perceived lapse was an expression of arbitrary authority and thus had no "power" over him. In a similar vein, Pete told a story of "insulting" a doctor during his work experience placement by calling out perceived bullying and by doing this not showing him the deference that was expected. However, he balanced this story

with an evaluative section explaining how he felt that his supervising consultant respected him for his actions, thus bringing in other voices to retrospectively justify his actions:

> *But, like, he, he still respected me for what I did, 'cos it's not easy.*
>
> PETE

Participants did not just tell stories of speaking out against individuals but also told stories of feeling compelled to speak out against powerful institutions such as the medical school. In several cases, this was closely related to the experience of a professionalism lapse: either the lapse occurred due to the participant's courage to speak out or their need to speak out arose as the result of a lapse. Henry, for example, experienced a professionalism concern following the submission of a reflective writing assignment that roundly criticised an aspect of the course. He described in detail how the group of students with whom he had undertaken the project had felt the same but had lacked the resolution to tell the medical school. In this way, Henry justifies his lapse as he was simply the only one who had the courage to express what everyone else was feeling.

> *Erm…but everyone else in my* […] *on my…*[quality improvement] *project, despite privately feeling this frustration…wrote, you know, what we all knew we were supposed to write. 'It's been such an interesting project, learning how to work as a team and this has really helped me develop these skills' and so forth. Complete bulls**t! Complete bulls**t!*
>
> HENRY

Interestingly, Henry willingly took this position as spokesperson despite being aware that his opinions may have contradicted those expressed by their peers. Though the result was a concern regarding his professionalism, he seemed to feel vindicated, particularly as his lapse had led to him meeting with senior faculty members, giving him further audience to voice his discontent:

> *…if I hadn't submitted it like that, I wouldn't have spoken to…seven or eight faculty leads and expressed my…dissatisfaction. And actually…there wasn't, there wasn't a single member of faculty who…erm…I think didn't…feel the same way to some extent?*
>
> HENRY

In this way, Henry's story implied that he was not motivated to align himself with his peers and the conventional expectations of the medical school as his alternative path had achieved his goal of being heard.

Some participants expressed a perception that the expectations for their behaviour in the professional sphere were very prescriptive and struggled to submit to these perceived requirements because it did not feel natural or normal to them. Instead of attempting to comply, however, they took ownership of their alternative performance of professionalism. Here, for example, Pete is evaluating his experience of a communication skills session in which he was described as "professionally unprofessional". Instead of this causing him concern, he embraces it, justifying his approach to communication in terms of how patients might wish to be communicated with.

> *…they want you to communicate in a certain way. They want you to nod your head in a-, after a few seconds or after a certain response the other person has said. Sometimes people just…don't want that.* […] *I feel I'm one of those people, like, I just can't, like…I'd rather have, like, this one-to-one conversation and just be like 'okay', like, 'I can talk whatever way I want to and express myself in any way I want to'.*
>
> PETE

As discussed in section 6.3.3., this suggests a renegotiation with himself regarding his identity, trying to reconcile being himself with the expectations of the medical school environment. In this case, however, Pete expressly rejects the conventional medical habitus in favour of a manner that feels more authentic to him. In other

instances, participants told me of alternative paths they intended to forge in order to find a place where they could 'be themselves'. Again, instead of finding a way to conform to the dominant medical habitus, they want to escape from it to find a context in which they do not have to be 'like the rest of them'. For example, David told me – in an evaluative section of the story of his elective experience – that he would like to work abroad in future:

> *…culturally, they're more touchy-feely, more huggy, more…erm…more close, which can be quite odd as an English person but I think it's, for me it's great 'cos it… A lot of people see me as too over-excitable and…intense.*
>
> DAVID

When this is contextualised with David's wider narrative of recurrent professionalism lapses that have largely occurred due to problems with interpersonal communication, it is clear that he is aware of his inability or lack of motivation to be 'like the rest of them'. It seems that he is resigned to this and has begun to project himself into a future where he can 'be himself', thus dismissing his professionalism lapses as temporary bumps in a long medical career road.

The other facet of this theme – 'because this has been harder for me' – describes the events and experiences that participants storied as additional barriers to their progress through medical school. Like the subtheme 'because I do not want to be', these were the elements of their narratives that seemed to act as justification or explanation of their professionalism lapses or academic failures. Many participants told stories of circumstances that had not been of their own making that had made life more difficult than it was for their peers, thus leading to difficulties with their progress through medical school. This contrasts with the subtheme 'I cannot make sense of myself' (section 6.3.3), in which participants told stories about struggling to understand their current identities in the context of their ideals about what is expected of a medical student or a doctor. Instead, here participants told stories outlining how their circumstances were expressly different from those of their peers and had caused additional problems for them.

In section 6.3.4, I outlined how participants described differences such as personal illness that separated participants from the perceived norm and positioned them as 'explicitly at odds'. In the subtheme 'because this has been harder for me', however, these differences were expressly storied as barriers to their academic and professional progress. One of the ways in which this subtheme came through in participants' narratives was in discussions of their experiences of specific learning difficulties. Victoria, for example, was diagnosed with dyslexia during her first year of medical school and told me the story of her interaction with the educational psychologist, who explained that academic life was going to be harder for her:

> *Erm, and…I said to her 'would it cause problems for me doing medicine?' and she said 'it will. You will have to try harder than the average student. You, you process information differently to others. That doesn't mean it's gonna be impossible but…it's gonna be tough…'*
>
> VICTORIA

This interaction was storied as a complicating action in Victoria's medical trajectory: she used the voice of the psychologist to describe dyslexia in terms of an additional hurdle that she had to overcome. The voice of the educational psychologist also acted as a form of orientation in the grand narrative of her disrupted journey through medical school. As one of the key features of her story was the difficulty she had experienced with repeated academic failure, Victoria returned to the theme of her dyslexia on several occasions to reinforce how much harder she had to work to keep up with her peers, thus justifying the academic difficulties she had experienced. Similarly, David was diagnosed with ADHD (attention deficit hyperactivity disorder) during his time at medical school. Here, he uses an evaluative voice to reinterpret previous professionalism problems in the light of this diagnosis, as demonstrated by this quotation:

> *I sort of look back now and I know I have ADHD and just seeing the traits and the things that I did and how I did them.*

DAVID

Interestingly, by using a diagnostic frame, they reflect back to 'The Medic' identity position, in that problems should be explained by careful investigation and diagnosis. Later in his narrative, David reinforced this further by discussing his perception that his performance improved once he was established on medication for his ADHD. In this way, he implies that his professionalism problems can be overcome by his medical treatment and perhaps could have been prevented if this had been started sooner. Thus, medical school has been 'harder for him' due not only to ADHD but also to diagnostic delay.

Indeed, David's story of diagnostic delay highlights the next aspect of the subtheme 'because it has been harder for me': participants told me of the ways in which they had been let down by friends and family, as well as the NHS and their medical school. Importantly, they connected failures on the part of these institutions with the personal challenges that they had experienced. In David's story, for example, he holds his medical school responsible for not identifying his diagnosis of ADHD sooner and thus preventing his professionalism lapses. In other examples, participants told stories of difficulties accessing help due to the structures of the healthcare service. In this example, Hannah was discussing ongoing problems with her health that were impacting upon her ability to attend clinical placement. She explained that she was unable to negotiate her roles as medical student and patient due to the appointment system at her local medical practice.

> *it's so hard to get a GP appointment with our schedules. Because, erm, I'm registered with the student medical practice…for them, you have to come in on the same day to get a same day appointment, which isn't possible if you're going to placement…*
>
> HANNAH

In her narrative, Hannah explains that she cannot attend placement due to her symptoms, thus raising concerns about both her attendance and her ability to keep up with her studies. Interestingly, though Hannah acknowledges that all medical

students may have this difficult due to "[their] schedules", she implies that the experience of poor health is unique to her. Thus, this is not a pervasive issue affecting many medical students but something making it 'harder for her'.

In section 6.3.1, I explored how self-diagnosis was an important feature of 'The Medic' identity position. In some narratives, however, this was storied in terms of necessity: participants had to diagnose themselves as they did not have the access to the help they required. Pete, for example, told a story of a period when he was having academic and professionalism problems due to poor attendance. He was referred for support but this was not forthcoming, as demonstrated by this quotation:

> *But there were so many periods when I needed to see* [psychological support service] *and I couldn't because...they're fully booked. I don't blame them, it's just, y'know. It's a flawed system.*
>
> PETE

Pete went on the explain that he resorted to searching the internet for help with his symptoms, leading him to the presumed diagnosis of Seasonal Affective Disorder. This demonstrates two layers of Pete's narrative that tell of life being 'harder for him': not only did he have difficulties with his mental health that led him to struggle with his studies, he also lacked the support that he needed to overcome these challenges.

These experiences of poor health and lack of support were storied in evaluative narrative sections as a contributory factor to the additional difficulties during participants' medical studies. In spite of this, however, the difficulties participants described never amounted to a sufficient barrier that pursuit of a career in medicine became impossible. For example, Victoria's dyslexia was making studying medicine "tough" but this was not insurmountable. Similarly, David's ADHD was controllable and thus not an insoluble problem. Though participants expressed doubts about their future, none of them told me that they should abort their medical career.

Some participants, in fact, explicitly storied their additional barriers as potential advantageous for their future practice, for example, giving them access to empathy unavailable to 'normal' students. That said, the negotiation between being a victim of adverse circumstances and having sufficient resilience to continue a medical degree was not explicitly stated. This 'untold' story will be explored in Chapter 7.

6.4. Summary

In this chapter, I have explored the stories my participants seemed to be intentionally curating. This happened in the course of their narratives by way of what they said – the emergent themes – and where they placed themselves in relation to their current self, the other characters, the wider societal discourses and me as the interviewer. I have illustrated these explicit identity positions – 'The Medic' and being 'explicitly at odds' – with reference to quotations from my participants. I have also expanded on the themes 'I think being a doctor is what I am supposed to be', 'I am not sure where I fit' and 'I am not like the rest of them'. These identity positions and themes have described the struggle that my participants narrated and the gaps between where they want to be and both their perceived situation and the perceived situation of their peers.

In the following chapter, I will go on to explore more identity positions and themes, though these are more tacit and seemingly unintentionally told, giving an interesting juxtaposition to the 'told' stories I have discussed here.

7. Findings 2: The Untold Stories

This chapter deals with the stories my participants did not seem to set out to tell. Here, I discuss the identity positions and themes that I have interpreted, both from the implications of what was said but also what was left unsaid. At the outset, I wish to be very explicit about my part in the analysis, even more so than in the previous chapter. I step further into an interpretive role and these interpretations are clearly influenced by my positions as a doctor and a medical educator. I have worked in a medical school since 2015 but have been involved in teaching and mentoring medical students and junior doctors for more than a decade. With this in mind, it is challenging to set apart my perception of the realities of the study and practice of medicine and take my participants' stories at face value. In the previous chapter, for example, I explained that interviewees told stories that did not necessarily hang together for me as a clinician. Taking the opening quotation from Chapter 6 as an example, David discussed the specialties that he had found interesting during his medical training:

> *But yeah, no, I quite enjoyed spinal injuries. I seem to like the more general specialities, you know, like things like rheumatology's much more interesting to me than cardiology, for example. You know, where you've got the systemic, sort of, stuff.*
>
> DAVID

This quotation not only demonstrates the fairly explicit social action on David's part of trying to find a shared professional space but also, to me, belies a lack of understanding of what a 'general' specialty looks like. Spinal injuries, for example, is a relatively small subspecialty and is therefore certainly not 'general'. Even as a rheumatologist, I would hesitate to call myself a 'generalist' given much of my working life is concerned with managing rare diseases and prescribing unusual medications. In this way, David's social action fails: his attempt to find common ground misses its mark.

A further example of a failed social action was Hannah's attempt to level criticism at the junior doctors she had come across in clinical practice.

> *Like catheterisation…we've been taught how to do it but…the way they do it in hospital doesn't always follow the same procedure and…they do…apparently they use some sort of numbing cream, but you're supposed to leave it on for, like, 20 seconds or something to a minute for it to even work, but some of them just…skip the numbing cream…*
>
> HANNAH

One would assume, given the one-on-one context of the interview environment, Hannah would be trying to evoke empathy in me as her interlocutor: she wants me to agree with her that this catheterisation practice is wrong. Instead, Hannah's criticism strikes me as naïve and immature. From my position as a doctor, I am aware that catheterisation practice is extremely varied and that use of a topical local anaesthetic – 'numbing cream' – is not universal. It struck me, therefore, that Hannah's appraisal of this situation comes from a relative lack of experience and her readiness to criticise junior doctors perhaps lacks nuance and understanding. As I explored at the beginning of Chapter 6, the purpose of my interpretation is not to claim that these experiences are necessarily unique to the 'unprofessional' student. Indeed, developing an understanding of ambiguity and uncertainty in clinical practice is a key aspect of developing from a junior learner into a practising clinician (Tonelli & Upshur, 2019). That said, the degree to which Hannah holds on to her teaching as the 'correct' way to practice and does not allow herself to question whether what she witnessed could also be permissible within a range of 'correct' practices perhaps indicates something more than a simple developmental journey. Instead, it perhaps belies a concrete belief about 'right' and 'wrong' that might mean differences in clinical practice were perceived by Hannah as challenges to her understanding of herself in the clinical *milieu.*

These examples of stories that were not congruent to me as a clinician are not of specific relevance to any of the themes or positions that I explore below. Instead,

they act as examples of how my position as interlocutor allows me to 'read between the lines'. In many way, my positions as researcher, clinician and educators are what allow me to undertake this analysis, as I can offer insights that may not be accessible to someone outside medical education. I am also aware, however, of the potential for my roles, and particularly my position as a medical educator, to influence my interpretations of participant's experiences of medical education. In order to maintain a reflexive stance, I referred extensively to my contemporaneous reflective notes during the analysis, to try and capture my instinctive reactions to each participant and to draw on my interpretations of each participant as a whole. The 'collective stories' (Appendix 2) go further in an attempt to covey participants as individuals.

	Positions	Themes
The Told Stories	'The Medic' 'Explicitly at Odds'	'I think being a doctor is what I am supposed to be' • 'I will get there eventually' 'I am not sure where I fit' • 'I am not sure if I can do it' • 'I cannot make sense of myself' 'I am not like the rest of them' • '…because I do not want to be' • '…because it has been harder for me'
The Untold Stories	'The Victim of Fate' 'The Self-made (Wo)man' 'The Maverick' 'The Lucky One'	'It feels like the world is against me' 'It is not what it looks like' • '…but I will play along'

Table 6.2 – Summary of identity positions and themes

7.1. Positions and Themes

In this chapter, I begin by exploring the identity position 'the victim of fate'. I then describe the remaining identity positions – 'the self-made (wo)man', 'the maverick' and 'the lucky one' – as well as the emergent themes, 'it is not what it looks like' and 'it feels like the world is against me'.

7.1.1. The victim of fate

At the end of the previous chapter, I discussed the role of health in the subtheme 'I am not like the rest of them…because it is harder for me' (see section 6.3.5, p. 132). Not only did health feature as an explicit theme, it also added to a narrative of the world being against some of my participants, which is encompassed by the identity position 'the victim of fate'. Participants told stories not only of ill health, but also imbued these tales with superlatives to communicate the extreme nature of the difficulties that they faced to express the extent of their misfortune. In David's narrative, for example, he spoke at length about a number of health problems he had faced, the most significant of which seemed to be a longstanding problem with back pain. In his narrative, he uses a number of metrics to demonstrate the severity of his problems, as illustrated by the following quotation:

> *By December, I was sleeping with a bottle of, erm, Oramorph by the bed. Having opiate medication regularly. Still in lots and lots of pain. The pain is getting worse. Er, I had sciatic symptoms. Erm, true sciatica, not the, sort of, just pain down my leg: I'm talking about the numbness, the burning, the, erm… I'd describe it feels like someone's heated up barbed wire, put it down your leg and is twisting it.*
>
> DAVID

In particular, David's reference to "true sciatica" seemed to imply that his suffering went beyond 'normal' back pain or what others describe as 'sciatica'. Indeed, the severe nature of his problem was corroborated by the description he gave of the nature of his pain. Furthermore, his position of victimhood relating to his back pain

was reinforced at several points in his story. For example, he associated the onset of his symptoms with a time when he had been hit by a car and not adequately assessed by the doctors in Accident and Emergency and his problems were exacerbated by "inappropriate prescriptions" for stronger and stronger pain relief. With this composite story that weaves throughout his grand narrative, David gives the distinct impression of having been unfortunate in a whole panoply of ways.

Interestingly, reflecting back to 'The Medic' position, David's quote above illustrated how participants used medical examples as a metric to communicate their distress, playing into the medical space that we shared as interviewer and interviewee. Here, David describes the severity of his pain in terms of the pain relief he required to manage it, knowing that Oramorph® (morphine) is only required for severe pain. David's characterisation of his former self seems to have been curated to invoke my sympathy. In reality, David's stories of being in pain and becoming reliant on opiates, did not evoke sympathy but instead raised concerns for me about his fitness to study. Though he successfully curated a position of victimhood, this did not lead to the desired perception of his character in the story.

David's was not the only example where medical knowledge seemed to be deployed to communicate the severity of an individual's illness and the extent of their distress. Hannah, for example, had suffered from a kidney problem – nephrotic syndrome – as a teenager and explained the severity of this by citing her own blood test results and the complications that she suffered.

> *and…my cholesterol was, like, 15 and albumin was like 20, so it was like classic nephrotic syndrome.* […] *The whole process was quite difficult, 'cos I already had, like, pulmonary oedemas.*
>
> HANNAH

Interestingly, in this quotation, Hannah misuses a plural of 'oedema' that again suggests that she is claiming 'The Medic' identity position but failing in this social action. Given the context of unprofessional behaviour, these stories of poor health seemed designed to create a narrative backdrop that absolves participants of

responsibility, something I will return to when discussing the theme 'it is not what it looks like'.

In addition to health issues, participants often told stories of lack of support to add to this backdrop of victimhood: not only were they struggling with their misfortunes, they were left to toil through them alone. Overall, the narratives had very few characters other than the protagonist themselves; however, one of the 'characters' that appeared in each was the faceless 'medical school'. The medical school was commonly storied as an antagonist: a character whose will was directly opposed to that of the narrator. In the quotation below, for example, Victoria discusses the process of an appeal following her repeated failure of her paediatric clinical assessment. In this example, she is clearly positioning the 'medical school' as an adversary in spite of the difficult circumstances she was experiencing with her Mother's illness.

> *I felt as though the medical school turned on me a little bit.* […] *Medical school…like, kind of, butted in and said 'we didn't know what was going on with* [Victoria's] *Mum.' And I turned round and I was, like 'I tried to inform you as much as I can. Like…how can you say that?'*
>
> VICTORIA

In a further example, Sarah told a story about feeling anxious before a mock examination and seeking reassurance from the faculty in her teaching hospital. In the quotation below, she tells of how she felt not only unsupported but threatened by their response.

> *The group at* [hospital] *instead turned around and said "well, look, if you don't sit the OSCE then we will send a Cause for Concern form about you. So, it's your choice…" Which didn't really help with anxiety, with my anxiety.*
>
> SARAH

Participants did not story the character of the 'medical school' with any sense that this organisation may have their interests at heart. From my position as a medical educator, I am aware that – providing there are no concerns about a student's ability to provide safe patient care – medical schools fundamentally want their students to succeed. There was, however, no sense communicated by my participants that the institution of the 'medical school' wanted them to successfully progress. That is not to say that participants storied themselves as being totally unsupported: students often singled out named individual faculty members as allies and advocates, supporting their cause and providing evidence that they have what it takes to continue. Named characters were also deployed in the story to confirm and reinforce the position of being a victim of difficult circumstances. For example, in contrast to the "group" of faculty members who failed to support Sarah in her time of need, she named an individual faculty member who she "found really easy to talk to", who she seems to recall corroborating her feeling that the professionalism concerns raised about her were insignificant:

> *When I spoke to* [name], *I mean, he…his reaction was just "this sounds…quite silly". All in all, it wasn't, sort of, I mean, apart from the attendance sheet where I was signing in for my friend, I think the other reasons were a little bit…very pedantic.*
>
> SARAH

Again, as a member of medical school faculty, I would assume that Sarah forging a signature on a register would be taken very seriously, particularly when combined with other professionalism concerns. Sarah, however, seems to use the voice of this particular faculty member to dismiss her professionalism concerns as "pedantic" and thus a further facet of her unfair treatment.

The characters that were named in participants' defence were not only medical school faculty members but also friends and family. Furthermore, there were characters, including peers and faculty, that emerged in the narratives as named adversaries of the narrators. These adversarial stories contribute to the following theme – 'it feels like the world is against me'.

7.1.2. It feels like the world is against me

Participants not only positioned themselves as victims in their narratives but also curated narratives in which the interventions of adversaries were complicating actions, leading to difficulties for the protaganist. In some cases, these complicating actions were not related to an individual or group but instead seemed to be attributed to circumstances were conspiring against them. This is captured by the theme 'it feels like the world against me'.

Firstly, participants told stories implying that individual members of faculty were trying to thwart their progress. Victoria, for example, when telling the story of her repeated failure of her paediatrics placement, associated each instance with the intervention of the module leader.

> *…when it came to my assessment I was assessed by the module leader. Er, the Child Health module leader. And he had failed me on…some reasons.*
>
> VICTORIA

> *This time I got…examined by the module leader who failed me the first time round.*
>
> VICTORIA

Later in her narrative, she implied that this module leader had taken a dislike to her, choosing to test her knowledge to an impossible extent, setting expectations for her that she was never going to be able to meet.

> *…he said 'oh, why don't we test* [Victoria]*'s knowledge?* […] *And he would quiz me and quiz me* […] *But he would ask me questions what…you would ask registrars? I'm not at the level: I admit that I've got a long way yet.*
>
> VICTORIA

In attributing her repeated failure to this one individual, Victoria stories his intervention as both complicating action and evaluation: he was the reason she failed and this is how she has come to make sense of her failure in retrospect.

Looking to professionalism problems, Sarah told a story that attributed her lapses to unrealistic expectations of the part of teaching hospital faculty.

> *I think from my point of view, it was just a big clash of…personalities between myself and the other staff at* [hospital…] *I think they're very perfectionist. They…they have very different standards to the rest of the hospitals…*
>
> SARAH

Here, Sarah stories the involvement of the hospital faculty as a self-contained small story within her wider narrative: she uses the 'clashes' and 'perfectionist' expectations as orientation, before describing the professionalism concerns as a complicating action. She ended this part of her narrative with a further evaluation that the faculty intervention had been unhelpful and explains the wider context that she was struggling with her mental health. By setting out the whole story in this manner, she reinforces how the faculty members had stood against her when she needed help. As an educator, these stories of being unsupported often did not ring true: I was all too aware of the lengths that medical schools go to to support students through difficult circumstances. These stories sometimes implied me that students had not asked for help when they required it but had expected their medical school to predict their need for it. Alternatively, help may have been offered but not in the way the student felt they required. This conflicting perception was interesting to reflect on and something I discuss further in Chapter 9.

Some participants did tell stories of being offered help by their medical school but in a way that seemed formulaic and did not address their needs. Interestingly, one aspect of these stories is that some participants were advised to seek a diagnosis to explain their challenges, for example being offered a 'routine' referral for dyslexia testing following exam failure. In this example, Henry explains his medical school

seeming to use Attention Deficit Disorder (ADD) to explain perceived behavioural problems:

> *…the school ended up encouraging me to go get an ADD diagnosis. Err, the justification being…well the reason I was told to get it, erm, was that it would essentially give me protection against, errr, future…disagreements with the medical school. 'Cos I could fall back on it as being, er, a disability. The head of wellbeing essentially described it as a carte-, a sort of carte blanche. Which I thought was…utterly, utterly bizarre. And inappropriate.*
>
> HENRY

The recommendation to seek a diagnosis was often, as demonstrated by Henry's quotation above, storied as a complicating action. In Henry's case, this complicating action followed a perceived professionalism lapse and he went on to evaluate this intervention as unhelpful and "inappropriate". A further example comes from Laura's story, where she describes a faculty member offering a dyslexia assessment following an examination failure:

> *then he, he just started saying, erm, 'have you thought about being tested for dyslexia? Maybe that was why you failed?'*
>
> LAURA

As I discussed in the theme 'I am not like the rest of them…because this has been harder for me' (section 6.3.5), some attempts to diagnose participants' difficulties were welcomed and this became incorporated into their storied identity. In the context of the theme 'I feel like the world is against me', however, stories of attempts to diagnose were woven into participants' narratives in a way that suggested that they were not understood by their medical school and thus lacked the appropriate support they required to succeed. In some narratives, this sense of not being understood extended even further into implications of betrayal by a peer or a member of faculty. Here, David stories the dramatic complicating action of a fellow student reporting a professionalism concern to the medical school:

	Positions	Themes
The Told Stories	'The Medic' 'Explicitly at Odds'	'I think being a doctor is what I am supposed to be' • 'I will get there eventually' 'I am not sure where I fit' • 'I am not sure if I can do it' • 'I cannot make sense of myself' 'I am not like the rest of them' • '…because I do not want to be' • '…because it has been harder for me'
The Untold Stories	'The Victim of Fate' 'The Self-made (Wo)man' 'The Maverick' 'The Lucky One'	'It feels like the world is against me' 'It is not what it looks like' • '…but I will play along'

Table 6.2 – Summary of identity positions and themes

> *But no,* [she]*, er,* [she] *went to the…to the medical school about this. Erm. The consultant hadn't heard anything about this. There was* [sic] *no complaints from the ward about this. It's simply a…he said/she said.*
>
> DAVID

When unpacking this complicating action in a later evaluative section, David attributes part of the pressure he felt in the situation to his fellow student, who was watching him take blood at the time. In this way, he shifts the responsibility for the actions that had caused concern to her: had she not been present, he would have acted differently and thus the concern would never have arisen. Indeed, the

professionalism concern raised by his fellow student about this blood-taking incident had been the trigger to a full fitness to practise investigation. Overall, this left me with the impression that David held his peer responsible for the circumstances in which he had subsequently found himself.

A further example of an adversary being held responsible for a professionalism concern came from Hannah's narrative. In her story, she explained that concerns had arisen as a result of a complaint made by her former boyfriend's mother to the medical school.

> *And she's not a very nice person. And yeah, she did, like, coerce him to do stuff and…and then lied a lot about a lot of things. So…yeah. I think it's just…a cultural thing but, yeah…because of…er, how he was spending his money and stuff…*
>
> HANNAH

In Hannah's narrative, she gave no real sense of why this woman had taken such a strong dislike to her that she had decided to complain to the medical school. In taking this circumspect approach to the story, she left me with the impression that she had a limited understanding of why the situation had arisen. Again, this acted as a potent narrative device to absolve her of blame: she could not be held responsible if she did not acknowledge that there were any grounds for the complaint.

In some narratives, participants used evaluative sections to reflect on a sense that circumstances, rather than individuals, were against them. In these cases, no individual, group or institution was named as being responsible for the student's problems; instead, there is a sense that 'the world' is against them. Here, for example, Victoria was talking about "getting [herself] back together" after having to resit a year of her medical course when her mother started to become ill.

> [I]*…just thought, like, 'why me? Am I just an unlucky person? Or…what is wrong with me? Like, why does everything bad happen to me?'*
>
> VICTORIA

In constructing her story in such a way that each time she seemed to get back 'on track', something else would happen to disrupt her progress gave the distinct impression that Victoria felt that 'the world was against her'.

These narratives of misfortune due to a bad lot in life or due to mistreatment by others were carefully counterbalanced so as not to construct a narrative of being incapable of continuing with medicine. In fact, participants used their stories to tell of how they had survived in spite of the odds being stacked against them, which I will explore in the following identity position – 'the self-made (wo)man'.

7.1.3. The self-made (wo)man

Having discussed the victim position and the theme of the world being in opposition to the narrator, it is important to clarify that participants did not take a position of abject victimhood. In fact, rather than storying themselves as entirely helpless, they often used their position of victimhood and their stories of adversaries to curate a position of being independent, agentic and resilient, which I have named 'the self-made (wo)man'. This position was an important social action, in that it is one way in which participants seemed to justify their ability to continue with their medical studies, as well as projecting themselves into a future of competence and capability.

As I discussed in the previous theme, 'it feels like the world is against me', participants often implied that the help that they were offered in times of need was not helpful. In response to this, however, they told stories of finding ways to help themselves. In response to her mental health difficulties, for example, Sarah told me the story of undertaking independent research to find ways to help herself.

> *I just started researching how to overcome nervous breakdowns, anxiety, depression, and…doing everything that they advised to do…*
>
> SARAH

David also told a story of self-help, discussing his role in engaging with mindfulness and yoga as a way to manage his back pain. In particular, David's story of self-help was set against the inefficacy of the interventions he had been offered by

conventional services: doctors had simply offered him more painkillers, which had exacerbated his problems. Later in his narrative, David even repurposes these experiences of self-help to offer advice to a patient regarding management of back pain.

> *…there's a lot of books on this thing called mindfulness, you know, that has helped some people in pain* […] *And so I was, sort of, saying about that and saying 'you know, maybe you wanna look into that. As it might be something that, you know, could help you…*
>
> DAVID

In addition to seeking solutions to their personal health problems, the position of the 'self-made (wo)man' was also taken by participants who were seeking answers to health problems they had witnessed in those close to them. Henry, for example, talked about his interest in studying medicine stemming from having witnessed his mother suffering from severe depression. In particular, this had led him to an interest in novel research into psychedelic-associated psychotherapy.

> *I'd read a lot about, erm….the sort of renaissance in the field of psychedelic-assisted psychotherapies. It had become very clear to me that…er, the psychological treatments available at the time were pretty impotent for a lot of patients. Having seen that up close.*
>
> HENRY

In these stories, participants were not positioning themselves as victims but as authors of their own fate: they were taking responsibility for forging alternative paths.

The position of being the 'self-made (wo)man' often inferred that significant efforts had been made on the part of the narrator: the challenges were not easy to overcome but (s)he succeeded in spite of these barriers. In a story where most of the characters seem to be acting in opposition to the protagonist, this was powerful

narrative device that allowed the participant to story a sense of control of their own trajectory.

Another way in which participants assumed this identity position in their narratives was by drawing contrasts between their current and former selves. This narrative action – storying their former self as weak, foolish or naïve – allowed them to position themselves as having constructed an improved self. Here, for example, Pete discusses his former immaturity that led to him having a significant car accident, in which a friend was injured:

> *I had a…car crash.* […] *I wasn't drunk or…intoxicated or anything like that, but I was just, like, I wasn't really looking at the realities of life and how things can just go, like, from this…from zero to hundred in just like that, you know?*
>
> PETE

In telling of his former self in this way – as "reckless" – Pete positioned his current self as wiser and more insightful: he had experienced something difficult but learnt from it. This position of former recklessness but subsequent wisdom was also employed by participants in the wake of professionalism lapses. David, for example, used many lengthy evaluative sections of talk to describe the newfound self-awareness that he had developed as a result of his professionalism concerns. In this example, he is discussing concerns that had been raised about how he behaves with female members of the healthcare team.

> *…it's something I really need to look out for is…how I interact with women. And why they, I need to work out why are they getting this impression?*
>
> DAVID

In this quotation, David does not seem to have fully completed this journey of introspection and personal growth. He expresses uncertainty about where these concerns arise from but is striving for an understanding of the problem so he can find a way through it. Indeed, this quotation is perhaps reminiscent of the theme 'I

am not sure where I fit' as David has not yet found a way to reconcile his perceptions of the expected performance with his understanding of himself.

Overall, this identity position created an impression that participants were reflective, mature and self-reliant, thus positioning them as individuals with qualities that are desirable in medical students and clinicians. As a social act, however, these stories fell short: to me, these stories often reflected a sense of desperation to have overcome problems or to find a way to make sense of themselves rather than a meaningful resolution. This was largely because they seemed to contradict the context of professionalism lapses and ongoing difficulties, such as those explored in Chapter 6. Participants also used the interview space in an attempt to advocate for themselves in another way: they used this interaction as an opportunity to defend and justify their perceived professionalism lapses, as I explore in the following section.

7.1.4. It is not what it looks like

One of the social actions that participants seemed to use the interview space for was to defend themselves against accusations of unprofessional behaviour. Rather than mounting an explicit defence, however, many told stories implying that the professionalism lapses had emerged from misunderstandings or miscommunications. This contrasts with the social actions of 'the victim of fate' narratives, where participants seemed to intentionally blame another. Instead, in this theme, participants constructed a space where they were, at least in part, absolved of blame, whilst not explicitly shifting this blame to another. This theme – 'it is not what it looks like' – captures participants' narratives of the 'truth' of their professionalism problems, in contrast with how others had understood them.

Some participants told a grand narrative with a significant, indisputable lapse at the centre; however, lower-level professionalism concerns subsequently emerged during the interview. These lesser concerns were often glossed over or omitted from the initial narrative and only disclosed in response to explorative questioning in the second part of the interview. These lower-level professionalism problems were commonly storied by participants as complicating actions in a different story, rather

than as a central event. For example, one participant told a story of receiving unfairly poor feedback from a GP placement and only in the course of this story did he mention concerns that had been raised about his attendance. In this way, some professionalism lapses were storied as tangential to the key events in the participant's overall story. The implication of these narrative choices was that the low-level concerns were perhaps down-played to give the impression that 'it is not what it looks like'. In other words, participants were not repeat offenders: instead, they had suffered one professionalism lapse and the rest were insignificant details in this story. Again, reflecting from my position as an educator and my knowledge of the professional guidance (GMC, 2017), I am aware that the cumulative effect of many low-level professionalism problems can be as significant as one 'big' professionalism concern. With this in mind, these stories that seemed to minimise the significance of some lapses did not ring true to me. That said, this could be due to a mismatch in the interpretation of professionalism lapses between students and faculty, which I explore further in Chapter 9.

Participants also attempted to minimise professionalism lapses in the interview space by suggesting that their medical school had not raised serious concerns at the time. This gave the impression that participants would have behaved differently had they been aware of the medical school's unease. By placing the medical school in the position of tacit responsibility in this way, participants were able to reject the 'unprofessional' identity: they would not accept the role of 'unprofessional student' because they had not been given sufficient opportunity to change. Participants used the viewpoint of other characters, for example peers or faculty, to reinforce this message. Here, for example, Henry recalls the reaction of the professionalism lead to a lapse:

> *…the first time I saw her was to discuss the end-of-placement surveys. And, er, she didn't seem particularly bothered. By that. It was just a, sort of, formality.*
>
> HENRY

By using the voice of the professionalism lead in his evaluation of this event, Henry could corroborate that there were no meaningful concerns about his professionalism. Similarly, Sarah described a meeting with a faculty member following reports of professionalism lapses. In this meeting, Sarah describes everything 'feeling fine', implying that any concerns she had about her own professionalism were dispelled.

> *…they sent the cause for concern form to, I think* [student support lead]*, and…I mean, I find it really easy to talk to him. So, when he called me in, I…it was fine, I explained everything and it felt fine.*
>
> SARAH

As an educator it seemed strange to me that faculty members would go to the lengths to organise a meeting with a student if they did not have some concerns. This implies to me that perhaps there were concerns about participants' professionalism but the faculty members they encountered were trying to take a kind and empathic approach to the lapses and perhaps the students did not perceive the underlying concern. Alternatively, it may be that the student has re-storied the event in a way that has erased any concerns that were expressed about their professionalism. They may have done this intentionally, adapting or omitting parts of their story for the purposes of the interview. Participants may, however, have unintentionally recalled events in a favourable light in order to resolve a tension between their perception of themselves as 'professional' and the perceived accusation of a professionalism lapse. In order to achieve a congruent sense of their own identity, participants may have told *themselves* the story that there were no meaningful concerns about their professionalism.

Participants also used evaluative sections of narrative to reflect on how their subsequent behaviour was influenced by the medical school's response to perceived professionalism lapses. David, for example, explained that he had seen his student file as part of the fitness to practise process and that there were concerns documented therein that had never been raised with him. In highlighting these low-level concerns, David seemingly implied that, had more significant sanctions been

imposed earlier in his medical journey, he could have better understood the gravity of the situation, altered his behaviour and prevented subsequent lapses. These stories in which the medical school seemed to fail to communicate the seriousness of lapses add to the theme 'it is not what it looks like' as participants implied they *would* have changed their trajectory away from the 'unprofessional' but had not been given an opportunity to do so.

Participants also attempted to minimise professionalism concerns by suggesting that their behaviour had not, in fact, been unprofessional but had merely been a misinterpretation of the facts. Here, for example, David tells the story of one of the professionalism concerns that was raised about him. In this evaluative section, not only does he reflect on the immediate misunderstanding – that he had not intended to give morphine – but also the intent of his actions. In fact, he implies that he has desirable characteristics, in that he was willing to go above and beyond to assist the healthcare team, thus claiming a medical identity:

> *… I was trying to be helpful. That's what…a lot of my professionalism concerns come from me trying to be helpful.* […] *And I said, erm, like "I'll help you with that. Oh yeah, yeah, I've been signed off for, erm, for IVs." I was sort of referring to the idea of cannulating the patients and making sure they were ready. But it was taken to be that I was wanting to give morphine…*
>
> DAVID

This is perhaps the most overt claim that 'it is not what it looks like': David was stating that no part of his behaviour had been unprofessional. Indeed, he went onto a further conclusion that the individual who had raised the concern had only been tangentially witness to the situation and thus had misunderstood the interaction. Sarah told a more subtle story of misunderstanding: she admitted to having engaged in an 'unprofessional' behaviour but dismissed the concern as she had been doing this to help a friend.

> *I…signed in for my friend, who was going through a really hard time and she was worried about her attendance…*

SARAH

By explaining the rationale for her actions in this way, Sarah seems vindicated in her choice. On balance, she does not seem to perceive that her behaviour was 'unprofessional' as her motivation was kind and empathic.

Some participants used evaluative sections to justify their behaviour by suggesting that it was no different to that of their peers. Here, for example, Pete suggests that the professionalism reports made against him were unfair on the grounds that they applied to a significant proportion of his cohort:

> *I feel like a lot of them were, like, they weren't really warranted? Like…like…the first one wasn't warranted, because it was…basically, like 50 people in my year got that one.*

PETE

By highlighting how common this professionalism concern was, Pete made the claim that it 'was not what it looked like': he was not unprofessional, instead the medical school's systems for highlighting professionalism concerns were flawed. Importantly, he did not make space in his narrative for the alternative explanation that professionalism lapses are common and thus it would be possible for all 50 students concerned to have been unprofessional. This was an important social action as to acknowledge that the other students had behaved unprofessionally would force Pete into a position of accepting that he too had been unprofessional. Instead, he chose an outright rejection of the 'unprofessional' label on behalf of himself and his peers.

In addition to participants' attempts to minimise and explain away professionalism lapses, a subtheme emerged from the narratives that I have named '…but I will play along'. In spite of seemingly not feeling truly responsible for their actions, some participants developed an awareness of the best way to align themselves with the medical school system. They told stories of a formulaic response to professionalism lapses: when concerns were raised, they would be seen to reflect, apologise and set out a plan to avoid recurrence of the behaviour. Participants rarely told explicit

stories of having played the system; however, a contradiction emerged within the stories that they told me. In the interview, they positioned themselves as the innocent party but in telling their stories of how they managed their interactions, they spoke of the contrition and apologies that were necessary. Pete, for example, told a story of attending a panel hearing at his medical school to account for the professionalism concerns that had been levelled at him.

> *…explained the reasoning behind it. Took full accountability for it. Everything: full accountability. Er, and told them how, how I'd improve. How I have improved and how I'm going to improve.*
>
> PETE

This contrasted with the way that Pete had discussed these professionalism concerns earlier, claiming that they were "unwarranted". This juxtaposition implied that Pete was aware of the performance that the medical school expected of him and was prepared to attempt it, even though it was not heartfelt.

Having said that participants attempted to minimise their professionalism lapses, this was not always the case. In fact, some explicitly acknowledged their shortcomings in the interview space. Participating in my research seemed to offer them the opportunity to present themselves to me as reflective and mature, distancing their current selves from their former behaviour, as I have explored in 'the self-made (wo)man'. This social action could be interpreted as a way of students using the interview to save face or even 'play along' even more effectively: they wear the mask of appropriate reflection in order that I develop a 'good' impression of them.

In summary, participants used their narratives to retrospectively justify their actions and reactions and seemingly to reject the identity of the 'unprofessional' student. In addition, they told stories of apologies and behaviour change that may not be entirely authentic as these stories were contradicted by the aspects of their narrative that told of their unprofessional behaviour being 'not what it looked like'. Instead, their reflections may be part of a façade intended to appease the medical

school and achieve their end goal to continue their medical studies. At times, participants seemed to suggest that they had greater insight into medical institutions and structures than their peers, practising clinicians and university staff, allowing them to 'play along'. This superior insight was also often expressed in evaluative narrative sections suggesting ways in which these systems could function better and is conveyed in the following identity position – 'The Maverick'.

7.1.5. The Maverick

In the previous chapter, I discussed the subtheme 'I am not like the rest of them…because I do not want to be'. In that section, I discussed participants' stories of explicitly setting themselves apart from their peers and the medical establishment. This identity position that I have termed 'The Maverick' goes beyond

	Positions	Themes
The Told Stories	'The Medic' 'Explicitly at Odds'	'I think being a doctor is what I am supposed to be' • 'I will get there eventually' 'I am not sure where I fit' • 'I am not sure if I can do it' • 'I cannot make sense of myself' 'I am not like the rest of them' • '…because I do not want to be' • '…because it has been harder for me'
The Untold Stories	'The Victim of Fate' 'The Self-made (Wo)man' 'The Maverick' 'The Lucky One'	'It feels like the world is against me' 'It is not what it looks like' • '…but I will play along'

Table 6.2 – Summary of identity positions and themes

this self-imposed separation to an express position of authority over healthcare and educational institutions. This is related to but distinct from the 'explicitly at odds' identity position (section 6.3.4), in that 'The Maverick' position often emerged from a sense of worldliness or unique insight. In addition, 'The Maverick' identity position was characterised by the radical: not only did participants have unique insights and understandings, they made recommendations for reform. From my position as interlocutor, the recommendations – particularly when discussing healthcare and medical education – sometimes seemed both drastic and transformative. Furthermore, participants seem to use this identity position to intentionally dissociate themselves from a system that they are simultaneously striving to join. Participants gave the impression of wanting to reshape the systems and institutions that constrained them to find a more comfortable future in medicine.

From a reflexive point of view, I am aware that my comparative seniority and experience of healthcare and medical education makes me potentially cynical to students' ideas for reform. Importantly, I want to highlight that I am not attempting to criticise the suggestions made by participants but merely to describe my interpretation of the social actions of these narrative elements.

One way in which participants tied recommendations for reform into their narratives was as a means of reflecting on their experiences of professionalism lapses or academic failure. In particular, a number of participants made suggestions about how medical schools could support their students better. Here, for example, Victoria suggests that her medical school should be kinder to students and take the whole context into account, implying that this was not what was offered to her:

> *I just think…it's always important for…any professional…or any medical school to not be so harsh on a student. Especially when they're going through much. 'Cos there's always a bigger picture: there's always a story. And I think they sometimes are so…involved with the rules and regulations process…*
>
> VICTORIA

Hannah also spoke about a lack of support provided by existing structures and how this could be made more robust by providing something bespoke for medical students. Interestingly, in the following quotation, she harks back to 'The Medic' identity as she sets medical students apart, putting them in a place of privilege over other students.

> *…have something separate from the main University for medical students but, yeah…that's something that would help medical students, 'cos even I don't feel like going to the main university for help because I feel like they don't understand exactly.*
>
> HANNAH

Interestingly, as part of the preparation for each interview, I looked up the support services available at each institution to provide to participants as part of the debrief process (see Appendix 3). I was therefore aware that Hannah's medical school *did* provide a bespoke support service for medical students and signposted her to this after the interview. This demonstrates an interesting aspect of 'The Maverick' identity position: the position of expertise claimed by participants was not necessarily based in tangible knowledge or understanding. As the interviewer, I was left with the impression that taking the stance of 'The Maverick' was a way of having a position of authority in an interview space that otherwise potentially focused on participant's difficult experiences and shortcomings.

Another way in which participants took 'The Maverick' identity position was by critiquing dominant medical understandings, thus placing themselves in the position of relative knowledge and power in a medical setting and consequently contradicting traditional hierarchies. For example, in Henry's narrative, he discussed the ways in which he felt psychiatry was limited by Western biomedical paradigms. In the following quotation, he reflected on how he felt that psychiatry training was flawed by these perceived limitations.

> *…one can become a consultant psychiatrist now without…ever having studied…anthropology. Or the philosophy of science. Or the philosophy of mind*
>
> HENRY

Later in his narrative, Henry made more obvious claims to a position of expertise in that he made explicit suggestions for how the practice of psychiatry should shift. In this quotation, for example, he places the onus on himself to "figure out" how this can be done, thus overtly claiming the identity position of 'The Maverick' reformer.

> *I'm still trying to figure out…ways in which…psychiatry can…learn from more of this enormous ethnographic and, er…and historical evidence of people having these non-ordinary experiences.*
>
> HENRY

The position as an expert was often linked to a sense of participants being individuals with the potential to reform systems and institutions, such as the example from Henry above. This is an interesting social action as it separates the narrator from institutions that occupy a position of control over their future. Societal norms ordinarily require a degree of respect for institutions such as universities and the healthcare system. Their critiques and recommendations for reform distance participants from the norms of these institutions, even conveying disrespect. Furthermore, their dissociation from dominant institutions suggests a sense of being at odds with society more widely.

In some instances, participants also used their ideas about healthcare systems reform to contextualise their professionalism lapses: they are not unprofessional, the system simply perceives them that way. In the following example, David talks about his experience of teamwork during an elective placement in Brazil:

> *…the way they do team work, I think's a bit better, sometimes. Er, they are a bit less hierarchical, which for me is good. There's a bit more…the right answer is the one that's the right answer, doesn't matter where it comes from.*

Putting this in context, David discussed a number of professionalism concerns during his narrative, many of which had focused on teamwork and hierarchies. He went on in a later evaluative section to recommend that the medical school curriculum should also explicitly teach more teamworking skills, as well as how to negotiate hierarchies in the clinical environment. In combination, this gave the impression that David was positioning himself as someone to improve and reform the system, at least in part so that he fits more comfortably within it. The courage – or perhaps audacity – to make recommendations for reform potentially implies a degree of societal privilege, in that David tacitly suggests that the healthcare system should evolve to suit him, rather than the converse. This dichotomy between unacknowledged membership of a privileged social group and rejection of institutional conventions is something that I will explore in the following identity position – 'the lucky one'.

7.1.6. The lucky one

This final identity position is challenging to explore as, more than anything else that I have discussed, it probably applies to many medical students, regardless of whether they have experienced professionalism lapses. In the identity position 'the victim of fate' and the theme 'it feels like the world is against me', I have discussed participants' narratives of misfortune. These narratives, however, stand in stark contrast to the place of privilege that they hold in society. For example, participants told stories of lack of support by their families; however, their story of how they supported themselves financially was left untold. This could clearly be interpreted in several ways as it is difficult to fill in what is unsaid; however, some participants did speak openly about financially supporting themselves, contributing to their narrative of victimhood, struggle and difference from their peers. With this in mind, the untold story seems to be that participants were receiving financial support in counterpoint to their told story of being unsupported.

Participants also referred to the difficulties that arose for them when emotional support from their families was not readily at hand. Here, for example, Hannah was

discussing the difficult experience of having to attend a hearing about her professionalism concerns.

> *I didn't really…my parents didn't know any of this. So…that was another thing I had to deal with. So… And they were so far away, so they couldn't, like, support me, either.*
>
> HANNAH

In this short quotation, however, Hannah both makes a claim that her parents could not support her due to the physical distance and also that she did not give them the opportunity as she did not tell them what she was happening. To me as her audience, this told a story of Hannah potentially having the privilege of a supportive family but not acknowledging this due to the relatively minor barrier of a few hundred miles.

In several participants' narratives, their response to difficulties at medical school was to return to their parental home and rely on familial support. When participants told their stories of ill health, they often relied on family structures such as a 'home' to return to that allowed them to continue with medicine. Participants who felt that they lacked family support altogether told express stories of the struggles that ensued when they did not have this to 'fall back on'. Here, for example, Sarah was reflecting on a time when she needed to take time away from medical school for mental health reasons.

> *if you don't come from a good, supportive family, there's not really much in the way of what you can do in terms of resting* […]
> *There's not really anything in place for you.*
>
> SARAH

Though I acknowledge that this experience must have been difficult for Sarah, it does give a sense that she fails to recognise all of the advantage she did have such as a secure place to live and the ability to support herself financially. Overall, these untold stories indicate a position of societal privilege that is, at least in this context, unacknowledged on the part of my participants.

A further way in which participants seemed to fail to acknowledge their privilege was in their stories of helping others, both during clinical placement and outside of medical school. It is important not to assume that all lives unlike my own, Western experience of the world are somehow inferior. That said, when participants told me stories of working with refugees and orphans in the developing world, their expectations for these people seemed strikingly low. For example, Pete described a refugee camp he worked in as "really nice" because the people living there had beds, shelter and three meals a day. This mismatch between their expectations for themselves and for others seemed to belie a position of unacknowledged privilege.

In some cases, participants did perceive their privilege to a certain extent; however, this was not linked to stories of advantage. David, for example, acknowledged the privileged position he occupied but used this to illustrate how he struggled to come to terms with being dependent on pain relief as this was not his expectation of himself:

> *I'm reliant on this medication. Erm…and, I don't realise how reliant I am on it. I believe I'm in control of it. I believe I'm…middle class, white, I'm going to be a doctor…*
>
> DAVID

When counterbalanced with the identity position 'The Maverick', a tension arises between a position that participants seem to wish to curate and what is untold. Where participants take 'The Maverick' position, they seemingly wish to reform institutions that actually favour them given their relative privilege in society. For example, medical students and practitioners tend to be treated favourably by healthcare systems but participants wish to change these systems to treat people better. Though this could be perceived as selfless, I suspect it once again belies a lack of awareness of their privilege.

I appreciate that the invitation to these participants was to tell their story of becoming a doctor in the context of a study about professionalism lapses. In view of the privileged nature of medical study and practice, it is unsurprising that students

do not always perceive their societal privilege: in relative terms, they may well lack privilege compared to their peers. When contextualised in narratives of struggle and difficulty in a world that stands against them, I was still struck by the seeming lack of insight into the wider world. Whether this self-centredness is a common trait in all medical students; is a trait common in students that experience professionalism issues; or develops as a result of professionalism concerns is impossible to extrapolate from the narrative data at hand.

7.2. Summary

In this chapter, I have discussed the stories that participants did not intentionally tell. I have discussed positions that seemed to be intentionally implied as a social action – 'the victim of fate' and 'The Maverick' – and the ways in which these actions failed for me as an audience. In addition, I explored one identity position that seemed entirely accidental – 'the lucky one'. Furthermore, I have discussed the themes in which participants storied their lack of support – 'it feels like the world is against me' – and sought to justify and defend their perceived unprofessional behaviour – 'it is not what it looks like'.

In the two findings chapters, I have referenced examples from participants' narratives, in order to give context to my interpretations. I have told stories of participants who desperately want to succeed in medicine and have worked hard to achieve this goal, including attempts to adapt to a medical identity performance. I have also told stories of discomfort, with participants diverging further and further from the 'norm' due to their life experiences, academic failures and professionalism problems. I have told stories of participants feeling as though they do not fit into a conventional medical identity, because circumstances have conspired against them or because they have chosen to separate themselves from this expectation. I have told stories of participants feeling as though the world is against them, including a sense that no one is helping them to move forwards and that they must forge a path for themselves. I have told stories of participants' distaste for systems and institutions that they see as imperfect and their expressed desire to change things

for the better. In order to understand these stories further, however, they must be contextualised in reference to relevant literature. In the following chapter I explore theoretical frameworks such as identity dissonance and liminality, as well as theories of blame attribution and cultural capital to explain the themes and narrative positions that emerged from my analysis.

8. Discussion of Narrative Themes and Positions

In the two preceding chapters, I have outlined the outcome of my analysis of the stories of my participants. These participants intentionally positioned themselves as 'The Medic' and being 'explicitly at odds', whilst also implying positions of being 'the victim of fate', 'the self-made (wo)man', 'the maverick' and 'the lucky one'. My participants told stories of believing that being a doctor is what they are supposed to be, being unsure where they fit in and feeling different from their peers. They also implied stories of feeling as though the world was against them and of their actions being misunderstood or misinterpreted. In this chapter, I draw these findings together with existing empirical research and theoretical frameworks to better understand the implications of this study for the management of unprofessional behaviour. I return to theories of identity development and explore the concept of identity dissonance in the context of unprofessional behaviour. I also draw on theories of cultural capital and 'blame' and use these to understand how institutions may be creating structures that exacerbate the professionalism problems demonstrated by the participants' narratives.

8.1. An unprofessional identity?

As I discussed in Chapter 4, there is a wealth of medical education literature that describes becoming professional as a process of professional identity formation (R. L. Cruess *et al*., 2018; Hafferty, 2016; Irby & Hamstra, 2016; Passi & Johnson, 2015; Sharpless *et al.*, 2015). This led me to question whether 'unprofessional' students are on an alternative identity development trajectory. Some authors imply that a professional identity is intrinsically connected to professional behaviour (Barnhoorn *et al.*, 2019; R. L. Cruess, Cruess, Boudreau, Snell, & Steinert, 2014), suggesting that students who behave unprofessionally have a problematic – even unprofessional – identity. Other educators have attempted to target professional identity as a means of remediation following professionalism lapses (Bebeau & Faber-Langendoen,

2014); however, I have critiqued these approaches due to the interpretations of identity upon which they rely.

It may seem a logical deduction that if one does not *feel* like a doctor, it is difficult to motivate oneself to *behave* in the manner expected of a doctor, thus increasing the likelihood of unprofessional behaviour. One of the key outcomes from this study, however, is that the 'unprofessional' students that participated did, at least in part, *feel* like doctors-in-training: they embedded their stories firmly within the context of a medical paradigm, using expressions and language that situated them within this field. From this study, therefore, there does not seem to be an absence of professional identity formation from the perspective of the participants themselves.

As I outlined earlier in this thesis, identity is performed for an audience for a purpose (Goffman, 1956). These identity performances are influenced by an individual's understanding of the expectations of the audience (Goffman, 1956) and the extent to which the performer wishes to meet with these expectations (Holland *et al*., 1998). With this in mind, professionalism lapses can be conceived as identity performances that do not match the expectations of the audience. Here, I use existing theoretical frames to explore the reasons why these 'unprofessional' performances may occur.

8.1.1. The liminal medic

In Chapter 6, when discussing 'The Medic' identity position, I touched on the inconsistencies in the medical narratives of my participants: on many occasions, a story failed to hang together for me as a practising clinician. Furthermore, participants took identity positions such as 'The Maverick' and 'The Lucky One' that felt jarring given my knowledge and experience of the healthcare environment: they seemed to lack understanding of the inner workings of systems that they have experienced. It could be assumed that a lack of consistency in medical narratives was due to a professional identity that is incomplete, weak or vulnerable and thus in need of remediation (Bebeau & Faber-Langendoen, 2014; Rees & Monrouxe, 2018). Alternatively, using the model of communities of practice (Lave & Wenger, 1991), my participants could be understood as peripheral to the medical *milieu* and thus

with limited insight into the institutions and systems they narrated. Using communities of practice theory, however, assumes a natural trajectory of resolution with increased exposure to the medical environment that does not seem to represent the experience of my participants. Instead, I believe that the identity performances of my participants speak to a liminal identity phase.

The term liminality describes a state "betwixt and between" (Turner, 1987, p.3), when an individual is on the road to becoming – in this case a doctor – but has not quite reached the destination (Beech, 2011; Rantatalo & Lindberg, 2018). This is a state of flux, in which an individual recasts their identity to fit into a new mould. In order to explore this state of flux, Shapiro (2009) presented medical student poetry to illustrate lived experiences of undergraduate medical education. In Shapiro's study (*ibid.*), students used poetry to describe the identity sacrifices that they made during medical education in order to achieve the goal of becoming a clinician (Shapiro, 2009). The subtheme 'I cannot make sense of myself' aptly reflected this liminal state: participants described difficulties with assuming the role of a medical student and reconciling a future in medicine with the expectations they had had prior to entering medical school. The struggle participants in this study articulated was not without a clear sense of purpose, however: the theme 'I think being a doctor is what I am supposed to be', as well as the identity position 'The Medic', demonstrated a still-strong desire to develop into a doctor. Importantly, conceptualising the identity development trajectory of these in terms of liminality is not 'abnormal' or 'pathological'. Instead, it is a way of understanding how new experiences impact on identities.

Reflecting on my previous definition of identity in Chapter 4, it is vital to acknowledge that identities are multifaceted and contextually-specific. Using the lens of liminality alone, one could assume that 'The Medic' is the only identity to which medical students aspire and that any incongruent aspects of their identity must be discarded in order to complete their identity journey. If this were the case, identity could readily be targeted for assessment and remediation following professionalism lapses: learners could be encouraged to leave behind aspects of

themselves that are unhelpful to their medical career and removed from their course if unwilling to do so. Instead, returning to Goffman's (1956) dramaturgical understanding of identity, an identity is brought to the foreground for a particular performance and retired to the background when not appropriate for the context. Therefore, instead of a singular identity being reshaped in the liminal medical student phase into one befitting a doctor, a new liminal medical identity is formed as a medical student. After all, being a medical student is a state of being 'betwixt and between': it is a state of both being a medical student and becoming a doctor. In this liminal phase, medical students must 'play' at being a doctor (Sharpless *et al.*, 2015) and find a way for a medical identity to co-exist with their other identities. Furthermore, according to Figured Worlds theory, medical students must choose the extent to which they wish to give a conventional medical identity performance (Holland *et al.*, 1998). This suggests that the medical student phase is a particularly challenging experience for identity development as one is forced to both sit within and without the community of medical practice, making identity choices difficult to rationalise. Medical students in Shapiro's (2009) study expressed some regret at the perceived loss of their former self but surrendered to it, acknowledging the necessity of resolving the perceived conflict between identities in order to move forwards. This does not, however, seem to capture the degree of otherness expressed in my participants' narratives. Nor does it seem to reflect the unwillingness to submit to the medical hegemony, expressed in particular in the identity position 'The Maverick' and the subtheme 'I am not like the rest of them…because I do not want to be'. In order to understand this sense of alienation and conflict, I draw on a theory known as identity dissonance.

8.2. A dissonant identity

Authors in medical education have previously used Costello's (2005) theory of identity dissonance as a basis for understanding how medical students negotiate professionalism dilemmas (Monrouxe, 2010) or as a means of interpreting expressions of multiple, seemingly disparate identities (Joseph *et al.*, 2017).

Costello's (2005) original work involved a lengthy and detailed ethnographic study of graduate students undertaking vocational programmes in law and social work at a university in the United States, identifying that some individuals found it much more difficult to adopt the dominant habitus of the programme than others. The term dominant habitus refers to the prevalent habits of a social group, such as dress and styles of speech. In the context of Costello's (*ibid.*) work, the dominant habitus included aspects such as eating habits and study practices. The dominant habitus was perceived by Costello (*ibid.*) as a consonant identity performance: the performance met the expectations of the audience, in this case peers and faculty. Difficulties adopting the dominant habitus took many forms in Costello's (2005) observations, such as the style in which students responded to lecturers when questioned. Furthermore, Costello (*ibid.*) interviewed some students that she had observed, who openly acknowledged a sense of difference from their peers, not unlike the participants in my study feeling 'explicitly at odds' and telling stories of being unsure where they fit in.

Costello (2005) identified that individuals experiencing identity dissonance were more likely to struggle academically, seemingly because their attention during educational sessions was consumed by trying to resolve their identity dissonance, thus limiting the attention that was paid to the class. Costello (*ibid.*) noted that poor academic performance then seemed to exacerbate a sense of not belonging, in some cases worsening identity dissonance. One of the subthemes that emerged from my analysis – 'I'm not like the rest of them…because it has been harder for me' – seems to reflect the identity dissonance that emerges from perceiving oneself as unlike one's peers. Importantly, the individuals in Costello's (2005) study that experienced identity dissonance were more often female, and those from Black and Minority Ethnic (BAME) backgrounds and lower socioeconomic classes were at particular 'risk'. Whether on the basis of race, class, gender, health or educational background, many of my participants began medical school with a sense of otherness, which is likely to have caused a degree of identity dissonance. The labour that these students then seemingly had to undertake in an attempt to resolve this

dissonance may have put them at risk of the assaults they described on their liminal medical identity, such as academic failure and professionalism lapses. Following these identity challenges, their identity dissonance is likely to have been exacerbated, leading to further labour to resolve it, as demonstrated in Figure 8.1.

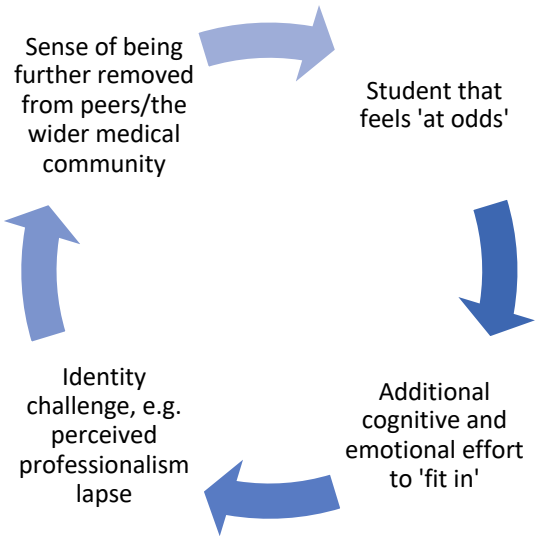

Figure 8.1 – A graphic representation of the cycle of identity dissonance

When framed in this way, the cycles of failure described by participants start to become more transparent: the more lapses they experience, the greater the identity dissonance that is created. Indeed, this does seem to confirm the sense expressed by participants that their path through medical education has been more difficult. What this model does not help us to understand is why these students experience identity dissonance in the first place. In the United States, there are seemingly obvious structures that make medical education inaccessible and inequitable, such as the cost of higher education and the lengthy nature of university for medics. Unlike the context of Costello's work, in the UK pre-University education is freely available to all; there is no variation in the cost of medical education between medical schools; student loans are readily available, as is means-tested financial support; and very few differences exist in the academic standards required for admission between medical schools. This suggests that all medical students should arrive equal, ostensibly with no advantage conveyed by a socioeconomic background of conventional privilege – theoretically creating a meritocracy in

medicine. Some authors have, indeed, praised the meritocracy in medicine (Frishman & Alpert, 2019) and there have been express attempts to increase diversity in medicine (Gore, Patfield, Holmes, & Smith, 2018). In spite of attempts to widen access to medicine, there is an understanding that a persistent attainment gap exists for students from BAME and lower socioeconomic status backgrounds (GMC, 2018d). Indeed, medicine has been described as having an "intractable class problem" (C. White, 2019). This suggests that there is more to success in medical education and practice than reaching the academic standard for admission, a concept often explained by Bourdieu's theory of cultural capital (Bourdieu, 1986).

In Bourdieu's (1986) conceptualisation, capital can take many forms: it is not simply material wealth but also less tangible assets that allow an individual to leverage an advantage in a particular social context. Bourdieu (1986) himself studied differential attainment amongst children from disparate socioeconomic backgrounds going through the same educational system and theorised that this gap in academic achievement resulted from children from some backgrounds having experience of culture – language, music, literature – that led to an understanding of social and educational institutions, making these contexts easier to negotiate. Bourdieu (*ibid.*) theorised that this literacy with regard to institutions and societal structures made access to further educational resources and qualifications easier, meaning that socioeconomic privilege was translated into educational attainment. Educational attainment also translated into potential for economic privilege, as qualifications created possibilities for income.

Cultural capital theory has been widely adopted across geographical and educational contexts to understand the failings of meritocratic societies (Lamont & Lareau, 1988). It has also been used to understand why particular patient groups may be disadvantaged by healthcare systems, as some individuals lack an understanding of the expectations of a 'good' patient (Sointu, 2017). Similarly, it seems plausible that, in spite of educational attainment, some individuals arrive at medical school with the language, habits and behaviours that professionals conventionally embody, whilst others do not. This leads to an immediate sense, upon arrival, that they are

'explicitly at odds' with their peers: they perceive their difference without being able to access the tools to resolve it. With this in mind, I have adapted Figure 8.1 to incorporate the concept of cultural capital causing a disruption to identity from the outset (see Figure 8.2). In the context of my study, there were seemingly stories of participants lacking cultural capital, exemplified by the identity position 'explicitly at

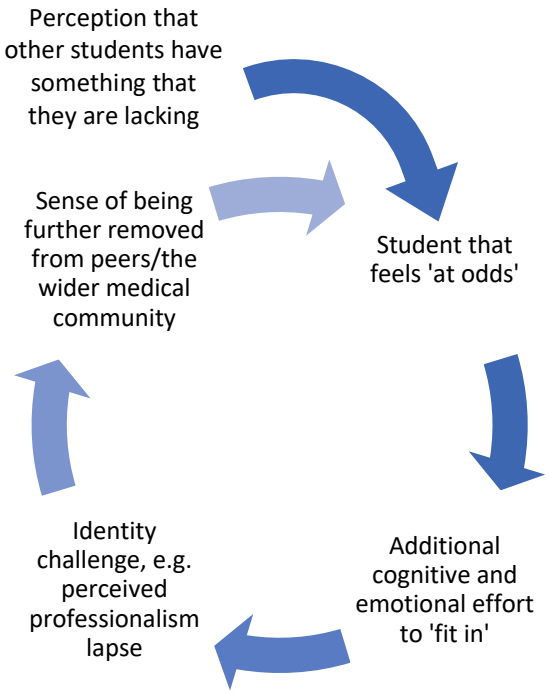

Figure 8.2 – A refined version of the cycle of identity dissonance to incorporate cultural capital

odds' and the themes 'I am not sure where I fit' and 'I am not like the rest of them'. On the other hand, there were stories of students who felt able to 'play along', giving an identity performance that met the expectations of the situation in which they found themselves. This suggests that these participants had a tacit understanding of the system that was advantageous to them in certain contexts, facilitating a consonant identity performance at critical moments. I return to this theoretical construct later in the chapter to understand how students negotiate with institutions following professionalism lapses.

8.2.1. Negative and positive dissonance

Returning to identity dissonance theory, Costello (2005) described two distinct types of dissonant identities: positive and negative. As discussed above, some individuals seemed unable to give an identity performance that sat comfortably with their

sense of self or with the expectations of the environment – termed negative identity dissonance (*ibid.*). Identity positions such as 'the victim of fate' and 'explicitly at odds', as well as the themes 'I am not sure where I fit' and 'I am not like the rest of them…because it has been harder for me' seem to express a negative identity dissonance. In these stories, participants seemed to be attempting an identity performance that met the expectations of the audience but failing to achieve this. These identity performances may be well-meaning, as expressed by the theme 'it's not what it looks like': these students may well have been motivated by positive professional values (Shapiro, 2018) but were in some way unacceptable to their audience.

Importantly, the failure of the identity performance is defined as much by the *expectations* of the audience as it is by the identity that the individual is trying to project. In the context of the discussion of professionalism I set out in Chapter 2, it is vital to consider that the professional norms and expectations may neither be equitable nor reflect the diversity of modern medical practice. Indeed, at their worst, professional norms can be contradictory: though a conventional definition of professionalism seemingly requires values and behaviour that are beyond reproach, there are cultural practices that are common within medicine that may not be acceptable to their patients. One example is the drinking culture that is still pervasive in many medical schools (Owens, 2018). Though binge drinking – and the antisocial behaviour that can ensue (Faulkner, Hendry, Roderique, & Thomson, 2006) – could easily be seen to be falling short of a definition of professionalism, this behaviour has been common amongst medical students for so long that it is deemed acceptable and even expected, providing this behaviour does not encroach upon the clinical environment. Importantly, the binge drinking culture in medical schools is tied to a historically white, masculine and heteronormative understanding of what it means to be a medical student and seems to have evolved relatively little in spite of the changing nature of medical student populations. In this way, a student may engage in an identity performance that some would consider unprofessional – such as posting photographs of themselves on social media, obviously intoxicated and with a traffic cone on their head – but this performance is consonant with

expectations and thus may be dismissed by medical faculty as relatively trivial. When professionalism lapses are conceptualised as identity performances that are dissonant with the expectations of the profession, it is important to consider that the *expectations* and not an individual's identity that may be the problem. Thus, I consider dissonance in terms of the space where the student's identity performance meets its audience, where a mismatch between the identity performance and the expectations is created.

In Costello's (2005) study, students experiencing positive identity dissonance sought self-improvement through access to professional qualifications and separated themselves from their former identities relatively willingly. This seems to broadly align with Shapiro's (2009) description of liminal identities – medical students were aware of the identity sacrifices that they must make but the end of becoming a doctor justified these sacrifices. Some individuals in Costello's (2005) study, however, seemingly chose to resist the dominant habitus, instead giving an identity performance that was consonant with their sense of self rather than the expectations of the educational environment.

Reflecting on the identity positions of 'The Maverick' and 'the self-made (wo)man', as well as the subtheme 'I am not like the rest of them…because I do not want to be', positive identity dissonance seems to become particularly pertinent. Drawing these themes and positions together, they seem to express a sense of pride in their difference, a desire to preserve a sense of separation from their peers and a connection to a sense of self that they perceive to be authentic. In this, they resist adopting the dominant habitus of the medical profession or unquestioningly submitting to the process of becoming a doctor. These acts of resistance storied by my participants may have been conscious identity choices to rally against a medical hegemony that does not represent their values. Through these acts of resistance, however, participants engage in professionalism lapses and once more drive a wedge between their performance of a medical identity and the expectations of their medical school.

In summary, participants' narratives seem to reflect both positive and negative identity dissonance, which I theorise increase the risk of engaging in 'unprofessional' behaviour and also worsen the outcome following professionalism lapses for these individuals, perpetuating a sense of otherness. Students from underrepresented in medicine (UiM) backgrounds are likely to experience the highest levels of identity dissonance, which has important implications for the manner in which professionalism lapses are perceived by medical schools to ensure equity for all students. Importantly, a dissonant identity performance may represent a student deliberately resisting expectations that do not represent 'professionalism' to them. Before exploring these implications in more detail, I will first discuss the role of blame in further exacerbating identity dissonance.

8.2.2. The Blame Game

In Chapter 3 of this thesis, I discussed the importance placed by medical educators on learners demonstrating insight into their behaviour following professionalism lapses. This echoes much of the literature on the topic of unprofessional behaviour and its remediation: insight is seen as key to success in remediation following professionalism lapses (Hauer *et al.*, 2009; Mak-van der Vossen *et al.*, 2016; C. Roberts & Stark, 2008; C. Sullivan & Arnold, 2009; Van Mook, Gorter, *et al.*, 2010). This is further reinforced by the guidance from the GMC and MPTS in the UK (GMC, 2017; GMC & MSC, 2016; MPTS & GMC, 2018), who identify insight into misconduct as an important factor in deciding whether remediation is possible following a professionalism lapse. When analysing the concept of insight, however, must a learner acknowledge that what they have done is perceived by their medical school as unprofessional or must they perceive that what they have done is unprofessional? In my mind, the distinction between these two is lacking from the discussion of insight and may seem immaterial. In either case, the learner wishes they had acted differently, whether they truly regret their actions or simply understand that their medical school wishes them to behave differently. In my study, the subtheme 'it is not what it looks like…but I will play along' implies the former: participants acknowledged that they had been seen to be unprofessional,

but this did not reflect their perception of the situation. In their combined guidance for managing tribunals of practising doctors in the UK, the GMC and MPTS state the following:

> *A doctor is likely to have insight if they:*
>
> *a) accept they should have behaved differently (showing empathy and understanding)*
>
> *b) take timely steps to remediate […] and apologise at an early stage before the hearing*
>
> *c) demonstrate the timely development of insight during the investigation and hearing.* (Medical Practitioners Tribunal Service & General Medical Council, 2018, p. 17-18)

This does not serve adequately to distinguish between the two constructs I have suggested, though the implication of showing "empathy and understanding", as well as requiring apologies, is that 'true' insight requires acceptance from the individual that the actions themselves were wrong. After all, it is difficult to meaningfully apologise for something if one does not feel as though one has done anything wrong. This is important as, when translated to the context of undergraduate medical education, demonstration of insight effectively requires the learner to assume the blame for their actions. In Chapter 3, I drew parallels between the way professionalism lapses are managed and the criminal justice system. Again, these parallels can be seen between the construct of insight in medical education and acceptance of blame in the criminal justice system: pleading guilty leads to reduced sanctions. When discussing how to manage professionalism lapses, authors rarely discuss the attribution of blame and, when blame does feature in academic discourse, it is ordinarily to claim that it is explicitly avoided in the management of unprofessional behaviour (Parker *et al*., 2008). I argue, however, that by requiring learners to demonstrate insight into their professionalism lapses, medical schools ask them to shoulder the blame.

Douglas (1992) explored the construct of blame across a variety of cultures and contexts, concluding that all cultures attribute blame as a means of understanding misfortune and determining actions that should be taken. Douglas (*ibid.*) described three fundamental blaming paradigms:

- that the subject of the misfortune is to blame, having committed a transgression of some kind;
- that an individual adversary is to blame, who managed to outsmart the victim;
- that an individual outside the community is to blame, having somehow dishonestly infiltrated the community.

In either of the first two, the individual is deserving of their fate. In the third, however, the blame lies squarely at another's door and the individual is a victim. Importantly, each of these paradigms evoke a response. In the first instance, both the individual and the community must modify their behaviour to follow the rules in order to avoid further transgressions. Alternatively, the second paradigm requires that each individual must work to protect their own interests, becoming smarter or more skilled than others. Finally, in the third instance, the community must work together to punish the enemy and protect itself in future. In Table 8.2, I present a worked example translating these blaming paradigms to explain a professionalism lapse – in this case, problems meeting deadlines.

Though this worked example may seem trivial, it serves to illustrate a fundamental dichotomy that is exemplified in the narratives of my participants: whether the student themselves is responsible for her actions or whether external individuals or forces beyond their control are the root of the problem. In my study, participants seemed to partially accept blame, exhibiting in students telling stories 'playing along', openly expressing fault in particular circumstances. For example, when faced with a formal panel hearing, some participants told stories of having openly accepted responsibility for their perceived lapse for the benefit of their institution. This was, however, counterbalanced by the stories of 'it feels like the world is

Blame paradigm	Explanation of blame	Required response
The subject is to blame, having committed a transgression	The medical student is at fault for failing to meet the deadline, for example because she has not worked appropriately to the deadline. She is also to blame for not understanding the importance of deadlines in medicine.	The student must modify her behaviour to align with the rules. She must work harder and more efficiently to meet the deadline, as well as reflect on why deadlines are important in medicine.
The subject is to blame, having been outsmarted by another	The medical student is at fault as she has relied on a colleague to inform her of the deadline. Her fellow student deliberately misinforms her as he perceives that she should know better.	The student must learn not to rely on her peers as they are also her competitors, developing systems to ensure she is not outsmarted in future.
An external force is to blame, having dishonestly infiltrated the community and attacked the subject	The medical student is not to blame: she missed the deadline because the computer system was faulty, meaning that she could not upload her assignment before the deadline.	The medical school must look at the system to ensure it is 'trustworthy' in future and work to protect its students from similar problems.

Table 8.2 – a worked example of blaming paradigms applied to a commonplace professionalism lapses

against me' and the position of being 'The Victim of Fate'. In taking the victim position within their narratives, my participants utilised the blaming paradigm of having been subject to an attack from outside the community. Participants told in-

depth stories of their adversaries, who treated them unfairly and – in the eyes of the student – not in accordance with the rules and norms of the medical community. Although superficially the individuals named by participants, for example faculty members, may be seen to come from within the community, participants used narrative devices to set them apart. For example, participants told stories of unfair decisions or practices, implying that these individuals were not following the rules of the community and were thus *de facto* imposters. Furthermore, participants used stories of other peers or faculty that were on their side to 'other' their adversaries, placing them firmly outside an accepted community. In so doing, participants placed the blame for professionalism lapses firmly at their door.

The effect of participants assuming an alternative blaming pattern to their medical school is potentially profound. Ultimately, the medical school is a powerful institution and thus the student is required to be seen to accept blame in order to continue their medical studies: they must tell stories of contrition and humility. This leads to the curation of a student blame narrative that the student deems appropriate for the consumption of medical faculty (Fernandes, 2017). Given the stories we tell about ourselves become a facet of our identity (Bruner, 2004; De Fina, 2015), this seems to lead to 'unprofessional' students developing a particular 'unprofessional' identity for the benefit of their medical school. This allows students to practice the required performance of contrition for particular contexts. In the interview space, however, participants told stories of victimhood that did not align with this identity performance: they had different stories to tell when their future medical careers did not rely on the acceptance of blame. Participants seemed to develop a different identity for 'backstage' spaces (Goffman, 1956) of being innocent and unfairly treated. These two co-existing identities clearly conflict with one another, which is likely to exacerbate the negative identity dissonance perceived by 'unprofessional' students. With this in mind, I have further modified Figure 8.2 to include the effect of blame attribution (see Figure 8.3).

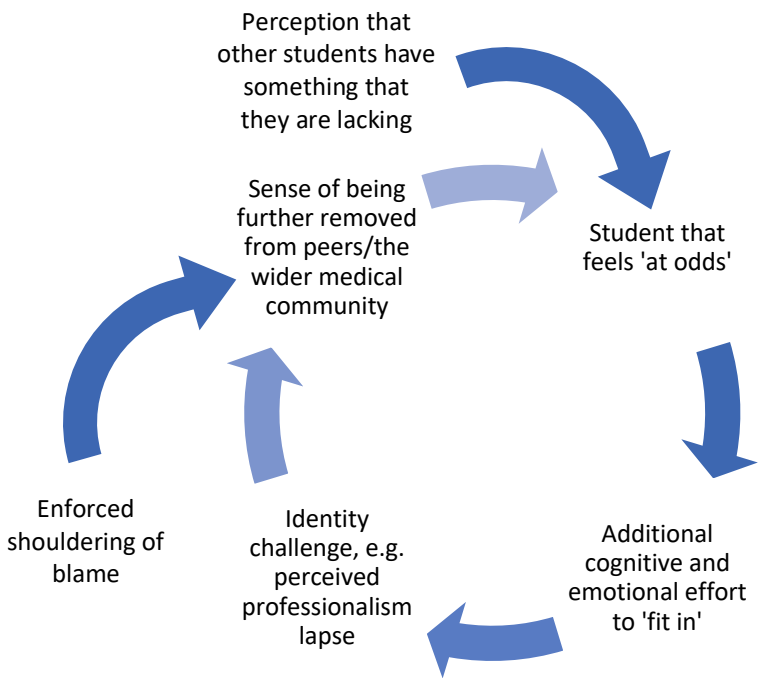

Figure 8.3 – A modification of the cycle of identity dissonance to include blame

One of the concerns raised by medical educators in my study of current remediation practices (see Chapter 3), as well as in the complementary literature (Mak-van der Vossen *et al.*, 2016; Ziring *et al.*, 2015) was that students would be seen to have remediated following their professionalism lapses but this remediation was only 'skin deep', leaving students at risk of future professionalism lapses as their attitudes had not fundamentally altered. I theorise that patterns of blame attribution not only have impacts upon professional identity formation but may also impact upon behaviour in the wake of professionalism lapses. If an individual has transgressed and is to blame for the lapse, the required response is behavioural modification. Thus, if a student truly sees themselves as to blame for their lapse, they are likely to 'tow the line' more closely in future in order to avoid further lapses. This may explain why some students seem to readily modify their behaviour in the wake of professionalism lapses (Mak-van der Vossen *et al.*, 2019a). If, however, an individual feels as though they have been a victim of an external attack, their response is to protect themselves more carefully from future onslaught. This, in effect, leads to students seeking a safe haven among individuals they perceive as 'on their side' and rejecting the opinions of their adversaries. Importantly, in

seeking empathy and understanding, 'unprofessional' students may flock together to form a tribe that stands against the medical school. Indeed, this 'unprofessional' sub-group may develop norms that promote professionalism lapses. This has important implications for how medical schools address professionalism lapses to try and avoid becoming perceived as an adversarial institution, potentially worsening professionalism problems.

This theory of blame attribution also has important consequences in terms of equity in matters of professionalism for medical students. Firstly, returning to the concept of cultural capital, it may be that some students come to medical school already equipped with tacit knowledge of how to negotiate professionalism problems: they are aware not only of expectations but of norms around accepting blame. In this study, there certainly seemed to be some participants who were more willing to accept blame as a means to continuing their studies than others, suggesting awareness of the importance of this process. In addition, Douglas (1992) discussed blaming practices as cultural. With this in mind, there may be individuals from particular cultural backgrounds who find accepting blame particularly alien, who may therefore be seen to lack insight into professionalism lapses. In Chapter 2, I discussed the potential inequities enshrined in the concept of professionalism, which still reflects historic norms that are not necessarily relevant to the current medical workforce (Shirley & Padgett, 2006; Wear & Aultman, 2006). In the case that professional expectations already potentially disadvantage some students, it is even more important that management of professionalism lapses is equitable. With this in mind, I believe a careful refinement of the concept of insight is required, as follows:

> *Insight is the understanding that one's actions or omissions fall short of the expectations of one's profession and the acknowledgement of the importance of these expectations for future practice.*

Importantly, this definition does not require a learner to accept blame but instead makes space for the developing practitioner to align their identity more closely with that of their chosen profession, rather than being forced further away.

In summary, it is important for medical schools to acknowledge that current practices of managing professionalism lapses potentially require learners to accept a responsibility for their behaviour that does not ring true. In requiring students to tell blame narratives, there is a potential to reinforce an 'unprofessional' identity and thus exacerbate identity dissonance and alienation from professional norms. This practice is potentially inequitable and requires medical schools to use the construct of insight with caution in order to avoid learners being in a position of 'double jeopardy', where they are disadvantaged both by a lack of awareness of both professional norms and normative responses to professionalism lapses.

8.3. Summary

In this chapter, I have contextualised the findings of my study of 'unprofessional' students' identities using identity dissonance theory. I have used this framework to understand the origins of identity performances that are conceptualised as 'unprofessional'. In addition, I have proposed a model that explains why unprofessional behaviour may beget further unprofessional behaviour, as 'unprofessional' students are forced to labour to resolve their perceived identity dissonance. I have also used the construct of liminality to understand why medical students may be at particular risk of identity dissonance, given they are simultaneously attempting to *be* a medical student and *become* a doctor. Using the theory of cultural capital, I have explored why some learners may be at heightened 'risk' of professionalism lapses and that a lack of cultural capital may further limit their ability to negotiate institutional structures in the wake of lapses. In particular, I have highlighted the understandings of blame that may negatively impact upon a student's ability to engage with their medical school following a professionalism lapse.

All of these theoretical understandings have important implications for the management of professionalism lapses at medical school. In order to operationalise these understandings, however, they must be contextualised in current remediation practices and a forward direction must be agreed with key stakeholders – namely medical educators and students. In the following chapter, I report a further study conducted for this purpose.

9. Using stakeholder engagement to finalise a remediation framework

In Chapters 6, 7 and 8 of this thesis, I have explored in-depth the lifeworlds of medical students described as 'unprofessional'. The purpose of this narrative research was to gain insights into the lived experience of these individuals and to build new understandings of the factors that may contribute to 'unprofessional' behaviour. This was in response to the findings of Chapter 3, in which I demonstrated that medical schools in the UK currently feel uncertain about approaches to remediation and there seems to be a lack of cohesive approach across institutions.

The purpose of the thesis as a whole is to formulate a framework to support remediation of individuals following professionalism lapses that is grounded in the understandings gained through my empirical research. In this chapter, I discuss stakeholder engagement workshops that I undertook to expand upon the insights from the narratives of 'unprofessional' students and further inform a remediation framework. Here, I discuss the purpose of this stakeholder engagement process and the methods used. I present the findings of the workshops and relate these to relevant theoretical constructs. In the concluding section of this chapter, I draw the threads of the previous chapters together to present a proposed framework for remediation.

9.1. Why stakeholder engagement?

Following the narrative study outlined in Chapters 6,7 and 8, I gained detailed insight into the identities of students following professionalism lapses and suggested that current interventions may have a negative impact on these individuals' identities. Furthermore, I proposed that the current dominant understandings of professionalism may lead to interpretations of identity performances that unfairly disadvantage some students. The methodological approach (see Chapter 5) I adopted relied on my individual interpretations; however, as set out in Chapter 5, it

is a useful exercise to explore the resonance of my findings with the medical education community (Given, 2008). Tracy (2010) describes resonance in terms of the extent to which findings can be extrapolated across contexts. In my case, it is useful to explore the extent to which the findings ring true for medical educators at UK medical schools.

Returning to my social constructivist and post-structuralist feminist epistemologies, it is vital to engage members of the community to build a framework that represents the lived experiences of stakeholders: in this case, not just my 'unprofessional' student participants but other students and medical educators. In this way, a stakeholder engagement process helped to build a bridge between my findings as they stood and a pragmatic, operationalisable approach to remediation. I explore the rationale for a stakeholder engagement process in more detail below.

9.1.1. Bridging theory and practice

At its core, the purpose of developing any framework is for it to be put into practice. It requires a substantial step, however, to go from a concept of 'unprofessional' medical students experiencing identity dissonance and perceived alienation from the medical community to suggesting realistic ways of approaching the 'unprofessional' student in practice. In order to create a framework, I need to bridge the divide in a way that maximises engagement of the medical education community.

In the medical world, there is a burgeoning interest in 'translational research': broadly defined as actions taken to translate scientific discoveries into medical practice (S. H. Woolf, 2008). More broadly, the process of translating theory into practice is described using a range of terms, including 'dissemination and implementation research', 'knowledge utilisation' and 'knowledge exchange' (Tabak, Khoong, Chambers, & Brownson, 2012). In a narrative review by Tabak *et al.* (2012), 61 different existing models designed to translate theory into practice were identified; however, many of these models focused on sharing knowledge and recommendations, rather than engaging stakeholders to generate novel ideas for implementation. Indeed, the purpose of translating research into practice in these

methods seems to require a fundamental assumption: that the framework the researcher is seeking to implement is useful and robust. Instead, I wished to use a stakeholder engagement process to discuss current practice in the context of the understandings I have developed in my previous studies and move towards a new understanding of how to undertake remediation. With this in mind, I wished to encourage an open dialogue of my research findings rather than presenting them *a priori* for participants to accept or reject.

Many stakeholder engagement processes in the medical world rely upon an expert consensus – using various iterative processes of discussion and judging to come to an agreement (Waggoner, Carline, & Durning, 2016). Any consensus-building process in this vein, however, rests on one fundamental assumption: that the *status quo*, represented by the 'experts', is a useful starting point. In Chapter 2, I roundly critiqued the extant definition of professionalism as outdated and reflecting historical medical norms that do not align with the current medical workforce or the population it serves. With this in mind, to rely purely on expertise to develop a remediation framework would risk uncritically perpetuating a *status quo*. In addition, many consensus group techniques are intended to resolve perceived conflicts between studies in a given field (Jones & Hunter, 1995). To undertake such a process rests on a positivist assumption of truth – that there is a single 'correct' answer – which I have also rejected in previous chapters of this thesis. Taking a constructivist approach, any process of stakeholder engagement must allow for continuing disputes and conflicts, as interpretations will be based on prior knowledge and lived experiences. Engaging with stakeholders in a constructivist paradigm makes my role in the process key: I must act as a critical analyst of the discussions, attempting to see how dominant discourses influence the understandings of participants and any resultant remediation framework. Furthermore, the definition of 'stakeholder' must be expanded beyond that of 'expert' to encompass those who would be impacted by any proposed framework. In the case of this study, this demands the inclusion of both medical students and medical school staff.

In summary, I sought to design a stakeholder engagement process based on the following principles:

- inclusion of appropriate stakeholders, including medical educators and medical students;
- constructed around a dialogue that contextualised my research findings in current practices;
- focused on the development of realistic actions;
- that I remained a critical analyst, seeking to understand discussions within the frame of dominant discourses.

In the following section, I describe the method used to effectively address these principles and move towards the development of a remediation framework.

9.2. Methods for workshopping data to develop a remediation framework

Having explored why I deemed stakeholder engagement workshops a useful addition, I now describe how these were designed and undertaken. In the first instance, I required a means by which to effectively communicate the themes and positions described in Chapters 6 and 7 in a way that represented the nuance and complexity of the original narratives whilst maintaining confidentiality of the participants. In order to do this, I wrote 'collective stories'.

9.2.1. Collective stories

Writing 'collective stories' (L. Richardson, 1988) based on participants' original narratives is an effective way of representing the lived experiences of a group without revealing unique life events that may render participants identifiable. A 'collective story' is therefore a single, fictional narrative that combines multiple real-life stories in a way that anonymises the original narratives. Ensuring anonymity was of particular relevance here as there was a significant overlap between schools that recruited to the previous study (see Chapter 5) and that participated in this study, so faculty and student workshop participants may be have able to identify the participants in my narrative study.

The ‘collective story’ narratives were designed intentionally to be read and discussed in the workshop setting and were thus limited in length to approximately 500 words. These stories were scaffolded around the positions and themes that emerged from my analysis. I wrote them using an iterative approach, going back and forth between participants’ narratives and the ‘collective stories’ to align the exemplars as closely as possible with the lived experiences that had been shared in the interview setting. An example of this scaffolding is shown in Figure 9.1 below and the ‘collective stories’ are presented in Appendix 2. A total of five ‘collective stories’ were produced for the purposes of these workshops as this adequately represented the themes and positions, whilst giving workshop participants sufficient time to discuss each narrative in detail.

For each ‘collective story’, I also presented a short commentary to orient workshop participants to the main positions and themes. This was intended as a primer – I wished workshop participants to enter into a dialogue about the extent to which the positions and themes represented reality in their context without presenting them in a reductive way that did not represent the nuance of the stories I had been told.

9.2.2. Participants and recruitment

I selected potential participants from within the undergraduate medical education community as these individuals would have prior knowledge or lived experience of professionalism lapses and ‘unprofessional’ students. Importantly, I defined stakeholders as medical school staff with an interest in or experience of managing professionalism lapses. I intentionally did not restrict this to academic faculty as professional services staff are often – formally or informally – involved in highlighting and addressing professionalism concerns, supporting students through professionalism processes and monitoring outcomes. Furthermore, medical students are key stakeholders in any remediation processes as highlighted above. In addition, I did approach regional representatives of the regulatory body – the General Medical Council (GMC) – but received no response and was thus unable to include them in discussions.

Lisa started her story of her professionalism lapses at the point where **she first applied to medical school. She had applied at 18 and had got a place** but really hadn't enjoyed the course. **She told me that it was too lecture-based** and **she had struggled to make friends**, **so she had ended up dropping out after the first semester. She went on to study psychology at university** but **she still wanted to be a doctor and applied again** as a postgraduate and got a place at a different university.	Story oriented around being 'The Medic' 'The Maverick' 'I am not like the rest of them' 'I think being a doctor is what I'm supposed to be; I will get there eventually' 'Explicitly at odds'
When Lisa started medical school this time, **she was aware of how much older she was than the 'normal' students. She didn't really feel like she fitted in** and it took her a while to find the other postgraduate students who were closer to her age. **Things hadn't been smooth sailing after that, though. She had found medicine much harder than her first degree and she hadn't really been prepared for the amount you need to know. In spite of a lot of revision, she had failed her first year exams**. **To say she had been devastated would have been putting it lightly and she couldn't get her brain into gear to study for the resits, so she failed those too.** In the end, **she had to resit the whole year** but it had been easier the second time, with friends in the year above to give her some help.	'I think being a doctor is what I'm supposed to be; I will get there eventually' 'Explicitly at odds' 'I am not sure where I fit; I am not sure if I can do it' 'Explicitly at odds'
During third year, **life had got difficult again. Lisa's boyfriend, who was also a medical student, had ended their relationship out-of-the-blue**. **She had found it so difficult that she had struggled to go to placement.** After a few weeks**, the medical school had noticed and pulled her in for a meeting to talk about her attendance. She told them about the break-up but they didn't really seem to care: they were more concerned with telling her what would happen if her attendance didn't improve. They had suggested she go to the support service but this seemed to be to tick a box more than anything**. **None of her friends had been in serious relationships, so they couldn't understand how she was feeling.** All-in-all, she had felt totally alone.	'I'm not like the rest of them, because it has been harder for me' 'The Victim of Fate' 'I'm not like the rest of them, because it has been harder for me'
The medical school monitored her attendance really closely but she just couldn't bring herself to go in because she was worried about seeing him. **She had had to go to another meeting, where they told her she hadn't attended enough to pass the year**. **She had pleaded her case: she explained how sorry she was about her attendance; how difficult it was for her; and how she would manage things differently in the future.** The medical school had agreed to let her resit third year, which she was part way through at the time of the interview**. She told me at several points about how much younger and less mature her 'peers' were, and how she should be graduating the following summer**. **It was hard for her to be left behind by everyone and she felt like the next couple of years were going to feel interminable.**	'The Victim of Fate' 'I'm not like the rest of them, because it has been harder for me' 'It's not what it looks like, but I will play along' 'It feels like the world is against me' 'Explicitly at odds' 'I am not sure where I fit; I am not sure I can do it'

Figure 9.1 – A worked example of the creation of a collective story

Participating medical schools were identified pragmatically: I contacted all medical schools who had recruited to my previous narrative study as described in Chapter 5, as well as other medical schools that I could reasonably travel to for the purposes of a workshop. In total, I communicated with eight medical schools, three of which were unable to participate in the study. At the remaining five medical schools, I was permitted access to faculty at all and students at three. The participating medical schools varied in size and structure but are not named here to preserve the anonymity of the institutions. This was an important guarantee as it allowed participants the opportunity to speak frankly about any perceived shortcomings of their existing policies and practices.

At each participating medical school, faculty and students were invited to attend via email, which provided details of the study including a participant information sheet. These two groups were invited separately and there was no overlap between faculty and students in order to optimise honest engagement with the topic from each.

Of five organised faculty workshops, one was cancelled due to inadequate numbers of participants. Similarly, of the three student workshops, two were cancelled as only one participant expressed interest at each site. Participant numbers are displayed in Table 9.1 below.

Institution	No. of participants
School 1 – faculty	10
School 1 – students	5
School 2 – faculty	3
School 3 – faculty	8
School 4 – faculty	5
Total	31

Table 9.1 – Summary of workshop participant numbers

9.2.3. Workshop structure

Workshops were conducted between November 2019 and February 2020. Each workshop followed a basic structure, though I made changes depending on the number of participants, as I detail below. For all workshops, participants received a participant information sheet in advance. In addition, they were given the opportunity to ask any questions before completing a consent form.

I began each workshop by asking participants to introduce themselves and used an icebreaker to orient them to the topic – the question 'what is unprofessional to you?'. I then briefly introduced the rationale for my study, the methods used and described how the 'collective stories' were constructed. The remainder of the workshop time was dedicated to reading and discussing the 'collective stories'. For workshops with more than six participants, I divided the group into subgroups of up to five participants. Each subgroup was given a different narrative to read and discuss, before feeding back to the larger group and generating more general discussion. For workshops of six participants or fewer, all narratives were read and discussed by the whole group. In either case, each participant was given the opportunity to read each 'collective story' and consider their response prior to sharing with the group. The rationale for this approach was to mimic a think-pair-share teaching methodology, which has been shown to increase learner confidence, participation and critical thinking (Kaddoura, 2013; Ochsner & Robinson, 2017). The discussions were scaffolded using the questions below (see Box 9.1), which

1. What does [name's] story tell you about their lived experience?
    a. What about their experience of medical school?
2. What kind of person do you think [name] is?
3. What does this story tell you about [name's] professionalism?
4. What do these stories tell you about 'unprofessional' students?
5. What do these stories tell you about how we manage 'unprofessional' students?
    a. How do you think a professionalism lapse would be dealt with now?
    b. What should we do differently?

Box 9.1 – Questions used to orient workshop participants

participants were provided with to prompt their thinking.

All workshops were audio recorded in full, using several devices for larger groups to capture breakout discussions as well as whole-group feedback. I also took contemporaneous reflective field notes to inform my later analysis.

This study was approved by the University of Liverpool Committee on Research Ethics (reference no. 5356). Some participating institutions required further local approval and this was granted prior to recruitment at that site.

9.2.4. Analysis

I approached my dataset using an adapted version of inductive thematic analysis (Braun & Clarke, 2006). Classically, thematic analysis requires full transcription of audio data (Clarke, Braun, & Hayfield, 2015), as described in Chapter 5. In this study, however, I was conscious of preserving the interactions between participants that can be lost when working from transcripts alone (Georgakopoulou, 2007). Researchers have used direct coding of audio data to capture participants' voices (Crichton & Childs, 2005) and I chose a blended approach here: to work from both audio and transcripts. I familiarised myself with the audio data through repeated listening with extensive analytical note-taking and surface-level descriptive coding (Clarke *et al*., 2015). Parts of the text were transcribed verbatim following familiarisation, particularly sections I had highlighted. Alongside verbatim transcription, I kept interpretative notes to anchor further coding and organisation of the data. These partial transcripts were then coded manually and I went back to the original audio data to transcribe further sections to develop the coding framework. Codes were then organised via an iterative process into illustrative, interpretive themes. These themes were cross-checked with my analytical notes and contemporaneous field notes to ensure they represented the workshop conversations as I had perceived them. The resulting themes are presented in the following section.

9.3. Findings

In this section, I will explore the themes that emerged from my analysis of the workshop discussions. There were six key overarching themes, some of which were divided into subthemes as represented in Table 9.2. I repeat this table for reference throughout the results section of this chapter.

Theme	**Subtheme(s)**
Medical school is a time for growing up	Things happen along the way
There is no excuse for not conforming	You should keep calm and carry on
The haven of professional discourses	The difficulties with insight
Students and faculty are seemingly at cross purposes	Language matters
The desire to be equitable	Equity requires medical schools to be critical
Students must be supported	Current support structures are flawed Support is not always enough

Table 9.2 – Summary of themes and subthemes of workshop data analysis

In general terms, both faculty and student participants seemed to engage willingly and frankly with the discussions. Importantly, the 'collective stories' seemed to ring true, aligning with participants' experiences of 'unprofessional' medical students. Of interest, there seemed to be little qualitative difference between the responses of the faculty and students – though I appreciate the numbers of each are small and I am not seeking to extrapolate to wider populations. That said, the major discrepancy seemed to be in the degree of sympathy expressed for the character in the story. The initial reaction of the student participants to each story was to acknowledge the difficult circumstances the character had found themselves in. This was not so evident with faculty, whose 'gut instinct' reactions were generally speaking more critical. For example, where faculty tended to have a strongly negative reaction to the character of Freddie, the initial student reaction was as follows:

This is just a case of how he worded his feedback, really

STUDENT PARTICIPANT, SCHOOL 1

The other observation I made across all five workshops was that participants often found it difficult to see beyond a judgement of whether the behaviour described in the story was 'unprofessional'. Though the stories were not written to represent narratives of professionalism lapses – and this was explicitly explained to participants during the workshop – it seemed to present a challenge to take a step back and look at an individual in a more holistic way. This perhaps reflects educators looking for the 'unprofessional' narrative because 'unprofessional' students spark interest in medical education circles, as I reflected on in the introduction to this thesis. Alternatively, participants may have been looking for the 'unprofessional' due to an existing binary in medical education – that a student is either unprofessional or not. This potential binary is an interesting observation given that some participants described professionalism lapses as part of a developmental process, as demonstrated by the first theme 'medical school is a time for growing up'.

9.3.1. Medical school is a time for growing up

In discussions regarding the 'collective stories', one of the key themes that emerged was that students attend medical school at a time in most of their lives when they are also developing and maturing. In many examples, this was used as a critique of the characters in the story: 'he's not very mature'; 'she needs to grow up'. Often these sentiments were attached to messages that the character should 'get on with it': that 'growing up' involved acquiescing to the rules and expectations of the institution. In particular, this maturity was aligned with the expectations of a future career, in that students were expected to see the relevance of their current behaviour in the context of their future practice, as illustrated by this quotation:

> *…she's not making the link…between what would be expected of her by the NHS when she's actually a doctor*
>
> FACULTY PARTICIPANT, SCHOOL 3

Other responses were more sympathetic to this developmental stage, acknowledging that professionalism lapses may represent a learning process as individuals mature. For example, here a participant recognised that one of the characters needed to mature emotionally for him to succeed:

> *…he can do the job. He's obviously, he's passed the tests and done the work and he just needs to learn to cope a bit with his emotions…and learn the value of wider education*
>
> FACULTY PARTICIPANT, SCHOOL 3

Participants also identified the importance of key stages in students' developmental trajectory, particularly the transition into medical school. In the following quotation, a participant highlighted how students may no longer have the capacity to compensate for issues such as mental health problems when their familiar social support is removed:

> *…that transition period…and particularly that first semester how…the support is absolutely crucial at that point* […] *they've gone through their teenage years or sixth form with these issues. They've not been dealt with. And then they come here and, you know, we've kind of got to help them address them*
>
> FACULTY PARTICIPANT, SCHOOL 4

As part of the trajectory of maturing into adulthood, there was an acknowledgement that life events are commonplace during medical school, encapsulated in the subtheme 'challenges happen along the way'. For example, one of the 'collective stories' described a student overcoming mental health problems. The following quotations demonstrated how common this was perceived to be:

> *…this is one of the things I say that we see the most.*
>
> FACULTY PARTICIPANT, SCHOOL 4

> *it could happen to anyone…like, it does sound like someone that I know*
>
> STUDENT PARTICIPANT, SCHOOL 1

A number of challenges were identified as common, both through the 'collective stories' and through participants' experiences. These included personal health problems, family health problems, relationship breakdowns and financial difficulties. In particular, health problems – personal or family members' – raised an important concern amongst participants regarding whether students are adequately taught how to negotiate the separation of their personal and professional selves. There was an acknowledgement that there is a fine balance between "self-care and being one's own doctor" (faculty participant, school 1). Furthermore, this was seen to be a difficult balance to strike:

> *You have to learn how to cope with an unwell relative, 'cos we've all done it. Eventually it happens that someone who's close to you is seeing another health professional and you're questioning everything that health professional does and wanting to be there but you can't be their doctor*
>
> FACULTY PARTICIPANT, SCHOOL 3

There was, however, little discussion of the impact of this conflict arising during medical school. Though all medical professionals will have to deal with illness in the family at some stage in their career, for many this will come at a time when they are more mature and thus potentially have more awareness of how to negotiate this difficult situation. To me, there was a sense that all students must 'grow up' with little acknowledgement that this had to happen faster for some than others. There was, however, an appreciation that the pressure to assume responsibility could be particularly acute in some families, for example where a student was the first to attend university. Some responses also suggested that having knowledge of the healthcare system could place you at an advantage, making it difficult to distance yourself from the situation:

You're privileged…you know how to negotiate the system…you know how to sometimes get the best out of the system

FACULTY PARTICIPANT, SCHOOL 2

Importantly, participants recommended that it is incumbent upon medical educators to articulate the tension between the personal and the professional to medical students and attempt to teach ways to manage these situations. This was seen as a key way to reduce lapses in professionalism that may occur as a result of this tension. There were also supportive interventions that were recommended for students who face these tensions; these are discussed further below in section 9.3.6.

In summary, difficulties in medical school were described as normal and expected. Some of these challenges were felt to cause difficulties for learners negotiating the personal/professional space and recommendations for focused teaching to be incorporated into medical curricula to address this were made.

9.3.2. There is no excuse for not conforming

Perhaps because participants perceived that complicating life events are common during medical school, they did not seem particularly tolerant of the characters in the 'collective stories'. In particular, participants did not seem to believe that much flexibility in expectations should be offered, even for students experiencing difficulties. Regardless of the circumstances, few deviations were seen to be permissible and outcomes were described in very concrete terms. This particularly related to attendance and thus hours of medical training. One of the key arguments made – both by students and faculty – was that it is vital to ensure fairness for all students and thus policies must be inflexibly adhered to:

the medical school's got to be fair […] *he's still going to be a doctor so he still has to do everything that everyone else has to do*

STUDENT PARTICIPANT, SCHOOL 1

Medical school faculty also used the argument of 'fairness' to defend their existing policies and practices, for example:

> *I want to be able to do something to help you right now but my hands are tied* […] *even if I know…I potentially might be able to do this but then I can't because that's inequitable for other students or that goes against our policy or whatever*
>
> FACULTY PARTICIPANT, SCHOOL 3

Furthermore, given that students' challenges were perceived as normal, participants suggested that there should be no excuses for not meeting the requirements of the curriculum, represented by the subtheme 'you should keep calm and carry on'. This was often demonstrated by a critique of students for lacking awareness that their peers were often experiencing similar challenges, providing a sense that 'if the others can manage, why is this individual having such difficulty?':

> *he doesn't seem to acknowledge that everyone's got problems. Everyone's got hurdles. The number of students that do have mental health issues is huge*
>
> FACULTY PARTICIPANT, SCHOOL 4

That said, there were acknowledgements that students often do not discuss their difficulties openly amongst their peers. In conversations, the lack of open discussion amongst peers was frequently related to the perceived associated stigma, particularly with mental illness. This was felt to create an environment in which it was difficult to 'stick one's head above the parapet'. One faculty participant explicitly acknowledged that there was a mismatch between the awareness of the students and faculty that may affect a student's perception of their own situation:

> *they don't know about each other's problems, so they've potentially got more likelihood of positioning themselves as 'I'm the student who's got the hardest life' but not knowing that other students also have difficult things going on in their lives.*
>
> FACULTY PARTICIPANT, SCHOOL 3

This quotation stood out in stark contrast to other faculty participants, who often implied a lack of empathy for the 'collective story' characters positioning themselves as having a difficult time. Amid the discussions, there was a sense that none of the stories represented exceptional adverse circumstances. Indeed, the student characters were described as "narcissistic", "selfish" and "hard done by" because of the identities of otherness and victimhood described in the narratives. The acceptable identity performance seemed to involve a student adapting readily to adversity and continuing to meet the course requirements, with any alternative arousing concern from faculty. Overall, there was a sense from this theme that, regardless of the circumstances in which they find themselves, students should continue to conform to the expectations of their medical school. This was also reflected in a professional discourse of medicine requiring 100 percent commitment, as I will explore in the following section.

9.3.3. The haven of professional discourses

In the previous section, I have discussed how faculty used the argument of 'fairness' as a defence for lacking flexibility in policies and practices. This was often contextualised by referring to the expectations of the medical profession and – in particular – the regulatory body. This was dominant and widely accepted in conversations: the needs of the GMC must be served and their expectations must be met. Furthermore, the GMC was often used as a reason for medical training being inflexible and medical schools not being able to accommodate all students' needs. For example, in a discussion about whether less than full time medical training was possible, the following statement was made:

> *As I understand, the GMC doesn't permit us that flexibility*
>
> FACULTY PARTICIPANT, SCHOOL 1

This was directly contradicted by a participant in a later workshop, as follows:

> *There's no rule saying you can't* [study medicine part-time]…*I've actually seen it done but it's very difficult to manage*
>
> FACULTY PARTICIPANT, SCHOOL 4

This mismatch in understandings demonstrated that the GMC or – more widely – the expectations of the medical profession were unquestioningly accepted by faculty. Furthermore, rumours seemed to circulate regarding the GMC's 'rules' that were not necessarily based in fact. The discourse of being under the jurisdiction of a regulator seemed to provide faculty participants with confidence in their judgements and decisions regarding professionalism lapses. Arguably, this discourse was even employed by faculty participants as a 'scapegoat': educators were excused from difficult decisions as the GMC regulations rendered them impossible.

A further source of security seemed to be the use of a medical diagnosis as a lens through which to understand students' difficulties. Only one 'collective story' explicitly referred to mental health problems; however, participants often sought to diagnose the characters with mental illness as a means of rationalising their stories. Given the majority of participants were medical students, practising clinicians or former clinicians, it follows that the professional discourse of explaining 'problems' through diagnosis is replicated in medical education.

The perceived clinical environment was also used as a justification for treating students with a firm hand. Participants often expressed a sense that, should medical schools provide too great a degree of flexibility and permissiveness, this would set students up to fail in later clinical practice, for example:

> *When she's practising as a doctor* […] *patients will be relying on you.*
>
> FACULTY PARTICIPANT, SCHOOL 3

This was, however, counterbalanced by a few participants who acknowledged that possibilities exist in postgraduate training that are not open to medical students. For example, practising doctors have the opportunity to train less than full time or to move around the country in response to changing circumstances. A doctor may apply to work far from their family home but choose to move when a family

member becomes ill. If, however, a student applies to a distant university, it is currently all but impossible to make a move during a medical degree course.

Another key discourse that was invoked by participants was the sense that studying medicine must be prioritised above all else, regardless of life circumstances, as demonstrated by this quotation:

> *We all have things going on in our lives…there has to come a point, unfortunately, you have to prioritise*
>
> FACULTY PARTICIPANT, SCHOOL 3

This requirement for total commitment was justified by the challenging nature of the medical course and a career in medicine: students who failed to prioritise medicine were deemed to lack commitment to the profession. Indeed, the motivation of the 'collective story' characters to pursue a career in medicine was often questioned in light of their stories of victimhood and adverse circumstances. Many faculty members recommended interventions that would help students realign their priorities with this perceived need for commitment:

> *She feels she has the burden of going to all these medical appointments with her Dad so she can 'translate' but that's not her role* […] *maybe that's where Steve could give her permission not to take on that role*
>
> FACULTY PARTICIPANT, SCHOOL 1

In this example, there is an assumption that the character in the 'collective story' does not need to attend medical appointments with her family and that a helpful intervention would be to give her insight into this.

The professional discourse of 'insight' was common throughout the workshops, as represented by the subtheme 'the difficulties with insight'. The characters were judged on the extent to which they were felt to have insight into their behaviour and insight was certainly deemed necessary following professionalism lapses. That said, unlike other discourses, this seemed to concern rather than reassure faculty participants. There was a sense that true insight was difficult to differentiate from

the mere performance of sincerity, reflection and apology. Furthermore, students with particular 'personalities' were felt to be able to give a more plausible performance, raising the concern that medical schools may miss opportunities to adequately address professionalism lapses:

> *I think its's quite interesting that some students, based on how they come across and how charming they are and what sort of personality they are, erm, sometimes can determine the outcome of what people will think about their behaviours*
>
> FACULTY PARTICIPANT, SCHOOL 1

In response to this, some faculty participants highlighted the importance of seeking to triangulate any expressions of insight with future behaviour to assess the extent to which it is authentic.

In summary, professional discourses surrounding regulation and the expectations of medicine as a career generally provided participants with reassurance or even excuses: the responsibility for any decisions seemed to be delegated to an anonymous other. Furthermore, this seemed to be done fairly automatically, with perceived 'rules' accepted uncritically. A further assumption that seemed to underpin faculty's thinking around professionalism lapses was that students perceived them as an adversary, lacking understanding of why difficult decisions had to be made, as I will explore in the following section.

9.3.4. Students and faculty are seemingly at cross purposes

The previous theme set out how faculty seek reassurance in professional discourses when managing professionalism issues, providing some absolution for individuals making difficult decisions. This theme explores one reason why this defence may feel necessary: faculty expressed an awareness that students see them as adversaries, trying to thwart their progress. In particular, the support that was offered by medical schools in the 'collective stories' was often criticised by the character, as it was by the 'unprofessional' students I interviewed. This accusation was generally rebutted by faculty participants, who described students often being

Theme	Subtheme(s)
Medical school is a time for growing up	Things happen along the way
There is no excuse for not conforming	You should keep calm and carry on
The haven of professional discourses	The difficulties with insight
Students and faculty are seemingly at cross purposes	Language matters
The desire to be equitable	Equity requires medical schools to be critical
Students must be supported	Current support structures are flawed Support is not always enough

Table 9.2 – Summary of themes and subthemes of workshop data analysis

dissatisfied with support that did not completely meet their needs. Faculty described students as wanting support services that could 'fix everything', whereas support services are often intended to triage problems and signpost students onwards. For example, in the following quotation a participant was describing a complaint that had arisen regarding the support that a student had received. The student in question had complained that all that had been done to support him with mental illness had been a referral to occupational health services.

> *His medico-legal advisor…turned round and he said '…what this student needed was a big hug'…It was a very good example of somebody who had gone for help, had been given – I think appropriate – help and advice but was quite unable to realise this had been quite good.*
>
> FACULTY PARTICIPANT, SCHOOL 4

This example reflects back to the security faculty find in professional discourses: a student with a perceived illness was sent to see a healthcare professional. In addition, it demonstrates the mismatch between the expectations of the student and the expectations of the medical school.

There were concerns raised about how interventions deemed to be supportive by faculty may sometimes be perceived differently by students. In particular, this

pertained to taking time out of the medical programme. Offering students time out was seen as a key intervention by faculty – particularly in the context of mental health problems and family stressors – but they were aware that this could be received negatively by students, perhaps as a threat to their competence or a barrier to their progress. This is demonstrated aptly by this quotation from a student participant, discussing a peer who had been advised to interrupt his medical studies:

> *…and it's like 'I've just spent a whole year working: I'm not going to not sit my exams. I'm not deferring my life for a year.'*
>
> STUDENT PARTICIPANT, SCHOOL 1

One of the key issues that was raised in the discussions of the discrepancy between faculty and student perceptions is described in the subtheme 'language matters'. Participants identified that the words used in discussions with students about support and progress can be key in how these conversations are interpreted. In a discussion about the importance of language, one faculty participant identified the words used in identifying and discussing professionalism lapses as potentially problematic:

> *'Concern' is the biggest problem I have. Medicine has taken this word 'concern' to mean some sort of professional clinical inadequacy. And actually, in everyday parlance, we use 'concern' very differently.*
>
> FACULTY PARTICIPANT, SCHOOL 3

In this conversation, there was a suggestion that even from the earliest identification of potential professionalism problems, the language used could build barriers between faculty and students. In a number of workshops, the language used around taking time away from medical school was discussed. I had used the term 'suspension' in the 'collective stories', as this is the terminology used in my context. In all four faculty workshops, however, this was highlighted as potentially problematic as 'suspension' is reminiscent of a punishment for poor behaviour at

school. Several alternative suggestions were presented, such as 'leave of absence', 'pause' and 'taking a break'. Faculty, however, also recommended that the language was not the only factor and that the staff-student relationship was key to how this suggestion might be received.

On the topic of supportive interventions, this faculty member identified the term 'support' itself as problematic:

> *I'm worried about the word support. I think it's an absolute menace because it means different things to different people. I think it's very, very misunderstood.*
>
> FACULTY PARTICIPANT, SCHOOL 4

In the context of this discussion, faculty recommended providing students with written information to clarify the meaning of the term 'support' in the context of medical training. In summary, faculty identified using language clearly and concisely in the context of managing and supporting students was key to ensuring that interventions were received in the manner in which they were intended. This was important for a student to feel that they had been treated fairly by the medical school. Furthermore, my participants highlighted the need for all students to be treated equitably, a concept that I will explore further in the next section.

9.3.5. The desire to be equitable

In previous themes – 'there is no excuse for not conforming' and 'the haven of professional discourses' – I highlighted the way in which fairness was used a rationale for lack of flexibility. In this sense, treating all students the same represents 'fairness'. This rigid construct of 'fairness' was reinforced by the perceived need to follow inflexible regulations from the GMC. In contrast, however, there were aspects of the workshop discussions that acknowledged that all students may not have the same requirements, as represented by this theme – 'the desire to be equitable'. First and foremost, this was represented by a desire for medical schools to give their students a meaningful space to explain themselves following any accusation of 'unprofessional' behaviour. For example, the

suggestion that a professionalism concern might be raised anonymously evoked the following response:

> *I'm worried to hear that a student is being complained about behind their back and suddenly gets summoned: that's terrible!*
>
> FACULTY PARTICIPANT, SCHOOL 4

This participant went on to emphasise the importance of sharing any concerns with a student both in person and in writing to give them an opportunity to respond in order to treat all students justly. The student participants also highlighted the importance of being able to give an account of oneself as an important way of redressing the power imbalance between the medical school and an individual student:

> *It has to come down to, like, you having a meeting with the person who's been unprofessional, getting to the root of it.*
>
> STUDENT PARTICIPANT, SCHOOL 1

In order to provide equitable treatment of students, there was a sense that medical schools must appraise current policies and be aware of potential sociocultural sources of disadvantage, as described by the subtheme 'equity requires medical schools to be critical'. There were acknowledgements that existing practices may actually exacerbate professionalism lapses and that interventions may unfairly disadvantage some groups. One participant gave an example of a student who was resitting a year following a period of mental illness. This student had attended half of the year on the first occasion and was felt to be falsifying periods of physical illness to 'cover up' a lack of attendance. Though the falsification of absences was concerning, there was also an understanding from the faculty member that this behaviour was understandable in light of the lack of flexibility around repeating elements of the course. In this example, the medical school was portrayed as contributing to 'unprofessional' behaviour through their policies. There were also examples given of medical school policies potentially exacerbating difficult situations, often relating to repeating an academic year. Medical school year

groups were described as 'tribal' and the loss of one's 'tribe' was described in terms of being an othering experience. In addition, several participants identified the inequity of financial disadvantage for students when resitting: students with ample financial support would inevitably find this a less difficult and threatening experience than those seeking to support themselves. Though participants acknowledged that policies may be inequitable or even harmful, professional discourses were still invoked to limit the possibilities of overcoming these inequities. Many participants seemed to genuinely want to treat students equitably but this was deemed impossible due to existing policies or regulations.

This leads on to a key point that was expressed about equity: some students require additional support. This was particularly described in terms of sociocultural background or life experiences prior to medical school. For example, some families may have an expectation that a student fulfils a caring responsibility that arguably does not fit neatly within a Western, individualistic society:

> *It's bread and butter to see students particularly from certain minority groups who have family responsibilities. Er, the oldest child. Er, there's seven or eight siblings. Both the parents are ill; one of them might die. And they've got parental responsibilities that have been thrust upon them and trying to make education work alongside family commitments, whether it's a parent or offspring…*
>
> FACULTY PARTICIPANT, SCHOOL 4

This is an important acknowledgement as it accepts that the dominant culture may disadvantage certain sociocultural groups.

In addition to the criticism of current practices, there were open acknowledgements that medical schools' expectations of their students may be unfair or unrealistic. Student participants, for example, described the difficulties they faced requesting leave if a family member becomes critically ill:

> *…if someone is ill on the Monday and they don't die until the Friday, you just can't take a week off placement*
>
> STUDENT PARTICIPANT, SCHOOL 1

More broadly, there were discussions around the highly context-specific nature of professionalism, which medical schools do not permit. In the first instance, this was expressed in terms of differing professional norms in different specialties:

> *We are not pushing out all of the same people because they're not all doing the same job. We do need people to be able to work across multiple specialties in medicine and the reality is certain personalities suit different types of jobs that these people go into, whether it is orthopaedic surgeon or research or paediatrics or oncology or palliative care. And maybe we should find a way of nurturing and supporting that to get the better outcomes.*
>
> FACULTY PARTICIPANT, SCHOOL 1

This is an interesting observation as it seems to contradict the absolute reliance on the GMC to define professionalism and professional standards. Instead, this seems to offer medical schools the space to be more open to alternative performances of professionalism. This more relative view of what is expected in a 'professional' performance was also expressed in terms of culture. This participant asked the question "is it [medical educators] that should be having the identity crisis?" before going on to describe their multicultural medical student population thusly:

> [They are] *a fantastic resource for understanding the populations we serve and we don't see them that way. We see them as people who struggle and need extra help, rather than saying 'what can you teach us? What can we learn from you?'*
>
> FACULTY PARTICIPANT, SCHOOL 2

That said, it is important to bear the context in mind: this study took place in UK medical schools, whose role is overwhelmingly to train doctors to practice within the UK. With this in mind, graduates must understand the dominant sociocultural

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Table 9.2 – Summary of themes and subthemes of workshop data analysis

norms of this context, regardless of their own background. I expand on this discussion later in the chapter.

In summary, this theme describes the desires participants expressed to seek equity in medical education, as well as acknowledgements that this requires institutional reflection, analysis and critique. An important aspect of equity is providing adequate, appropriate support for students, which I will explore further in the final theme.

9.3.6. Students must be supported

An important aspect of all the workshop discussions was the imperative for medical students to be adequately supported. The recommendations for how this support should be delivered were relatively few but the purposes of support were clearer. As I have discussed in the previous sections, one of the key reasons for providing support to students was to assist a student in continuing with their studies in spite of adverse circumstances. One participant reflected that "we'd be very short of FY1 doctors" if they failed to adequately support their students. Importantly, a number of faculty participants criticised some of the descriptions of support described in the 'collective stories' for offering false reassurance, for example:

> *… this dreadful quote – it really enrages me – 'he told her not to worry about anything.' That is a disgrace.*
>
> FACULTY PARTICIPANT, SCHOOL 4

This reflects discussions regarding supportive relationships and a number of participants emphasised the importance of setting clear boundaries for such relationships. There was a sense from participants that support should challenge students and that this may take several forms. For example, one participant described the process of giving a formal warning as a supportive intervention as it set clear boundaries for the student moving forwards. In addition, a number of faculty participants recommended coaching-style relationships, with in-built explicit goal-setting and accountability.

Some facets of 'good' support were described during the workshops. In particular, one participant described an intervention in terms of the way we would manage a complex patient:

> *If they were patients, you'd make a care plan. You'd have an MDT.*
>
> FACULTY PARTICIPANT, SCHOOL 3

This reflected the discussions regarding support being equitable and aligned with the needs of the individual student. Other recommendations for features of 'good' support were that: it should be unthreatening and unrelated to disciplinary process such as fitness to practise; it should aim to help students to negotiate complex policies and procedures; where possible, it should be longitudinal to foster good staff-student relationships; and that it should link well with other organisations to help provide social support where possible.

Support was not, however, purely discussed in 'supportive' terms. It was described as necessary as part of due process in managing 'unprofessional' behaviour: it was incumbent upon medical schools to provide support in order to protect themselves from legal challenge. Furthermore, a student's engagement with support was felt to be a proxy for 'insight' and thus useful when making decisions regarding

discipline and progress. Indeed, lack of engagement with support was almost equated with a fitness to practise concern in itself, as demonstrated by this quotation:

> *If he's not willing to engage in that professional support, as a practitioner, how will he be placed to advise people seeking support?*
>
> FACULTY PARTICIPANT, SCHOOL 2

In addition to discussions of what support should do, there were also reflections on and criticisms of existing support services, as described in the following subtheme 'current support structures are flawed'. Many faculty participants framed this in terms of a critique of what other medical schools offer, distancing their institution from the limitations of support services. There was a sense that the anonymous institutions described in the 'collective stories' were unlike their own; however, the method of recruitment I used meant that there was a significant overlap between participating institutions.

One of the key problems identified with support services was that medical schools' own support services do not necessarily align well with those provided by the central university, as illustrated by this quotation:

> *..are they set up to support people achieving professionally or are they just set up to support as a student?*
>
> FACULTY PARTICIPANT, SCHOOL 3

This was identified as a potential source of conflict and confusion for the student as university support services may provide advice that contradicts the policies of the medical school. Participants acknowledged that medical school policies were often different to those of the wider university and this could be complex for students and support services alike. Furthermore, medical schools were criticised for relying on General Practitioners to provide mental health support and treatment without input from specialist mental health services:

> *GPs probably vary as to how much they know and don't know* […] *I'm not convinced that GPs are good at dealing with depression and anxiety just because they see tonnes of it.*
>
> FACULTY PARTICIPANT, SCHOOL 4

There was a clear sense from some medical schools that bespoke, specialised support should be provided for medical students so that it could be meaningfully informed by the requirements of the course and an understanding of the demands of medical education. In addition, some participants identified that both students and support services could be task-oriented: their primary goal was to keep the student on the course. This was criticised for failing to address underlying issues such as previous academic failure as demonstrated by this quotation:

> *Medical schools…they're very good at, you know, the same thing, churning out medical students. But, perhaps not so good at thinking about the psychology behind the very different people who turn up to, you know, these programmes. And their expectations and their experiences…and some of them pretty traumatic, like, you know, the 'A' level grade thing. Y'know, that's the stuff that will keep eating away at you.*
>
> FACULTY PARTICIPANT, SCHOOL 3

Furthermore, there was an identification that support services should not stop when the immediate issue was resolved and that there was currently a lack of follow-through. Returning to the example of advising a student to interrupt their studies, this was criticised for taking an 'all-or-nothing' approach. When students are away from medical school, they are unable to engage in any learning activities that could contribute to their progress. Then, upon their return, participants identified that there is often a lack of opportunity for a gentle, phased return or gradual reintroduction.

The final subtheme – 'support is not always enough' – describes a key limitation of support structures and arguably medical education more generally: not all medical students are destined to be doctors. In response to a number of the 'collective

stories', participants questioned whether a career in medicine was the right path for the character. A number of participants described examples of students being pressurised into a medical career by family, with professionalism lapses representing their underlying lack of motivation. Furthermore, there were discussions about students who were simply 'not cut out' for medicine, as they lacked the life skills to manage the course and a future career, for example:

> *They have the motivation to be a doctor but they don't necessarily have the life skills to have a plan for what that's going to look like on a day-to-day basis.*
>
> FACULTY PARTICIPANT, SCHOOL 3

In response to this, some faculty identified the need for medical schools to provide alternative ways in which medical schools could support students. In particular, aligning undergraduate medical education with the flexibility offered in postgraduate medical training was identified. As I touched upon in Section 9.3.3, for example, a number of faculty participants recommended medical schools bringing their curricula into line to allow some degree of geographical flexibility. This was identified as a way in which students could be offered better social support: at present, medical students often study at great distances from their family and these choices are made at times when difficulties are not anticipated. By allowing a student in difficulties to transfer their studies closer to home – either for a short period or for the remainder of the course – this was felt to offer the potential for them to complete their studies. In addition, the lack of opportunity for undertaking medical training less than full time was criticised as follows:

> *…it's a complete anomaly. And I think it's beginning to be recognised that you can, as a doctor, postgraduate training you can do part-time but as a medical student you can't and that's an absolute nonsense. It's the organisational difficulties of making it work that's the problem. But the idea that it shouldn't happen is rubbish.*
>
> FACULTY PARTICIPANT, SCHOOL 4

Even with these fairly radical structural reforms, however, there was an acknowledgement among participants that not all medical students could or should complete the programme. Faculty acknowledged that perhaps this should be explored earlier in students' trajectories, rather than waiting until the student expresses doubts before suggesting alternative careers. More importantly, any process – perhaps short of a formal exclusion from a medical programme – was couched in supportive terms, so that students could find a fulfilling future career away from medicine. That said, all of these recommendations require time and resources. In order to justify this investment, medical schools require a robust, empirically- and theoretically-grounded framework into which they can fit. In the following parts of this chapter, I explore how a remediation framework can emphasise supportive intervention based in the empirical evidence I have collected.

9.3.7. Summary

In this section, I have summarised the six key themes that emerged from the discussions with stakeholders. In the first instance, medical school was identified as a life stage that involved more than learning medicine and other challenging life events happen alongside medical training. These life events were described as almost inevitable, meaning that there was relatively little sympathy for students who struggled in response to them. Medical faculty used dominant professional discourses including 'insight' to describe how they negotiate professionalism lapses, though they also acknowledged that their policies and practices set them at odds with their students. Finally, there was broad acknowledgement of the importance of equity and robust support of students, though the application of these principles is currently imperfect. In the next section, I will seek to contextualise these findings in terms of existing theory, as well as the conclusions drawn from in Chapter 8. This will allow me to draw together several threads to weave into the final framework.

9.4. Discussion

9.4.1. Drawing together findings

One of the key purposes of this stakeholder engagement exercise was explore the extent to which the 'collective stories' did or did not resonate with stakeholders through conversations with medical educators and medical students. The stories were intended to communicate the meanings derived from my narrative study (Chapters 6, 7 and 8) and stimulate discussion and debate to highlight parallels and discrepancies between the experiences of stakeholders and 'unprofessional' medical students. In this section, I draw together the findings of the programme of research I have conducted to explore key aspects of a remediation framework.

Firstly, one of the core conclusions outlined in Chapter 8 was that students experience identity dissonance, both potentially leading to and in the wake of professionalism lapses. There was certainly a sense from stakeholders that the characters in the stories did not fit within the expectations of a medical student identity performance. In particular, the theme 'there is no excuse for not conforming' and the subtheme 'you should keep calm and carry on' demonstrate that educators and fellow students believe that all medical students should seek to fit the conventional mould, regardless of their circumstances. Furthermore, in questioning the commitment of the 'collective story' characters to the medical profession, workshop participants implied that these individuals did not belong in medical school. In addition, the theme 'students and faculty are seemingly at cross purposes' seems to justify the position of victimhood assumed by 'unprofessional' student interviewees: though educators may not intend to be adversaries, there is an acceptance that they may be perceived this way by students. Given the victim position was perceived so negatively by workshop participants, it follows that a student performing this identity may also be perceived negatively by faculty and peers. This seemingly reflects the otherness and worsening alienation described in my model of identity dissonance presented in Chapter 8.

The theme 'the desire to be equitable' demonstrates that medical educators are aware of existing inequities in medical education, including policies and practices

that potentially disadvantage certain students. That said, educators in this study did not seem to feel capable of making changes. This aligns with themes from my previous study (Chapters 6 and 7) such as 'I am not like the rest of them…because it has been harder for me': there are some students who are materially and systematically disadvantaged by current practices in medical education. This seems to represent a serious failing and may in part explain differential attainment in medical education, as I discussed in Chapter 8.

Finally, in Chapter 8, I used blame theory (Douglas, 1992) to understand the cultural practice that requires students to demonstrate insight into professionalism lapses. This was very clearly reflected by the theme 'the haven of professional discourses', in which faculty set great store by the demonstration of insight following professionalism lapses. 'Unprofessional' students (see Chapters 6 and 7) described attempts to perform demonstrations of insight that were not necessarily sincere. Concerns regarding performances of artificial insight were reflected in the uncertainty expressed by faculty in the subtheme 'the difficulties with insight'. Interestingly, this was also echoed by the uncertainty described by participants in my questionnaire pilot study described in Chapter 3. With these parallels in mind, this stakeholder engagement exercise seems to have provided useful confirmation of my previous findings. There were, however, new insights from the workshop discussions that I will now discuss in the context of existing theory.

9.4.2. The power of discourse

In the introduction to this chapter, I set out the importance of my position in the workshop setting: to act as a critical analyst, particularly sensitised to how dominant discourses shaped the discussion. Here, as I defined in Chapter 2, I use discourse to mean a sociocultural system that constrains what knowledge and understandings are possible in a given context. For example, the practice of medicine is framed by the discourse of 'illness' as a deviation from normality that should be addressed through treatments or interventions based in scientific understanding. In the context of medical education, as I have explored in Chapter 2, professionalism is a key discourse that comes with tacit messages about

commitment and altruism, which can be seen to be replicated in this study. Discourses are important to consider further as they are reproduced in organisational structures and by powerful institutions, maintaining a *status quo.* This is perhaps best demonstrated by the theme 'the haven of professional discourses'. Workshop participants seemed to utilise dominant discourses as an automatic justification of certain actions, such as the regulatory frameworks of the GMC. There was a sense that the GMC must be unquestioningly obeyed, with all GMC policy equated by one participant as 'the law'. Though the GMC's regulatory framework is underpinned by the Medical Act 1983, much of its guidance relating to medical schools is advisory. This use of the GMC as an umbrella defence of medical school policy and practice goes beyond the merely factual toward an expression of an unquestioned power relationship.

The work of Foucault centred on the relationship between knowledge, power and societal structures (Foucault, 1980). Foucault explored dominant discourses through analysis of historical texts to understand the creation and reproduction of knowledge by societies and institutions (Foucault, 1969). For example, in his work *Discipline and Punish* (Foucault, 1977), Foucault describes the ways in which the army as a powerful institution organises recruits to produce obedient soldiers or 'docile bodies'. In Foucault's (*ibid.*) case study, 'docile bodies' are not merely produced by frank punishment of deviation from the rules, but by organisational structures such as rigidly adhered to timetables and housing recruits in barracks away from wider society. In the workshops I conducted, some of these organisational structures were identified by participants. One way in which organisational structures were seen to exert power in this study was the temporal. The academic year was discussed as a fixed temporal unit that is rigidly adhered to, 'leaving behind' students that fail to fit within this structure. The spatial nature of a medical school also seems to exert power: medical schools have a physical domain in which they exist and these domains are circumscribed from one another. Medical students have to be physically present to be permitted to study. Furthermore, there is little relationship between medical schools, so students who cannot commit to being physically present in the space of their medical school must

abandon their studies. That said, in the context of the current covid-19 pandemic, this geographical structure and mandate for physical presence has been disrupted, arguably for the first time in the history of medical education. Clinical placement activities, however, will always require physical presence and thus the medical school as a physical institution – buildings and hospitals – is unlikely to disappear altogether in the foreseeable future.

Using Foucault's (1977) theory of 'docile bodies', the identification of these organisational structures suggests that medical schools are – perhaps unconsciously – attempting to produce students who are compliant and passive. The theory of 'docile bodies' has been used to understand how student behaviour is constrained within both medical education (Jaye, Egan, & Parker, 2006) and more widely in higher education (Dwyer, 1995). Indeed, Green (2002) described how dominant structures produced 'docile bodies' in dance education: dance students were expected to adhere to strict routines and practices, submitting themselves unquestioningly in order to be accepted into the community. In the context of my research, the desire for medical students to be 'docile' (Foucault, 1977), is perhaps best demonstrated by the theme 'there is no excuse for not conforming', in that the expectation of students seemed to be that they yield to the dominant discourse. Indeed, active attempts to remediate professionalism lapses could be conceptualised as attempts to reinforce the dominant discourse and render students 'docile'. Overall, this may help to explain why narratives or identity performances expressing victimhood or challenge seemed to be received so negatively by faculty participants. It is possible to envisage how identity performances such as these would be received in interactions between 'unprofessional' students and faculty, with narratives of victimhood and difficulty invoking a tacitly negative reaction. In this way, faculty could be attempting to control the identity performances of 'unprofessional' students, constraining their narratives into those that are 'docile' and acceptable.

Power discourses were replicated by stakeholders in terms of the possible: it is *impossible* to study in a distant location; it is *impossible* to make up for parts of the

course without repeating a year. Interestingly, however, there were conflicts between faculty participants about what is indeed possible – highlighted by the contradicting statements quoted above regarding less than full time medical training. This indicates that resistance to the dominant discourse is possible and the route to this is through knowledge and understanding. Furthermore, the perpetuation of falsehoods suggests that medical educators are receiving tacit messages about what is indeed possible that are not necessarily accurate. I will explore the emergence of these discourses in the following section, exploring the impact of the 'hidden curriculum'.

9.4.3. The 'hidden curriculum' applied to medical educators

As discussed in Chapter 2, the concept of the 'hidden curriculum' has been widely adopted in the medical education literature to describe the things that students learn that are not intentionally taught (F.W. Hafferty & Castellani, 2009; Hafferty & Franks, 1994). In particular, this has been related to how students develop as professionals, becoming socialised into the norms of the medical profession (Hafferty, 2016). Becoming a medical educator, however, is a far less formal process that becoming a doctor, with multiple and potentially circuitous paths. As discussed in Chapter 5, medical education is a multi-disciplinary field with academics from backgrounds including medicine and other healthcare professions, social science, education and natural science. There is little by way of formal accreditation of medical educators and thus most medical educators learn their craft through experience. In the absence of a formal curriculum for medical educators, the 'hidden curriculum' is likely to be extremely dominant, replicating norms and hegemonic discourses with little to no resistance or critique. This perhaps explains the firmly held but false beliefs about the possibilities of medical education, such as the ability to train less than full time. It is also important to acknowledge that rules and regulations shift over time and the lack of uniformity in medical education outlined above may mean that messages around policy change take time to trickle down. Taking the example of less than full time medical training: though the GMC have not explicitly prevented this, there was previously a

maximum permitted time from registration to graduation, which effectively made it impossible. The cap on years studied has now been lifted but the discourse regarding the possibility of less than full time medical training is seemingly yet to meaningfully change. Indeed, even the participant who stated that it is possible acknowledged that it is very challenging within the current structures.

A relatively unchallenged 'hidden curriculum' potentially creates a conflict between discourses that cannot be fully resolved. For example, in this study educators expressed a desire to achieve equity for medical students, making space for diversity in medical schools. This is reflected in the medical education literature, with frequently espoused desires to widen participation and reduce differential attainment (Gore *et al*., 2018; K. Woolf, Rich, Viney, Needleman, & Griffin, 2016). These aspirations of diversity and inclusion, however, seem to be at odds with the dominant professional discourses about what it takes to be a doctor, such as medicine requiring total commitment. Returning to the example of the (im)possibility of less than full time medical training, this would be an opportunity to attract students with caregiving responsibilities or personal health concerns that might limit their ability to train full time. This seems to present an opportunity to address some of the inequities in medical education; however, students could also readily be criticised for lacking commitment to medicine as the profession has not been prioritised above all else.

In Chapter 3, I explained the impact that the work of Papadakis *et al.* has had on the perceived importance of professionalism lapses (Hauer *et al.*, 2009; Papadakis *et al*., 2004, 2005). This has subsequently been reflected in the guidance issued by the GMC (GMC & MSC, 2016), creating a discourse that student professionalism is of vital importance and even small deviations from the norms should be dealt with firmly and promptly. This discourse seems to be reflected in the findings of the workshops, in that the theme 'there is no excuse for not conforming' identified a perceived need to be unforgiving and inflexible.

Importantly, one of the ways in which educators currently recommend addressing the 'hidden curriculum' is through explicit teaching (R. L. Cruess *et al.*, 2016).

Whilst the 'hidden curriculum' cannot be eliminated altogether, by educating learners about alternative ways of seeing the world, change is possible over time. In the context of this thesis, there seems to be an imperative to explicitly educate medical faculty about professionalism, exposing the roots of inequities and disadvantage and discussing ways in which these could be addressed. Investing in faculty knowledge also gives them the tools to examine – and perhaps challenge – the dominant discourses, thus opening space for meaningful change in the discourses of medical education. This will be discussed further in the following section, presenting my proposed framework for remediation following unprofessional behaviour.

9.5. A proposed framework to support remediation

In this section, I draw together the findings of this thesis to present a framework that is grounded in my findings and the theoretical perspectives I have employed to interpret them. At each stage of my research, I encountered challenges with recruitment and engagement of participants. It was difficult to engage institutions – both medical schools and the GMC – in my research, as well as to recruit individual faculty and students to participate. It is difficult to surmise the reasons for this, though perhaps it reflects the strain institutions are working under and the challenging nature of the topic. It might indeed be the case that institutions were unwilling to engage as they wished to protect their policies and practices from criticism. In the event of the latter, this may suggest that any new framework may be resisted by the dominant institutions. I present my ideas, however, as a means of communicating the scope of my research, to offer alternative discourses and to create possibilities for remediation that I believe meets the needs of the learners in question.

This framework is intended to be used as a scaffold for medical schools to inform the planning and implementation of remediation following professionalism lapses. Importantly, this is intended to be a high-level, strategic framework rather than a step-by-step process for individual learners. That said, in spite of the wide-reaching

approach I have taken, improvements in remediation practice will be limited by the context of medical education more generally and this framework should be considered alongside radical reforms to improve equity and access. Over the course of this thesis, I have explored the complexity that lies beneath professionalism lapses and it would be disingenuous to attempt to translate this into a one-size-fits-all approach. Importantly, institutional context can potentially constrain a medical school's ability to implement recommendations. Very specific, process-level recommendations may be adopted in a piecemeal fashion, which is unlikely to meaningfully improve the experience of remediation for learners or educators. This framework is therefore intended to create a culture shift that approaches remediation in a wholly different way whilst working within the existing structures of medical education. Furthermore, Chou *et al.* (2019) discussed the importance of normalising remediation within medical curricula, in part to reduce the perceived stigma associated with these processes. Using a high-level framework that focuses on culture change seems to be one way to address this: many of the changes I recommend would apply to all faculty and students, not simply those found to be 'unprofessional'. This strategic approach allows medical schools to be proactive, seeking in the first instance to prevent identity dissonance and professionalism lapses, as well as to react promptly when they do occur.

Another important aspect of this framework is that I have acknowledged that 'remediation' does not begin with a formal interaction or action from a member of medical school faculty. As discussed in Chapter 3, many clinician educators may have informal conversations with learners following professionalism lapses that are intended to have a corrective effect. Though these clinicians may not describe these conversations as 'remediation', they fall within my definition thereof. Furthermore, the threshold at which remediation becomes a formal process is currently defined by an institution's existing process. I have therefore deliberately encompassed all educators responding to a perceived professionalism lapse within this framework.

Finally, this framework is underpinned by a position, developed through the evolution of this thesis, that 'unprofessional' medical students are not broken, sick or deviant: they are simply individuals whose identity performances do not fit the norms and expectations of their educators. This framework is designed to narrow the gap between individual 'unprofessional' students and the norms and expectations by addressing both sides of the divide. Once again, this justifies the macroscopic nature of the framework: cultural and institutional changes are necessary to make space for effective remediation of individuals.

9.5.1. A note about language

In this chapter, I have described the key role that language and discourses play in perpetuating power structures. In previous chapters, I have critiqued existing definitions of 'professionalism' as reflecting a white, male, heterosexual, cis-gendered, non-disabled hegemony and identified the potential negative identity consequences of using the term 'unprofessional'. The term 'remediation' itself can readily be criticised as assuming that an individual has deviated from the norm and (s)he requires corrective intervention. It would be useful to open a debate about appropriate language in the context of medical education; however, this is not yet happening. With this in mind, I have made the conscious choice to continue to use the term 'remediation'. The purpose of this framework is for it to be operationalised and thus must be comprehensible to the medical education community. I feel using existing terminology, though in a critical way, will optimise accessibility and thus implementation of the following recommendations.

9.5.2. The individual: longitudinal coaching to balance of support and challenge

One of the key findings of the stakeholder engagement workshops that I am yet to discuss was the imperative to support students in an equitable, fair and challenging way. In light of my conclusions in Chapter 8 regarding the identity dissonance experienced by 'unprofessional' medical students, it follows that a supportive intervention to reduce dissonance would be of use. One method of supporting students that has been recently popularised – including in the contexts of professional identity formation and remediation – is that of 'coaching' (Steinert,

2016; M. K. White & Barnett, 2014). As the name suggest, this involves adoption of techniques from domains such as professional sport and relies on the following principles (Lovell, 2018):

- that there is individualised, formative feedback for the learner;
- that the coach and learner collaboratively set individualised goals;
- that the coach acts as a facilitator to develop new behaviours or insights into their existing behaviour;
- and that the coach is a relevant expert.

Workshop participants identified the need for students to be supported in a way that challenges them to reflect and potentially alter their behaviour. Describing this through the lens of identity performances, students need to develop an understanding of the expected identity performances and be expertly guided through the identity dissonance that may arise from this awareness. In the wake of professionalism lapses, this guidance needs to cultivate awareness of how their behaviour failed to align with the expected identity performance. Furthermore, students experiencing identity dissonance need a space where it is possible to discuss this one-to-one in order to produce understandings that may help to resolve dissonance and support choices that need to be about identity performances. A coaching relationship seems to offer an opportunity to address these needs.

One of the themes that arose from each empirical phase of this thesis was that of 'insight'. Importantly, in Chapter 8, I have critiqued the imperative for students to demonstrate 'insight' as reproducing and exacerbating dissonance. Furthermore, the performance of insight does not seem to adequately reassure medical faculty that an 'unprofessional' student will not replicate their behaviour in future. By employing a supportive, coaching relationship, there is a space for longitudinal understanding and non-judgemental probing of a student's awareness of norms and expectations. Coaching offers an opportunity for *faculty* to develop meaningful insight into a student's behaviours and attitudes and thus the ability to understand

what previous – and potentially ongoing – dissonant identity performances represent.

Another facet of a coaching relationship is that it is framed positively: it is designed to optimise performance rather than correct underperformance. The 'unprofessional' students I interviewed used narrative positions such as 'the maverick' and 'the self-made (wo)man' that express potential to be proactive agents of change. In the narratives I analysed, these positions were mostly employed as a means of criticising medical schools; however, a coaching relationship could foster these ideas and encourage students to channel their energy in a productive way. For example, if a student has found mindfulness useful to address her anxiety, she could be encouraged by a coach to explore mindfulness training or promote the value of mindfulness practices amongst her peers. Indeed, fostering interests beyond desperation to complete the medical course may help some students to identify an alternative career, thus addressing some of the difficulties expressed by faculty with guiding students out of medical school.

With the arguments above in mind, coaching relationships seem to offer a useful possibility for 'remediation' in the wake of professionalism lapses. An appropriate threshold for introducing these coaching relationships is important and will depend on existing medical school processes for identification and recording of professionalism lapses. As discussed above, there have been calls for remediation to be normalised in medical education (Chou *et al.*, 2019; Cleland, Cilliers, & van Schalkwyk, 2018), suggesting that it is useful to have a low threshold that encompasses relatively large numbers of students. Including more individuals in remediation processes also has the potential to reduce identity dissonance for the students that go through them: remediation would be less alienating if an individual had more peers with whom to share the experience. The evidence from this thesis suggests that interventions should be introduced early in order to prevent worsening identity dissonance. For example, coaching should be offered after two reported professionalism lapses within an academic year, regardless of the perceived severity of those lapses. In some cases, if a lapse is deemed particularly

concerning, a single event would be sufficient to trigger a referral for coaching. This threshold allows for single low-level lapses that represent simple misunderstandings to be recorded without intervention, thus reducing the resource implications of introducing coaching.

The frequency of coaching meetings and the duration of coaching relationships must ultimately be decided in dialogue between the coach and the student. At the outset, meetings should be frequent – weekly or fortnightly – in order to facilitate a shared understanding of the purpose of coaching and building of a relationship. Meetings can then be spaced according to progress, goal-setting and key progression points. For example, it would be prudent to plan meetings at times of increased stress, such as around exam times, to provide additional support. Given the roots of identity dissonance can be deep-seated, arising from socioeconomic or cultural background, my findings support meetings continuing for the duration of a student's medical school career. These meetings need not necessarily be frequent, for example after a minimum of one academic year of regular meetings, check-ins every six to twelve months may be sufficient providing no further challenges arise. This ensures longitudinal support and development of a 'safe space' in which students can honestly share their challenges, as well as a deepening understanding of identities and potential sources of identity dissonance on both sides. Importantly, for a student in a pre-clinical phase, the coach should offer more frequent meetings for the first semester of regular clinical placement activities to support the transition to the clinical environment. This is because the nature of the expected identity performance shifts in the clinical environment and thus dissonant identity performances could once again become a problem. For students in their final year of study, coaching relationships should be continued into their early postgraduate training to ensure continuity of support. There may be challenges within the current UK system as there is little continuity or transfer of information between undergraduate and postgraduate training; however, it is in the interest of both the student and the employer to provide effective support at the time of transition. There is an increasing mandate from the GMC to accurately transfer negative information at the point of graduation (GMC & MSC, 2016), including

regarding professionalism lapses, and thus communication between undergraduate and postgraduate educators is becoming commonplace. Furthermore, in the UK, medical schools remain responsible for any FtP issues that arise during the first year of postgraduate training, which suggests that it would be appropriate to provide ongoing professionalism support during this time. In addition, the possibilities of remote meetings using online video calling make continuing supportive relationships increasingly possible, wherever a student may move for postgraduate training.

A longitudinal coaching relationship offers an important opportunity, particularly for students from UiM backgrounds: a faculty member who has a good understanding of a student is able to advocate for her at key progression points if this is required. One of the features identified in both the narrative (see Chapter 8) and workshop studies (see Section 9.3.5 above) I conducted was that some students may have resources that make medical school systems and structures easier to negotiate. For example, some students may have friends and relatives in medicine or other professional fields. These contacts give them access to help and advice that may not be accessible to students who are the first in their family to attend university. I theorised that students that lack sociocultural resources may be disadvantaged during their medical training. Given medical schools are actively seeking to recruit students from diverse backgrounds, it is incumbent upon them to provide additional support to allow these students to succeed. Having a member of faculty who has a good knowledge of the student's background and identities can understand and explain the identity dissonance (s)he is experiencing.

In order to deliver this coaching in a way that is informed and effective, there is a need to identify and train 'professional remediators'. These individuals must be trained in the principles of identity formation and dissonance, as well as delivery of coaching interventions. In order to provide this, robust faculty development is necessary, as I explore below.

9.5.3. Faculty development: clinical educators and 'professional remediators'

One of the key strands that seems to cut through this thesis is the need for targeted faculty training. There are several facets to this and different levels of training that will apply to different groups of educators.

Firstly, there is a need to train all clinical educators that regularly interact with medical students. Given my model of the perpetuation of identity dissonance presented in Chapter 8, it is of paramount importance to seek to optimise the response to every perceived professionalism lapse. In order to do this, clinical educators need to understand the potential complexity that underpins professionalism lapses and the potential impact of their interventions. They should be offered the tools to more effectively discuss professionalism lapses with individual students in a way that reduces identity dissonance. Furthermore, clinical educator training would ensure that these individuals know that a medical school has a fair, evidence-led approach to remediation. In previous research, educators identified a lack of apparent remediation processes as a barrier to raising concerns about a student (Dudek *et al*., 2005). Thus, good clinical educator training can empower individual educators to address and document concerns about a student's professionalism, which allows medical schools to build a longitudinal and holistic picture of a student's trajectory.

In order to ensure clinical educators are appropriately trained, all faculty involved with teaching medical students must be accredited in some way. At first, this may seem to present a further barrier to engaging clinicians in teaching; however, in UK postgraduate training, it has become standard practice that all educational supervisors must be accredited. With this in mind, there is a potential opportunity to offer additional training to those accredited educational supervisors, with medical schools keeping a register of local educators that have been trained. Furthermore, in order to encourage clinicians to engage with the additional training requirements, it should be formally recognised as contributing to their continuing professional development (CPD), which is a requirement for revalidation (GMC, 2018b). Providing training at this level, however, is unlikely to prevent lapses

coming to the attention of medical schools and thus training is required for those involved more formally in remediation.

In Chapter 3, I identified the diversity of existing remediation practices, including the faculty members that were engaged in this process. Importantly, in spite of the perceived burden of time and energy of remediation (Kalet, Chou, & Ellaway, 2017), the role of 'professional remediator' does not seem to exist. Using my proposed model of identity dissonance, there is a clear need for remediation to be handled carefully and for remediators themselves to have relevant knowledge and skills. Explicitly training 'remediators' as 'coaches' may help to address one professional discourse: the need to 'diagnose' a student in the wake of a professionalism lapses. Using the frame of identity coaching described above allows individuals to develop their own identity as 'remediators', distinct from any clinical role, using a process that is explicitly different to models of patient care.

If coaching is to be effectively adopted, remediators will also require a clear process for accountability and peer support. The latter is of paramount importance to ensure a critical perspective is maintained, preventing remediators becoming unduly enmeshed with students' emotional needs (Newman, 1997). In addition, the wellbeing of the remediator must be borne in mind as this could become a burdensome process from their perspective. Here, clinical psychologists have an excellent model of practice: in order to provide therapy, a practitioner must also engage in supervision and a therapeutic relationship (British Psychological Society, 2017). It is therefore not sufficient for a medical school to have a single professional remediator: each institution must have a team who share supervision and accountability relationships. In addition, identification of 'professional remediators' allows individuals from institutions to come together and share good practice.

In the case of 'professional remediators', it is important to delineate the training that would be necessary. I have already made a case for providing training in coaching skills; however, there is a more complex issue about tailoring these coaching skills to manage identity dissonance. During faculty engagement

workshops, I was interested that participants framed their definitions of 'what is unprofessional to you?' largely in behavioural terms. Arguably, this is because the existing guidance frames professionalism lapses in terms of behaviour (GMC & MSC, 2016), or because previous literature recommended a focus on behaviours to prevent value judgements of individual students (Ginsburg & Stern, 2004). Taking a behaviour-focused approach, however, would not allow 'professional remediators' to explore the identity dissonance that underpins 'unprofessional' identity performances.

There is an important argument to be made here regarding equity. By educating 'remediators' about identity performances that may arise as a result of professionalism lapses (see Chapter 8), there is a possibility to reduce the dissonance experienced by the educator that was evident in the reactions of workshop participants. This may then reduce the negative perceptions of faculty towards particular students and has the potential to reduce the disadvantage experienced by individuals with less cultural capital, who are less capable of producing an identity performance that is palatable to faculty (see Figures 8.2 and 8.3). In addition, there may be a potential to reduce the need for students to demonstrate 'insight' as the responsibility for understanding the dissonant identity performance rests on the 'remediator'. In turn, this reduces the requirement on the student to shoulder the blame, thus reducing the potential for worsening identity dissonance and helping to break the cycle of ongoing dissonant identity performances.

Having justified the need for good, identity-focused 'professional remediator' training, there is a need to present a solution. There is no existing training programme that is designed to help educators explore identities and identity dissonance. Interestingly, Cleland *et al.* (2018) trained faculty to interview students using methods they had developed for the purposes of their study of 'failing' students. With this in mind, it would be possible to train 'professional remediators' to use narrative interviewing techniques and analysis to explore and interpret identity performances. Another way of providing training regarding identity

positions and identity dissonance could be faculty workshops, utilising the 'collective stories' that I have created. These narratives seemed – in the course of workshops – to provide an accessible way to understand student identities and the structure of workshops could easily be reframed to focus on faculty training. Even with these steps for faculty development in place, however, it is not going to be possible to prevent all identity dissonance following professionalism lapses. There is therefore a need to ensure that robust, fair decision-making processes are in place that reflect the understanding of professionalism lapses as dissonant identity performances.

9.5.4. Faculty decision-making

In the event of professionalism lapses that are particularly concerning – such as a student accused of sexually assaulting a patient – there will clearly always be a need to investigate and question that student's fitness to practise (FtP) medicine, which may circumvent the opportunity for remediation. In addition, there will be instances where professionalism lapses continue despite attempts at remediation and questions arise regarding a student's FtP. Ultimately, not all students will be able to achieve the identity performances, underpinned by the knowledge and skills, to practise medicine and the safety of patients must remain at the heart of decisions regarding remediation and FtP (GMC & MSC, 2016). In instances where professionalism lapses raise concerns regarding FtP, it is vital that there is an equitable decision-making process. Based on my research, this should have two key elements: a critical approach to the concept of insight and joint decisions made by a diverse panel.

In Chapter 8, I critiqued the construct of 'insight', theorising that the demand for 'unprofessional' students to demonstrate insight has the potential to exacerbate identity dissonance. Furthermore, through both the workshops and the survey, there was a clear message from educators that they are not necessarily reassured by performances of 'insight' and remorse. Much of the discourse regarding insight in undergraduate education emerges from the regulatory framework that governs practising doctors (MPTS & GMC, 2018). In order to meaningfully refocus

remediation towards addressing identity dissonance, the absolute requirement for demonstration of insight into professionalism lapses needs to change. Demonstrations of insight do not seem to help students or educators to move forward following professionalism lapses. That said, to dissociate undergraduate education from the postgraduate realm – where the mandate to demonstrate insight is unlikely to change – potentially 'sets students up to fail'. With this in mind, there seems to be a need for a critical conversation about the meaning and purpose of insight in relation to professionalism lapses. Adoption of the definition I presented in Chapter 8 would be useful, focusing on individuals *understanding* the expectations, how these expectations relate to the practice of medicine and how their behaviour has been perceived to fall short of these. This removes the imperative for 'unprofessional' students to shoulder the blame and instead potentially facilitates reflection on the gap between expectations and identity performances. Furthermore, as I discussed above, the coaching relationship offers an opportunity for a member of faculty to develop a deep understanding of a student. This understanding should inform any interpretations of a student's insight and thus feed into decision-making. That said, it is inappropriate for a coach to be providing both a supportive role and act as a decision-maker with regards to a student's FtP. Thus, decision-makers should be carefully selected and trained.

In the first instance, good faculty development has the potential to improve equity of decision-making. If an identity-based understanding of professionalism lapses becomes the dominant discourse within an institution, it follows that decisions will be influenced by this philosophical stance. As discussed above, there is potential for identity performances to create dissonance for educators, evoking a 'gut reaction' to a student that is subjective. With this in mind, it is difficult to justify relying on a single decision maker to make progression or FtP decisions. In this way, it is useful to borrow from clinical practice. As a workshop participant identified, multi-disciplinary teams (MDTs) are now a ubiquitous way of managing complex patient care. The same is required here, in order to embrace the diversity that medical education has to offer. As discussed, one of the challenges that the field of medical education poses is the different background of its faculty; however,

this offers an opportunity for multiple perspectives to be represented when making key progression decisions. It is vital to acknowledge that the identity dissonance will not be the same for all educators and will be informed by their background and lived experience. Thus, a diverse faculty is an asset to decision-making and multiple decision-makers are necessary to improve fairness. There have previously been discussions about the value of lay members on FtP panels (David *et al*., 2009) but this is not mandated by the GMC at undergraduate level (GMC & MSC, 2016). Workshop participants identified problems with a mismatch between medical school and wider university policies and perhaps having a lay member from within the university offers an opportunity to address both issues. A member of staff from a discipline outside medicine could offer valuable balance, the perspective of a potential patient and a good understanding of the wider context of university policy and practice. Importantly, joint decision-making by diverse panels should not be reserved for summative decisions regarding a student's FtP: they should be employed at all progression points to ensure optimal equity and fairness. Decision-making is also informed by the wider culture within a given medical school and this is also important to address proactively to support equitable remediation.

9.5.5. The institutional environment

There seems to be an imperative for medical schools to take preventative action to recognise the possibility for identity dissonance and thus safeguard against it. In the stakeholder workshop discussions, there were conversations about the mismatch between the frequency of challenging life events and students' awareness of the frequency of these difficulties amongst their peers. Workshop participants also noted that it was difficult for an individual student to 'stick their head above the parapet'. With this in mind, recruitment of role models would be useful, to share their stories of challenging life events to normalise these experiences. An example of good practice in the postgraduate sphere is the recent 'This Doctor Can' campaign (RCP London, 2019), which involves doctors sharing narratives that exemplify the diversity to which the medical profession aspires. Recruiting practicing doctors – or perhaps senior students who have 'lived to tell

the tale' – to share narratives of challenging circumstances has the potential to reduce identity dissonance for current students experiencing something similar. Furthermore, if these narratives are incorporated into regular, routine communications – such as school newsletters and social media outputs – this further normalises these stories. Having intermittent, large-scale occasions – such as introductory lectures at the start of medical school – potentially risks 'othering' the tellers, making their stories all the more extraordinary rather than creating a discourse of diversity. Using frequent communication through 'normal' channels has the potential to truly celebrate diversity and the things that can be learnt from it, rather than problematising it.

One suggestion from workshop participants was that students should receive explicit teaching about how to negotiate conflicts that arise when family members are unwell. Though this could be done reactively, in response to individual challenges, there are also opportunities for proactive teaching. Professionalism lapses have been noted to arise when values come into conflict (Ginsburg *et al.*, 2000), which suggests that a programme of teaching regarding professionalism conflicts would be useful to provide students with tools to negotiate these difficult situations. As I have noted, not all students will experience conflicts during their time at university; however, proactively including this in the curriculum would reduce the inequity for the students who are unlucky enough to encounter difficult circumstances.

In Chapter 8, I identified lack of cultural capital as a potential source of identity dissonance. This suggests that it may be possible to identify students at increased risk of identity dissonance, to provide supportive interventions early on, prior to any professionalism lapses. This offers the possibility to reduce the risk of worsening identity dissonance, which may be a useful way to reduce differential attainment in medical education. Though this may initially seem to stigmatise some learners and exacerbate identity dissonance, there is some initial evidence that this is not the case. For example, one UK medical school has recently reported successful development of an extended medical programme – six years rather than

five – to address the academic differential attainment that has been noted in students from UiM backgrounds (C. White, 2019). Interventions such as this offer an opportunity to explicitly model professional identity performances and educate students regarding professionalism, which may be even more effective at reducing differential attainment in the longer term.

Many of the interventions I have outlined above rest on a key assumption: that students' identity performances *should* be moulded into a shape that fits the medical hegemony. I have taken this approach largely pragmatically: there are limitations to the speed and extent of change in the medical discourse, though this is something that I would advocate. Furthermore, though this framework is intended to be adopted by medical schools, I appreciate that it is challenging for a single school to shift from the cultural norm. With this in mind, medical regulators such as the GMC have a vital role to play in changing the discourse about what it means to be a doctor and how professionalism lapses are managed. These are ideas I will explore further in the concluding chapter of this thesis.

9.5.6. A proactive framework for equitable and inclusive remediation following professionalism lapses

Having explored the facets that a framework should offer, I can now present a summary – see Figure 9.2. Importantly, the individual is a only one facet of this framework, acknowledging that much of the work that needs to be done to meaningfully change the way remediation is managed is at an institutional level. Adoption of coaching alone, without the structures that support this, would likely be no more effective than the existing strategies for remediation. Here, I frame the challenge of remediation differently: it is not the job of medical educators to 'fix' individuals that are 'broken' but to make space for individuals to enact authentic identity performances that meet the norms and expectations of the profession. If norms and expectations can be broadened, the identity work required by these individuals is reduced, reducing their cognitive and emotional load, reducing identity dissonance and making space for them to succeed. In addition, if students can be coached to understand the importance of identity performances that meet

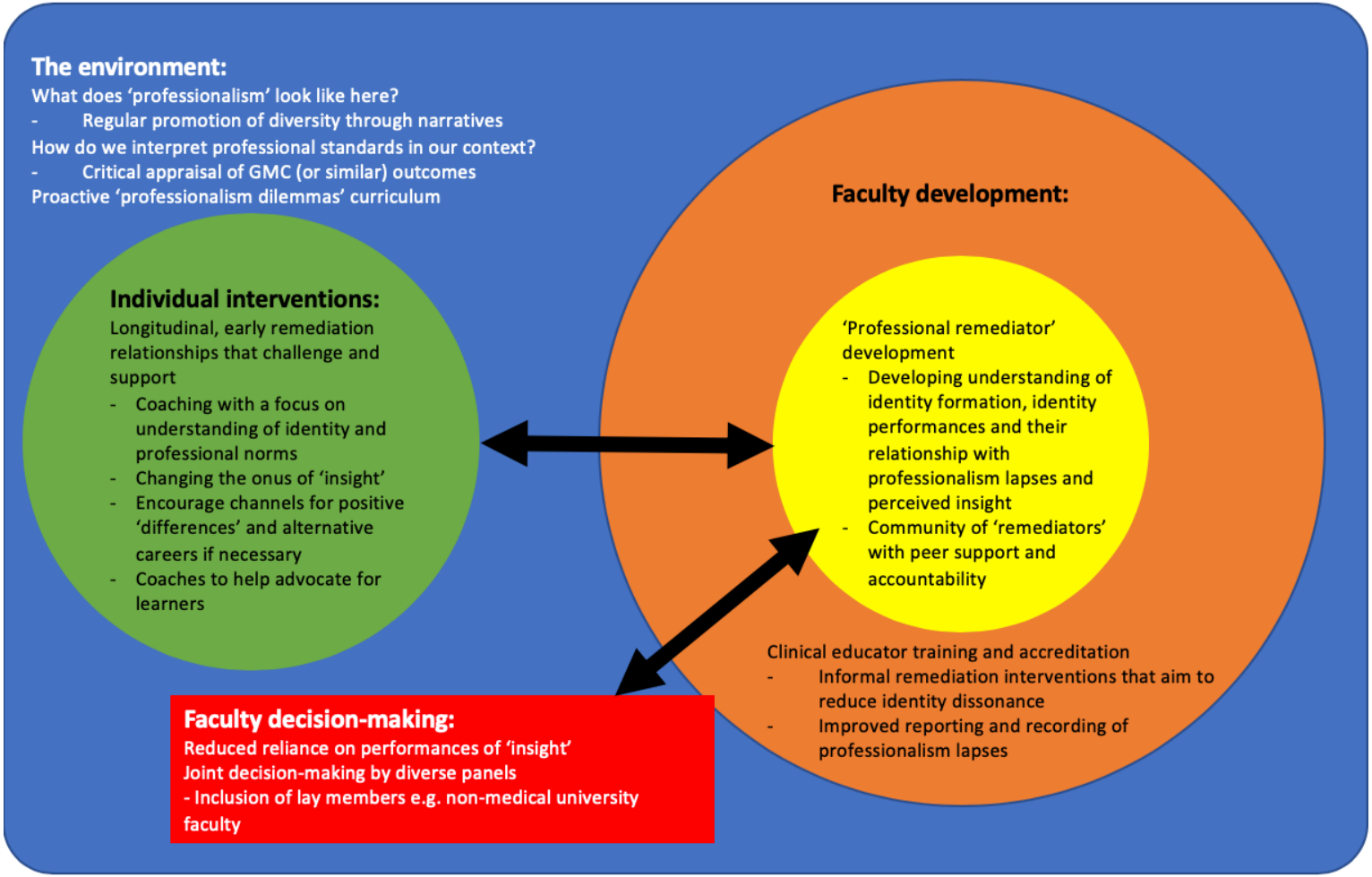

Figure 9.2 – A proactive framework for equitable and inclusive remediation

norms and expectations, educators can provide greater clarity regarding how to succeed in medical education. Finally, understanding the required identity performance makes space for a student who does not feel able to authentically enact this to choose alternative paths. Below, I present a worked example to demonstrate how this framework could be employed in practice.

9.5.7. Operationalising an equitable and inclusive remediation framework – a worked example

Lisa is a third year, graduate-entry medical student at a university that has adopted the remediation framework I have proposed. Over recent years, Lisa's medical school has provided faculty development workshops for all clinical educators to improve understanding of professionalism lapses. Furthermore, they have invested in training five 'professional remediators', who have coaching skills and a good working understanding of professional identity formation.

During a clinical placement block, Lisa stops attending her programmed activities. This is noted by her clinical supervisor, Ms Ahmed, who emails her to arrange a meeting to discuss things. During the meeting, Ms Ahmed draws on her training to discuss Lisa's perceived professionalism lapse, asking wide-ranging questions about Lisa's background, her enjoyment of medical school and her aspirations for the future. Lisa reveals a recent relationship break-up that has prevented her from coming to placement. Ms Ahmed is able to probe Lisa about this to understand why the break-up has prevented her from coming to placement, uncovering Lisa's understanding of herself as non-essential in the clinical workplace. They have a discussion about attendance expectations and why these are important for medical students, for example that we want to be sure that doctors are going to turn up to work in future and expect that students will model this behaviour during their clinical education. Ms Ahmed recommends that Lisa reflect on who she wants to be in future and how she can begin to model that identity now. Ms Ahmed also alerts the medical school to Lisa's absence and documents the discussion in Lisa's ePortfolio.

Several weeks later, Lisa has rotated to a respiratory medicine placement. Once again, her supervisor, Dr. Cheng, notes that she is frequently absent from scheduled placement activities. Several of Lisa's colleagues mention that 'she never comes in' and Dr. Cheng notes Ms Ahmed's documentation in Lisa's ePortfolio. Dr. Cheng decides that speaking to Lisa is unlikely to be fruitful and reports her attendance problems directly to the medical school.

In response to Dr. Cheng's report, Lisa is asked to meet with George – one of the remediation team at the medical school. This is the beginning of a coaching relationship that involves them meeting every week for the first twelve weeks. During this time, they explore Lisa's sense that she has never really fitted in, her concerns about not being as bright as her peers, her lack of family support as she is the first to attend university and her exhaustion at trying to be the 'good' medical student. They also explore Lisa's reasons for wanting to pursue medicine and where she sees herself in future. She explains that she wants to be a psychiatrist and thinks she can do this well, particularly as she has undergraduate degree in psychology. Lisa explains that her career aspirations do not always help her to feel like she fits in as she does not particularly enjoy specialties apart from psychiatry. This allows George to understand Lisa's difficulties and to set targets relating to her medical education. For example, George arranges for her to speak to some mental health service users to discuss what they expect of their doctor to help Lisa understand the expected identity performance. He also encourages her to use her psychology skills in patient consultations to develop a better understanding of the psychological impact of physical disease. This helps Lisa to see her 'niche' on placement and she begins to enjoy it more, finding it less burdensome and easier to motivate herself to attend. George and Lisa continue to meet monthly for the remainder of the academic year to check in. Over subsequent months, Lisa develops some resources for pre-clinical medical students about basic health psychology from the perspective of a clinical medical student.

At the end of the academic year, Lisa's medical school has a progression review conducted by a panel of three medical faculty and an academic staff member from

outside the medical school. This panel considers whether Lisa is able to progress into her next year of study. They have access to Lisa's ePortfolio with the documentation from Ms Ahmed, the report from Dr. Cheng raising concerns and a report from George. The panel notes that Lisa has missed a significant quantity of placement activities in spite of the early intervention from Ms Ahmed. They note, however, the progress she has made with George and her reflective writing that seem to demonstrate she is increasingly aware of the importance of being reliable as a doctor. The external panel member in particular is impressed by the teaching resource she has produced. Overall, the panel decide that Lisa should progress unimpeded to fourth year with ongoing support from George at least twice-yearly and the condition that her attendance is satisfactory for the remainder of the programme. Two years later, she graduates successfully, keen still to pursue a career in psychiatry but with an interest in the psychological impact of chronic disease.

9.6. Summary

In this chapter, I have explored the need for a stakeholder engagement exercise as a means of translating theory into practice. I have outlined the process by which medical students and medical educators participated in this process and the insights they offered. I went on to present a critical analysis of the contributions of stakeholders, before weaving the findings of my research together into a framework designed to support educators in the remediation of 'unprofessional' medical students.

10. Conclusions

I began this thesis by reflecting on my starting point: in earlier research, I conceptualised all unprofessional behaviour as requiring sanctions, disregarding the need for remediation altogether. Over the course of this thesis, my understanding of unprofessional behaviour has evolved and I now view lapses as dissonant identity performances that do not match with the expectations of the audience. This evolution in thinking has led me to far more wide-ranging conclusions about remediation than I would have anticipated and the framework I have created is more holistic than I originally envisaged. It is therefore useful to reflect briefly on the road that has brought me here and the questions that remain unanswered.

At the outset of this thesis, I conducted a literature review in order to define professionalism for the purposes of my programme of research. This literature review explored the inequitable nature of current understandings of professionalism, skewed towards white, male, heterosexual, cis-gendered, non-disabled conceptualisations of what it means to be a professional in the medical world. I also discussed the way in which identity theory has been utilised to understand how medical students become professional. In particular, I defined identities as multiple, constantly evolving and changing depending on the perceived requirements of the context. Indeed, I concluded that professionalism is an expected identity performance on the medical stage and thus 'unprofessional' behaviour is an identity performance that does not meet the expectations of the audience.

In the first of three empirical studies, I used a questionnaire design to explore current remediation practices in the United Kingdom. This gave insights into the difficulties faced by UK medical schools trying to address unprofessional behaviour, particularly the uncertainties regarding interpretation of 'insight' and perceived success. Furthermore, this study corroborated previous publications, finding that remediation is a labour-intensive activity for medical school faculties. I, therefore, concluded that there was an imperative to improve our understanding of the

identities that underpin an identity performance deemed unprofessional in order to design remediation more effectively.

In order to explore the identity of 'unprofessional' medical students, the second empirical phase of this thesis involved an in-depth narrative study with these individuals. Exploring the lifeworlds of medical students who had behaved 'unprofessionally' allowed me to develop an understanding of these individuals. This study highlighted the intentional identity positions that participants curated, as well as the identity positions they seemed to unintentionally assume. In particular, understanding the lived experience of 'unprofessional' students offered me insights into their perceived life challenges; their sense of alienation from their peers; their desire to succeed in medicine; their perception of the flaws of medicine and medical education; and their conceptualisations of a better future in which they can fit. Applying existing theories of cultural capital and identity dissonance, I developed a model describing a cycle of alienation and identity dissonance that seemed to represent the experience of my participants. In particular, I highlighted the potential for identity dissonance in students from UiM sociocultural backgrounds, leading to an increased 'risk' of identity performances that are interpreted as dissonant. This reinforced my interpretations of the extant literature: professionalism is not an equitable construct and current remediation practices may require identity performances that are inaccessible to some. In addition, I compared the concept of 'insight' with blame theory, showing that the requirement for students to demonstrate insight into their behaviour following professionalism lapses may further exacerbate identity dissonance. With this in mind, I presented a new definition of 'insight' that can be applied in the context of medical education.

In the final empirical phase of this thesis, I used a stakeholder engagement workshop method to bridge my model of identity dissonance into a framework for the practice of remediation. I used example narratives derived from the stories I was told by 'unprofessional' medical students to give participants and understanding of the lived experience of these individuals. These workshops deepened my understanding of the limitations of current remediation practices, which seem to be uncritically informed by dominant institutions and interpretations of professionalism.

Furthermore, these dominant discourses seem to constrain the perceived possibilities for remediation following professionalism lapses. Using existing Foucauldian interpretations of power, I was able to conceptualise both medical students and medical educators as 'docile bodies', passively submitting to the structures of power in the realm of medical education.

Combining the findings of my literature review, questionnaire study, narrative interviews and stakeholder workshops, I was able to build a framework for an equitable and inclusive approach to remediation. This framework includes a structure for medical schools to alter their approach to remediation wholesale. At the level of the medical school environment, I detailed the need for critical evaluation of the institutional discourses of professionalism and promotion of stories of diverse experiences of medical education. Furthermore, the framework outlines the need for wide-ranging faculty development and accreditation to support clinical educators in their day-to-day interactions with medical students. For a small group of faculty members, in-depth training using an identity-focused interpretation of professionalism lapses and the identity dissonance model that I have created would provide them with skills to offer effective remediation and support. These 'professional remediators' should also be trained in coaching methods in order to provide identity-focused coaching for students following professionalism lapses. These coaching interventions make space for longitudinal relationships and provide faculty with the opportunity for deep understandings of 'unprofessional' students. Finally, the framework includes suggestions to ensure equitable decision-making at key progression points, including – but not limited to – fitness to practice judgements. These aspects of the framework are intended to ensure that the diversity of the student body and the population more widely are mirrored by decision-makers, including recruiting non-medical members of university faculty to improve balance on decision-making panels. Overall, I have created a framework that I believe can address the mismatch between some students identity performances and the expectations of the medical *milieu*, making space for medical school to be a more equitable environment for developing doctors, whilst ensuring they are prepared to effectively address the needs of their patients.

10.1. Key reflections

Over the course of this thesis, my position with regards to professionalism lapses has certainly evolved. At the outset of this programme of work, I had little sympathy for students who behaved unprofessionally. I had little insight into why some students seemed unable to follow explicit rules or would engage in behaviours clearly incongruous with the practice of medicine. Though I acknowledged that there were individuals who may have mitigating circumstances – such as personal illness – I never believed that this *excused* professionalism lapses. Having undertaken this programme of work, my personal stance has changed dramatically: I now view all professionalism lapses as an opportunity to understand a student who may be experiencing a profound identity challenge and to help this individual with understanding why this identity challenge may have occurred.

One of the ways in which my thinking has developed is understanding the importance of language. In the discussion of my proposed framework, I touched on the potential for the existing language to perpetuate unhelpful discourses. Increasingly, I have used inverted commas to imply my scepticism about the utility of these terms. I have found, however, it impossible to do away with them altogether. In my understanding, professionalism lapses are not aberrances: they are misinterpretations of the expectations of the audience, requiring careful unpicking and interpretation. Indeed, the term 'professionalism lapse' emerged from a critique of the practice of describing students as 'unprofessional' (Ginsburg & Stern, 2004) and yet this practice is still common. It is my hope that beginning a conversation that conceptualises lapses as dissonant identity performances may change the discourse, sharing the responsibility for addressing lapses between students, faculty members and institutions. That said, I appreciate that this is unlikely to happen quickly and the rhetorical shift is likely to mirror a philosophical one. Therefore, it is vital to have a conversation about the framework I have proposed, the theoretical understandings that informed it and its application in medical education.

10.2. Wider implications for remediation

One observation I made during the course of my narrative research was the complex interaction between professionalism and academic performance. The remediation framework I propose focuses on professionalism lapses as this was my intention at the outset; however, there are potential implications for approaches to remediation more broadly. In the introduction to this thesis, I critiqued the current remediation literature for a lack of clear separation of academic and professionalism remediation, as there is a fundamental difference between the remediation of knowledge and skills and the remediation of identities. I am not advocating that professionalism and clinical knowledge and skills remediation are *combined* as I maintain the stance that they require different interventions. It may, however, improve all remediation if processes mirror one another, though with different targets and interventions as tools.

In Costello's (2005) work, she highlights the differential academic performance of students with dissonant identities. Furthermore, it would follow that academic failure could cause identity dissonance: in a population of medical students selected for their academic excellence, it could quite easily challenge their sense of self to fail an examination. Often, medical students fail for the first time at medical school, having excelled to that point. If academic failure also feeds the cycle of identity dissonance, it may make sense to align remediation processes for academic failure with those for professionalism lapses.

One of the criticisms of existing knowledge and skills remediation is that it is too often targeted at a particular assessment, creating targeted, strategic learning that does not truly address the underlying difficulty (Pell, Fuller, Homer, & Roberts, 2012). This creates a situation in which students repeatedly fail, potentially worsening identity dissonance. Furthermore, it is possible that academic failure predisposes learners to professionalism lapses as a result of identity dissonance. It follows that remediation for academic failures should account for the potential for identity dissonance and actively seek to explore this. Indeed, coaching strategies could be

adopted for remediation of academic failure in order to offer more holistic support to learners.

In addition, the discourse around academic remediation often follows a 'diagnosis of deficits' model similar to the existing literature regarding professionalism remediation (Hickson *et al.*, 2007; Saxena *et al.*, 2009). Indeed, some authors advocate routine testing for specific learning difficulties as a means of 'diagnosing' academic failure (Yellin, 2014). In order to consistently move away from a discourse of diagnosis, it is important that this applies across all remediation contexts, thus adoption of a similar framework for remediation of professionalism and academic difficulties makes sense. It is going to present a potential challenge for clinician educators to stop casting medical students in a patient role and thus the more consistently this discourse is abandoned, the greater the chance of success.

From the perspective of the medical education environment, creating a culture in which occasional failure is normalised and not seen as an insurmountable barrier to a successful career is important. In the framework, I advocate the promotion of diverse role models and narratives. This would also offer opportunities for students and clinicians to tell stories of overcoming academic failure, thus changing the discourse around a perfect academic record being necessary for a career in medicine. Shifting the environment has the potential to reduce identity dissonance in those at risk of academic failure, as well as to reduce it dissonance in those experiencing failure.

Finally, some of the participants in my narrative study seemed to struggle with the identity challenge of being labelled 'unprofessional' when they were academically successful. In these circumstances, aligning professionalism and academic remediation processes gives a clear message: both academic and professional development are of equal importance and both are required to make a successful clinician. That said, I appreciate that these discourses are wider than an individual medical school, as I will explore further below.

10.3. Wider implications for medical education

It is my hope that medical schools will adopt the framework wholesale, aligning their institutional culture and practices accordingly. Even if this happens in multiple medical schools across the UK, it is clear that regulators have a key role to play in challenging existing discourses and guiding structural reform. Furthermore, some changes require alignment of medical school curricula and thus are beyond the capacity of a single medical school.

In the course of workshop discussions (see Chapter 9), there were three key structural reforms that participants highlighted that I believe have their roots in truly making undergraduate medical education more equitable without producing students unprepared for the realities of the work environment. Firstly, it should be possible to train less than full time. This would allow students to balance personal illness, caring commitments and indeed interests beyond a career in medicine. Given this is already possible in postgraduate training, this strategy aligns well with existing practice. Although this would be challenging on a case-by-case basis, it is eminently possible for schools to intentionally design programmes with this in mind. For these programmes to be of use to students who encounter difficulties during undergraduate training, however, there would need to be flexibility to transfer between institutions. There are existing examples of students who complete their medical education across multiple institutions, for example, the University of St. Andrews provides a pre-clinical medical course and then students have a choice of several institutions in which they can complete their clinical training. One workshop participant also highlighted the model of German undergraduate medical training, which is arranged in phases allowing movement around the country at the end of each phase. It is not pragmatically possible to suggest that medical curricula become entirely uniform; however, there would be utility in agreed outcomes at particular checkpoints. For example, medical schools could agree educational outcomes that must be achieved by the end of the pre-clinical phase – ordinarily year two – and the end of the penultimate training year. If students meet these outcomes, there could be a relatively smooth process for accreditation of prior learning and transfer between institutions. Practically speaking, transfers would need to be agreed on an

individual case basis to prevent an influx towards popular or prestigious institutions; however, given medical schools already have processes for managing mitigating circumstances in relation to assessment, it is not beyond the realms of possibility that a similar process could be created. Importantly, this process should not rest on a student being able to eloquently plead their case as the students most in need of this support may be the individuals who lack these skills.

In addition, there seems to be a need for temporal flexibility in medical curricula. The rigid structure of an academic year was identified as a potential reason for othering of medical students who have faced adverse circumstances. Many other higher education programmes take a modular approach, allowing students to catch up more readily if they face a challenging event during an academic year. That said, a modular structure ordinarily requires that a course is not linear: each module cannot be contingent upon what has gone before. This is clearly not possible in medical education as there are core concepts that must be built upon. I am therefore not proposing infinite flexibility that allows students to step on and step off at their leisure. It would be useful, however, to have a creative conversation about whether the academic year as a temporal unit could be deconstructed.

The final thread that seems to bind the findings of my analyses together is that medicine has a problem with equity: being a medical professional still seems to require a level of commitment that some cannot offer and the performance of being a doctor has shifted little to reflect the changing demographics of the medical profession and society more broadly. Many professional bodies are starting to have critical conversations about diversity and inclusion, such as the 'This Doctor Can' campaign (RCP London, 2019). In addition, medical publications are beginning to highlight issues such as the entry requirements for medical school acting as an unfair barrier for students from UiM backgrounds (Tarmey, Wood, Lillicrap, & Canuto, 2019). These are important moves to changing ideas about what it takes to be a doctor; however, there are key structural reforms that could also meaningfully alter the discourse.

10.4. Strengths and limitations of this research

There are several key strengths to this programme of research that I believe makes it a valuable contribution to the field. First and foremost, rather than building on an existing paradigm of remediation, I intentionally chose to set aside existing practices and look again and the understandings of professionalism and unprofessional behaviour upon which they are built. This approach has allowed me to reconceptualise professionalism lapses using new analytical lenses and theoretical frames. In particular, in identity-focused narrative inquiry, I have found a methodology that is relatively new to the field of medical education, which has permitted new insights regarding 'unprofessional' students to emerge. Furthermore, I have drawn on a diverse range of theories and literatures to inform my interpretations, which has allowed me to look beyond the *status quo* in medical education.

Another key strength of this programme of research is that I have undertaken a series of empirical studies that were intentionally designed to complement one another. This multi-phase approach has allowed me to produce a framework that incorporates diverse perspectives. That said, I appreciate that the number of participants included in each phase was small and thus questions could easily arise regarding the generalisability of the findings I have presented. Importantly, having used a qualitative paradigm, I have always acknowledged the time- and context-bound nature of my interpretations. This means that the implementation of any of my findings must not be undertaken unquestioningly: there is a clear need to follow any operationalisation with careful evaluation and further research, as I discuss further below.

Finally, there is a key group of individuals whose voice is not represented in this programme of research: patients or service users. As described in the introduction to this thesis, my interest in professionalism research began by investigating the potential discrepancies between attitudes of the public and the profession to examples of medical student lapses (Brockbank *et al.*, 2011). In this research, however, I have chosen to focus on the stakeholders within the medical profession –

or those aspiring to join it – rather than the people that we serve. The patient voice would be important to understanding how acceptable my approach to inclusive remediation is and the inclusion thereof could have strengthened to my proposed framework.

10.5. Unanswered questions

In the introduction to this thesis, I cited the calls for longitudinal evidence for remediation programmes (Papadakis *et al.*, 2012). Though my proposed framework is informed by my programme of research, it is as yet untested and there is certainly no longitudinal data to support its efficacy. Furthermore, the only means I have included for the definition of 'successful' remediation is the agreement of the coach and the student through ongoing dialogue. The lack of a defined endpoint has already been acknowledged as a potential challenge to any remediation programme (Chou *et al.*, 2019) and, in many ways, using the broad, identity-focused remediation approach that this thesis supports makes this more challenging. I would certainly caution against any attempts to quantify identity development – the pitfalls of which I explored in Chapter 4 of this thesis. This leaves a key question unanswered: is it possible to define an endpoint in my construct of remediation? Furthermore, if an endpoint can be characterised, what should this look like? And if success cannot be more clearly defined, what are the implications of this for the evaluation and further study of my remediation framework?

One potential opportunity for defining success and evaluating remediation is the collection of longitudinal, narrative data. As I explored in the methodology for this thesis, the stories we tell are a projection of our identities in a given time and place. Thus, keeping records of students' narratives over time may give insights into their evolving identities and identity performances, allowing faculty to understand students' identity positions over time. Furthermore, collecting narrative data longitudinally offers the opportunity for the study of the lived experience of a remediation programme from the student perspective, allowing medical educators to critically appraise whether remediation provides equity and inclusion. This could

be complemented by a programme of research collecting longitudinal narrative data from 'professional remediators' to understand their evolving practice of identity-focused remediation; their perceived 'successes' and 'failures'; and the barriers and constraints they experience along the way. Finally, the seminal work of Papadakis *et al.* (Hodgson, Teherani, Gough, Bradley, & Papadakis, 2007; Papadakis *et al.*, 2004; Teherani *et al.,* 2005) has driven the imperative for remediation of unprofessional behaviour for over a decade. In order to determine the success of remediation – or indeed the ongoing need to study remediation – there is a need to collect longitudinal data regarding 'unprofessional' students and in their postgraduate careers. In the UK, this will require the co-operation of medical schools and the GMC over many years; however, if a programme of prospective data collection could be implemented alongside changes to remediation practices, this could be a valuable opportunity for educators and institutions to have increasing confidence in their remediation practices.

10.6. Further research

In order to address the limitations of this research, as well as the unanswered questions posed here, there is clearly a need for further research in the field. First and foremost, there is a need to establish whether the proposed remediation framework would be acceptable to members of the public. In order to do this, I would suggest adapting the stakeholder engagement workshops using the collective stories in order to allow lay people to discuss how they think lapses should be managed. This could then be complemented with a discussion of my remediation framework to discuss how well this aligns with participants' perceptions of how lapses should be managed.

As I have discussed in section 10.4, one of the key potential limitations of this research is the context-bound nature of my interpretations. With this in mind, it is important to investigate whether these findings are replicated in different contexts to add strength to my interpretations. This is particularly important when discussing professionalism as the nature of the expected professional identity performance will

change across contexts. It may therefore be useful to undertake further semi-structured interviews, with a question schedule informed by my findings, to see whether the lived experiences I have described are common to other 'unprofessional' medical students.

A further important piece of ongoing research would be to evaluate the implementation of the remediation framework across different contexts. For example, as faculty development is a key feature of the framework, there is clearly a need to robustly evaluate the learning that occurs as a result of any CPD activities. Importantly, this evaluation strategy should be informed by existing evaluation frameworks to ensure that it does not merely capture the popularity of the session(s). In addition, it would be important to go back and interview 'unprofessional' students in future to ensure that remediation practices had effectively reduced identity dissonance. This study could be undertaken using a narrative-focused methodology similar to that used in this research.

As described in section 10.5 above, the final aspect of any ongoing research should be to ensure that changes to remediation are effective in the long term. One of the key drivers for research and practice in remediation, as I discussed in the introduction to this thesis, has been the work of Papadakis *et al.* (2004, 2005, 2012) demonstrating a link between medical student behaviour and later professional misconduct. If the purpose of remediation is primarily to protect patients by preventing misconduct in professional practice, I propose that there is a need to build on the work of Papadakis *el al.* (2004) by collecting prospective data regarding professional misconduct. Future cases of misconduct could be investigated to establish not only whether the individual had experienced lapses during their medical school career but also the approach that their medical school was taking to remediation during their undergraduate education. Over time, this would allow a picture to emerge of whether the strategic, inclusive approach to remediation I have proposed protects patients and preserves medical careers.

10.7. Concluding remarks

In conclusion, the exploration of professionalism, current remediation practices and the lived experience of 'unprofessional' medical students has led me to the creation of a framework that I believe offers possibilities for a new approach to remediation. My explicit intention is that this framework improves equity and inclusion in medicine, not just at the point of entry but throughout medical curricula. In this concluding chapter, I have also explored possibilities for aligning academic remediation practices with my proposed framework. In addition, I have proposed possibilities for changing the structure of medical education in the UK to address potential inequities that may present insurmountable barriers for some groups of learners. I have identified key areas for further research so that our understanding of how to approach remediation of unprofessional behaviour continues to improve and evolve in future. Finally, I have challenged the *status quo* in the practice of remediation, proposing a wide-ranging framework for institutions and medical educators.

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Appendix 1 – Question schedule for online questionnaire

Part 1 – details about your institution

Please provide some basic information about your institution

Q1 – Where is your institution?

a) England
b) Northern Ireland
c) Scotland
d) Wales
e) Prefer not to say

Q2 – Which of the following best describes your institution?

a) Public – undergraduate entry only
b) Public – postgraduate entry only
c) Public – mixed undergraduate and postgraduate entry
d) Private
e) Prefer not to say

Q3 – Approximately how many students (excluding intercalating students) are currently enrolled on the medical course at your institution?

Part 2 – information about remediation

These questions pertain to students who undergo an individual, structured remediation process defined by your institution in response to unprofessional behaviour, which may or may not form part of a formal fitness to practise proceeding. This does not relate to informal remediation of unprofessional behaviour that may occur, for example between a student and a clinical mentor following placement feedback.

There may not be a single answer to some of these questions: please expand on your answers as fully as possible.

Q1 – How are students requiring individual remediation of unprofessional behaviour identified?

Q2. Whose responsibility is it to construct an individual remediation plan following unprofessional behaviour?

Q3.1 – Is remediation of unprofessional professional behaviour distinct from or part of the sanctions process?

Q3.2 – If distinct from, how is separation achieved?

Q4 – How is an individual remediation plan constructed for students who have behaved unprofessionally?

Q5 – Who is responsible for supervising an individual remediation plan for students who have behaved unprofessionally?

Q6 – How is the remediation plan for unprofessional behaviour supervised?

Q7 – Are cases reviewed following remediation of unprofessional behaviour?

a) Yes, always
b) Yes, mostly
c) No, not routinely
d) No, never
e) Unsure
f) Other (please specify)

Q8 – What is the process for reviewing cases of unprofessional behaviour following remediation?

Q9.1 – Are successful remediation outcomes defined prior to the remediation plan being put into action?

a) Yes, always
b) Yes, mostly

c) No, not routinely
d) No, never
e) Unsure
f) Other (please specify)

Q9.2 – If outcomes are not pre-defined, how is successful remediation of unprofessional behaviour determined?

Q10 – In your opinion, are the processes currently in place for remediation of unprofessional behaviour robust and effective? Please provide details for any perceived strengths or limitations of your processes.

Appendix 2 – The Collective Stories

Introduction

In order to preserve to anonymity of my participants, I am unable to report any one of their individual stories at length. Quotations taken out of context of a whole narrative, however, fail to communicate the complexity of the stories that participants shared. By way of a middle ground, I have written these 'collective stories'. Each of the characters below is fictional and each of the stories is a combination of story elements from different participants, with partial fictionalisation where details may have been identifiable. These stories have been written to represent the themes and identity positions that emerged from my analysis in a way that is as authentic to the original participant narratives as possible. I conclude each narrative with a short commentary to orientate the reader and stimulate thought.

It is important to highlight that these stories contain little in the way of explicit reference to professionalism issues. This is quite deliberate, as much of what my participants shared was not about their professionalism lapses. The intention of the study had never been to focus solely on unprofessional behaviour: I had set out to explore the identity of my participants. The stories are intended to express these identities, though the reader should bear in mind the context that the students I interviewed had been found to be unprofessional by their medical schools.

Kevin

Kevin told me a story of struggling with his mental health from the beginning of medical school. Knowing what he knows now, he thought he had probably been depressed since his teenaged years but had only been diagnosed in his first year of university. The diagnosis had come about around the time of his first year exams, as he was so low that he was struggling to get out of bed, let alone study. He hadn't been to his GP because, in spite of what the medical school had told them, he was

worried that concerns would be raised about his fitness to practise. A few days before the first exam, it suddenly hit him that there was no way he could pass and he had turned up at the student support service in a panic. They had been really supportive: referring him for counselling and encouraging him to see his GP. They also arranged for him to defer his exams so he could sit them in the summer alongside the resit students.

When he had gone to the GP had diagnosed moderate depression and anxiety with panic symptoms straight away and given him sertraline and a short course of diazepam. The medications had taken the edge off in the short-term but they certainly weren't a cure. Kevin told me that his mental health had had an adverse effect on most areas of his medical school career, causing problems with deadlines, attendance and academic performance. He told me that he had spent considerable time and effort trying to improve his mental health over the last few years: he had taken up mindfulness and meditation, which had been the only things that seemed to had made a sustained impact. He had read up about the evidence for mindfulness: it had seemed a much better option than medication and he had turned out to be right. The downside was the time and energy these things took up, which no one else really seemed to recognise. The medical school had the same expectations of him as everyone else, which he could understand – after all, they were all going be doctors – but it didn't quite seem fair that his additional difficulties weren't fully acknowledged.

Kevin was in fourth year at the time of the interview. It had taken so much effort to get this far that he wasn't sure he could keep going. Not only did the depression and anxiety make everything feel twice as hard for him as it was for other students, but sometimes he looked at the stress that junior doctors were put under and doubted whether he had the resilience to get through that experience. Then he had those moments with patients where his experiences allowed him to understand them better than other medical professionals – his mental health challenges made him more empathic – and he remembered why he had wanted to do this all along. It was that desire to help patients going through experiences like his that kept him going.

Commentary

In this story, Kevin is positioned as a victim of his circumstances: he had to work harder than others to continue his medical training and this additional effort has gone unnoticed. Kevin also told the story of having to be the driving force in his own recovery: he researched therapies for himself and found these more helpful than any professional assistance he was offered. Furthermore, this story communicated the doubts that Kevin had regarding the compatibility of his mental health problems with a career in medicine. That said, this doubt was counterbalanced by a determination to continue and a sense that medicine was his destiny.

Lisa

Lisa started her story of her professionalism lapses at the point where she first applied to medical school. She had applied at 18 and had got a place but really hadn't enjoyed the course. She told me that it was too lecture-based and she had struggled to make friends, so she had ended up dropping out after the first semester. She went on to study psychology at university but she still wanted to be a doctor and applied again as a postgraduate and got a place at a different university.

When Lisa started medical school this time, she was aware of how much older she was than the 'normal' students. She didn't really feel like she fitted in and it took her a while to find the other postgraduate students who were closer to her age. Things hadn't been smooth sailing after that, though. She had found medicine much harder than her first degree and she hadn't really been prepared for the amount you need to know. In spite of a lot of revision, she had failed her first year exams. To say she had been devastated would have been putting it lightly and she couldn't get her brain into gear to study for the resits, so she failed those too. In the end, she had to resit the whole year but it had been easier the second time, with friends in the year above to give her some help.

During third year, life had got difficult again. Lisa's boyfriend, who was also a medical student, had ended their relationship out-of-the-blue. She had found it so

difficult that she had struggled to go to placement. After a few weeks, the medical school had noticed and pulled her in for a meeting to talk about her attendance. She told them about the break-up but they didn't really seem to care: they were more concerned with telling her what would happen if her attendance didn't improve. They had suggested she go to the support service but this seemed to be to tick a box more than anything. None of her friends had been in serious relationships, so they couldn't understand how she was feeling. All-in-all, she had felt totally alone.

The medical school monitored her attendance really closely but she just couldn't bring herself to go in because she was worried about seeing him. She had had to go to another meeting, where they told her she hadn't attended enough to pass the year. She had pleaded her case: she explained how sorry she was about her attendance; how difficult it was for her; and how she would manage things differently in the future. The medical school had agreed to let her resit third year, which she was part way through at the time of the interview. She told me at several points about how much younger and less mature her 'peers' were, had how she should be graduating the following summer. It was hard for her to be left behind by everyone and she felt like the next couple of years were going to feel interminable.

Commentary

Lisa's story represents a sense of feeling at odds with her peers: not only was she older but she has also had an atypical path into medicine via the graduate entry route. In addition, her setbacks at medical school had driven her further from her peers and she has found herself surrounded by people who do not understand her. Not only did she feel unsupported by her peers, but she also felt as though the medical school were unconcerned about her distress.

Finally, Lisa's story does not give the impression that she felt she had done anything wrong. In spite of this, she met the expectations of the medical school by apologising and reflecting on her perceived professionalism lapse in order that she could continue her medical training.

Katie

Katie's medical school career had been disrupted by her Father's illness. He had started becoming noticeably breathless and tired when she was in second year. It had taken her months to convince him to go to the doctor, in spite of her medical knowledge. As far as she could tell, the GP didn't seem to do a great deal: she had suspected COPD and requested some routine lung function tests to confirm the diagnosis. Katie hadn't really been satisfied with this: she had learnt about COPD and knew that this was strongly associated with smoking. Although her Dad had smoked in his youth, he had given up in his twenties and she had read that there shouldn't really be any long-lasting damage on this basis.

Whilst he was waiting for the lung function tests, her Father's breathing deteriorated even further. He got to the stage where he was stopping on the stairs two or three times and could barely manage to wash and dress himself. At this stage, she insisted that he go to hospital as there seemed little point in going back to the GP. He was admitted as an emergency and the consultant seemed worried at first because his oxygen levels were low. He had an urgent CT scan that showed inflammatory changes in his lungs. Her Dad was started on steroids and, within a few weeks, his breathing was much better.

Katie had needed to take time off medical school to be there with him for a few weeks and Steve in the student support service had been so sympathetic. She had had to fill in some forms but he had seemed genuinely concerned about her and told her not to worry about anything. When she had gone back a few weeks later, Steve had got in touch again to offer to support and advice to help her catch up.

Due to the delay in diagnosis, there had been told that there was some irreversible lung damage and her Father was still not the man he had been before. He got really tired and his walking was limited to a few hundred yards but he was stable and gradually adjusting to requiring some help with things he had always done before. Katie explained that her parents needed quite a bit of support and that she went home most weekends to do what she could, as well as occasionally needing time away from placement to take him to appointments. She explained that her parents

weren't 'medical' and she needed to go to the appointments to make sure they really understood what the doctors were saying. This sometimes made balancing medical school really hard because they lived 100 miles away and she was often tired on a Monday, having rushed back late on a Sunday evening. She always approved any absences using the proper process with the medical school but she told me it felt like the applications were intended to be as difficult as possible. Also, the medical school didn't always seem happy for her to take time off and eventually she had run into problems. She really relied on Steve in student support: it felt like he was the only one on her side.

Commentary

First and foremost, Katie's story is about becoming a doctor: she used her new-found medical knowledge to negotiate with her Father and to navigate the healthcare system. She used this knowledge to level criticism at the way her Father's case was managed and to 'translate' for her parents during appointments.

This story is also about the perceived barriers that stand in her way: Katie not only felt her circumstances were difficult but also that the absence policy was unfair to her, making her life more challenging. Though she does not feel that the medical school in general is helpful to her, there is one individual – Steve – who is the exception to this rule.

Michael

Much of Michael's story was about his life outside of medicine: he had done a lot of travelling and was keen to share these experiences and stories about the people he had met 'on the road'. One of the things he told me was about volunteering in a Tanzanian orphanage during his gap year. He was frank about how naïve he had been going into this experience: he really hadn't understood the degree of poverty to expect when he'd gone out there. At the age of 18, he had had very little idea of what the world was like outside his social sphere and arriving in sub-Saharan Africa on his own had felt like being hit in the face. He had organised the whole trip

through a charity but had told me the ways in which he had learnt to be self-sufficient. For example, if he ever wanted to leave the orphanage and go into town, he had to get a 'dalla-dalla' (minibus) with the locals. The journey was always an interesting experience: the roads were in an awful state, the bus was cramped and the speed was unbelievable. After the first week, he had decided to embrace it and actually really enjoyed the sense of reckless freedom.

At the orphanage itself, the kids had loved him. He had played football with some of the older boys and had helped teach them to read and write. He'd also had to help with some of the more practical tasks, like changing nappies and cooking meals, but they were things that he'd never really done before and some of the other volunteers, particularly the girls, were much better.

He remembered being shocked when he was first asked to help with the medication. Lots of the kids had lost parents to HIV/AIDS and many of them were HIV positive themselves. Once the initial shock passed, he remembered thinking it was incredible that these children were going to have a chance at a normal life because of the medication. In fact, once he had settled into the orphanage, he had found it a really nice place to be. Okay, the food was the same every day but these kids were looked after with love, had a roof over their heads, were fed three meals a day and got all the medication they needed. Yeah, okay, it was a simple life but not a bad one, really.

Michael told me that he had talked quite a lot about Tanzania at his medical school interviews. He had learnt so much about understanding people from different cultures and finding common ground to empathise and communicate. In fact, he reflected that he had probably learnt more practical communication skills from experiences like this than he had at medical school. Michael told me he thought medical schools should probably encourage more students to pursue experiences like this during medical school: most of his peers seemed to live in a Western bubble with no idea about other cultures. He didn't really understand how these students were going to be able to serve such a multi-cultural population if they had no idea about where these people have come from.

Commentary

Michael's story focusses on cultural awareness. Firstly, he openly told a story of heightened cultural awareness due to his lived experiences, comparing himself to his seemingly ignorant. In this way, he set himself apart from his peers as he has unique worldly wisdom.

There is also a tacit story here about a lack of awareness: Michael seems to be blind to his own privilege. For example, he did not openly acknowledge the privilege expressed by being able to travel to Tanzania in a gap year. In addition, he makes a comment about tasks being divided along gendered lines – because girls are better at cooking and cleaning – implying unseen social stereotypes.

Freddie

Freddie's professionalism difficulties had started in third year. Before that, he told me that his medical school career had been straightforward. He'd had occasional warnings for not submitting work on time or looking 'scruffy' on placement but he told me it had 'only ever been small stuff' and he had always apologised, promising to improve, which seemed to keep him out of trouble. On one occasion, however, he'd done something that he described as 'pretty foolish'. He and a few peers had been allocated a Student Selected Module (SSM) at a GP practice on the other side of the city. It hadn't been what he wanted to do – his interest is in Emergency Medicine – and they had been asked to do an audit project about inhaler prescribing in asthma that he told me was 'ridiculous'. He hadn't seen the point of the project from the outset and felt like it was a waste of his time, not to mention money to travel there every day. What's more, he told me the other five students in the group felt the same. He had, however, diligently collected the data and written a report that he described as 'perfectly adequate'.

On the final day of the placement, the supervisor had sat the group down and asked for feedback about the project. For the first few minutes, the others in the group

came out with some niceties, like 'I found it really interesting', during which time Freddie was becoming more and more irritated. He'd found the whole thing pointless and couldn't believe that the others were willing to sit there and say what the supervisor wanted to hear. After perhaps 10 minutes of this, Freddie interrupted to add his feedback. He told me that he couldn't remember the actual words that he said but the GP had later quoted him as saying that the project was "infantile" and that he had learnt nothing from the experience. Freddie certainly remembered telling her that he hadn't enjoyed the experience and felt that his time could have been better spent learning skills applicable to his future career. In retrospect, he probably should have phrased it better but he had so much pent-up frustration and couldn't believe that he was the only one prepared to be honest about the experience.

At the time, Freddie remembers that the GP was pretty shocked at this feedback but she didn't speak to him about in person. The next thing Freddie knew about it, he had been called in to see the deputy dean – Helen – at the medical school. He had worried that he was going to be treated like a naughty schoolboy but was pleasantly surprised that she seemed interested in his side of the story. Helen actually seemed to agree that the SSM had been of little educational value and he was glad he had the opportunity to discuss this with such a senior faculty member. He also explained that the other members of the group had felt the same but seemed to lack the courage to speak up about it. He reflected that this was really worrying, given how important it will be in their future careers to be honest and have the courage to blow the whistle on a senior colleague if necessary.

Commentary

Freddie's story is most overtly about unprofessional behaviour. His story implied a backdrop of low-level professionalism issues that he had dealt with predominantly by telling the medical school what they wanted to hear. Though he acknowledged that the way in which he delivered the feedback to the GP was not ideal, he seemed to proudly set himself apart from his peers. Not only did he narrate himself as the only one who was prepared to speak truth to power, he contextualised this with

reference to whistleblowing, thus implying that his behaviour was actually a professional act. Furthermore, he implied that a senior faculty member is in agreement with him, thus effectively dismissing any accusation of unprofessional conduct.

Appendix 3 – Ethical Approvals

Questionnaire study

Below is the ethical approval for the online questionnaire study (see Chapter 3), followed by the relevant participant information sheet and consent form.

UNIVERSITY OF LIVERPOOL

Health and Life Sciences Committee on Research Ethics (Human participants, tissues and databases)

15 December 2016

Dear Prof Jha,

I am pleased to inform you that your application for research ethics approval has been approved. Details and conditions of the approval can be found below:

Reference:	1008
Project Title:	How do we remedy unprofessional behaviour in medical students? A study of what medical schools currently do.
Principal Investigator/Supervisor:	Prof Vikram Jha
Co-Investigator(s):	Dr Susannah Brockbank
Lead Student Investigator:	-
Department:	School of Medicine
Reviewers:	Mr Paul New, Dr Sobhan Vinjamuri
Approval Date:	15/12/2016
Approval Expiry Date:	Five years from the approval date listed above

The application was APPROVED subject to the following conditions:

Conditions

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Committee on Research Ethics (Human participants, tissues and databases)

UNIVERSITY OF LIVERPOOL

Participant Information Sheet

Title: ***How do we remedy unprofessional behaviour in medical students? A study of what medical schools currently do.***

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your colleagues if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Aims and purpose

Though the recent General Medical Council (GMC) guidance about unprofessional behaviour in medical students recommends that students who are identified as behaving unprofessionally should demonstrate that they have successfully remediated this behaviour, no recommendations are offered for how this should be achieved. This study, therefore, aims to establish what the current practice is in medical schools in the UK for remediation of unprofessional behaviour. This forms part of a larger project intended to analyse the efficacy of current practice in order to develop an evidence base for interventions.

Why have I been chosen to take part?

You have been identified as a representative of your institution involved in the remediation of unprofessional behaviour in medical students. You have therefore been selected as someone with a unique understanding of your institutional protocol and practice, as well as someone with insight into the efficacy of remediation processes.

Do I have to take part?

No. Participation is voluntary and you may withdraw at any time; however, once your data are submitted, they will be anonymised and will not be extractable.

What will happen if I take part?

This study involves completing a brief online questionnaire, which will take approximately 15 minutes. This can be undertaken at a time of your convenience, using the link in the email to which this documented was attached.

Expenses and / or payments

Participation in this study should not incur any monetary costs and no reimbursement or incentive is being offered.

Are there any risks in taking part?

No risks are anticipated.

Are there any benefits in taking part?

Given your role in constructing, implementing or supervising remediation following unprofessional behaviour, we hope that this study and the wider project will widen the evidence base and inform your practice in the future.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr. Susannah Brockbank (sbrock@liverpool.ac.uk) or Professor Vikram Jha (medvj@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

Data will be collected using online questionnaire software. You and your institution will not be identifiable from the data collected. Data is collected anonymously and will be stored securely on a password-protected University of Liverpool server.

What will happen to the results of the study?

Results of this study will form part of my PhD thesis and any resulting publications. If participants wish to be informed of any publications of these results, they should inform the investigation team separately by email (sbrock@liverpool.ac.uk) to ensure anonymity of the questionnaire responses. Your responses will not be identifiable in any publications.

What will happen if I want to stop taking part?

If you decide to withdraw prior to submission of your questionnaire responses, no data will be recorded. After submission, responses will be anonymised and cannot be withdrawn.

Who approved this research?

This study was approved by the University of Liverpool Committee on Research Ethics (reference no. 1008).

Who can I contact if I have further questions?

Lead student investigator: Dr. Susannah Brockbank

Tel.: 0151 794 8759

Email: sbrock@liverpool.ac.uk

Postal address: Cedar House

University of Liverpool

Ashton Street

Liverpool L69 3GE

UNIVERSITY OF LIVERPOOL

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Title of Research Project:	*How do we remedy unprofessional behaviour in medical students? A study of what medical schools currently do.*
Researcher(s):	Dr. Susannah Brockbank, Professor Vikram Jha

	Please tick box
1. I confirm that I have read and have understood the participant information sheet (V3) dated October 2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me or my institution in any publications.	☐
4. I understand and agree that once I submit my data it will become anonymised and I will therefore no longer be able to withdraw my data.	☐
5. I agree to take part in the above study.	☐

NB – consent given online therefore not signed

Lead student investigator:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Supervisor:
Professor Vikram Jha
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7955476
medvj@liverpool.ac.uk

Narrative interview study

Here, I include the ethical approval for the narrative interview study (Chapters 5-8), followed by the relevant example recruitment email, participant information sheet and consent form. In addition, I include an example participant debrief sheet. Each participant was provided with a version with relevant contact details for local support services at their institution.

UNIVERSITY OF LIVERPOOL

Health and Life Sciences Committee on Research Ethics (Human participants, tissues and databases)

5 September 2017

Dear Dr Joynes,

I am pleased to inform you that your application for research ethics approval has been approved. Details and conditions of the approval can be found below:

Reference:	1909
Project Title:	How do medical students describe their experiences of medical school following remediation of professionalism concerns?
Principal Investigator/Supervisor:	Dr Viktoria Joynes
Co-Investigator(s):	Dr Susannah Brockbank, Dr Marina Anderson
Lead Student Investigator:	-
Department:	School of Medicine
Approval Date:	05/09/2017
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

D Prescott

Health and Life Sciences Committee on Research Ethics (Human participants, tissues and databases)

edreseth@liverpool.ac.uk

Example recruitment email

Dear …,

You have been identified as someone who may be able to help with a research study at the University of Liverpool. This study is entitled "how do medical students describe their experiences of medical school following remediation of professionalism concerns?". There are some students who, for a variety of reasons, find themselves running into problems related to behaviour that is seen as 'unprofessional' according to University or GMC guidelines. The research team is looking for students who have run into such problems to try and get their version of events.

This study involves you being interviewed face-to-face about your experience of medical school. This will give you an opportunity to tell your story of medical school in general, including any incidents relating to professionalism and the subsequent remediation process, if you would like to share these experiences. Participation in this study will involve an initial half-day interview in order to give you an opportunity to tell your story in full and possibly a second, shorter follow-up interview to clarify any key points.

If you are interested in participating in this study, please contact Dr. Susannah Brockbank directly via email (sbrock@liverpool.ac.uk) and she will send more detailed information.

Thank you for your time and co-operation,

(gatekeeper)

On behalf of:

Dr. Susannah Brockbank

PhD Candidate and Clinical Research Fellow

Student researcher:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Principal Investigator:
Dr. Viktoria Joynes
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7949785
vjoynes@liverpool.ac.uk

UNIVERSITY OF LIVERPOOL

Participant Information Sheet

Title: ***How do medical students describe their experiences of medical school following remediation of professionalism concerns?***

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask me if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your colleagues if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Aims and purpose

Recent General Medical Council (GMC) guidance about unprofessional behaviour in medical students recommends that students who are identified as not meeting behaviour standards should be supported by their medical school in order to demonstrate that this behaviour has been addressed. Current understanding of students' experiences of this process is, however, very limited. In order to develop better systems for supporting students following remediation of concerning behaviour, this study aims to explore these experiences through the story you have to tell. This forms part of a larger project intended to develop guidance for remediation following allegations of unprofessional behaviour.

Why have I been chosen to take part?

You have been as a student who has been through a process of remediation following professionalism concerns, though the details of your case are not known to me. You have therefore been selected as someone with a unique story to tell about how this experience has affected you. You have been identified by a member of staff from your university who is aware of the details of your case but this information has not been shared with me.

Do I have to take part?

No. Participation is voluntary and you may withdraw at any time.

What will happen if I take part?

This study involves being interviewed, potentially on two separate occasions. The first interview will take up to half a day, in order to give you plenty of time to tell your story and for the interviewer to ask you some further questions. I may then contact you to conduct a follow-up interview, no longer than an hour in length, to clarify any points from your story. These interviews will be conducted by me, Dr. Susannah Brockbank, and can be arranged for a time and location that is convenient to you.

Interviews will be audio recorded for later transcription and analysis and the interviewer may also take notes for her own reference.

Expenses and / or payments

Participation in this study should not incur any monetary costs and no reimbursement or incentive is being offered. You will be provided with refreshments during each interview session.

Are there any risks in taking part?

No risks are anticipated; however, if at any time you feel distressed or uncomfortable, we can take a break or stop the interview altogether. Please let me know if you wish to pause or stop the interview.

Are there any benefits in taking part?

This study provides you with the opportunity to improve the experience for students going through a similar process in the future.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr. Susannah Brockbank (sbrock@liverpool.ac.uk) or the project supervisor Dr. Viktoria Joynes (vjoynes@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

Yes. Audio recordings will be stored securely in password-protected files on the University of Liverpool server. Transcripts of the audio files will be anonymised and stored securely in password-protected files on the University of Liverpool server. You will not be identifiable in either the thesis or any publications that may result from this study.

What will happen to the results of the study?

Results of this study will form part of my PhD thesis and any resulting publications. If participants wish to be informed of any publications of these results, they should inform the investigation team either in person, following the interview(s), or separately by email (sbrock@liverpool.ac.uk). Your responses will not be identifiable in any publications.

What will happen if I want to stop taking part?

You may withdraw from the study at any time, without explanation. Results up to the period of withdrawal may be used, if you are happy for this to be done. Otherwise you may request that they are destroyed and no further use is made of them, though once the data has been analysed, extraction of your contribution will not be possible.

Who approved this research?

This study was approved by the University of Liverpool Committee on Research Ethics (reference no. 1909).

Who can I contact if I have further questions?

Lead student investigator: Dr. Susannah Brockbank

Tel.: 0151 794 8759

Email: sbrock@liverpool.ac.uk

Postal address: Cedar House, University of Liverpool
Ashton Street
Liverpool L69 3GE

UNIVERSITY OF LIVERPOOL

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Title of Research Project:	*How do medical students describe their experiences of medical school following remediation of professionalism concerns?*
Researcher(s):	Dr. Susannah Brockbank, Dr. Viktoria Joynes, Professor Vikram Jha, Dr. Marina Anderson

	Please tick box
1. I confirm that I have read and have understood the participant information sheet (V2) dated May 2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐
4. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
5. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the purposes of transcription and analysis	☐
6. I agree to take part in the above study	☐

Participant Name	Date	Signature

Researcher	Date	Signature

Lead student investigator:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Supervisor:
Dr. Viktoria Joynes
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7949785
vjoynes@liverpool.ac.uk

UNIVERSITY OF LIVERPOOL

Committee on Research Ethics

PARTICIPANT DEBRIEF

Title of Research Project:	How to medical students describe their experiences of medical school following remediation of professionalism concerns?
Researcher(s):	Dr. Susannah Brockbank, Dr. Viktoria Joynes, Professor Vikram Jha, Dr. Marina Anderson

We would like to thank you for taking the time to participate in the study. We hope that you have found the experience interesting and enjoyable. If you would like to be updated regarding the project, or if you have questions regarding the project, please do not hesitate to contact us.

If you have found this process distressing and wish to talk to someone, were are the details of some services that you may find helpful:

[Details of local medical school student support service]

[Details of local University student support service]

[Details of local University counselling service]

Furthermore, if you are unhappy with the interview process, or you feel there is a problem, please feel free to let us know by contacting Dr. Susannah Brockbank (sbrock@liverpool.ac.uk) or the project supervisor Dr. Viktoria Joynes (vjoynes@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Many thanks,

Dr. Susannah Brockbank

Principal student researcher:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Supervisor:
Dr. Viktoria Joynes
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7949785
vjoynes@liverpool.ac.uk

Stakeholder engagement workshop study

Finally, this is the final ethical approval for the stakeholder engagement workshop study (Chapter 9). I also include the consent form and two versions of the participant information sheet – one for student participants and the other for faculty participants. Finally, there are example recruitment emails for each participant group, followed by a question schedule used in the workshops.

UNIVERSITY OF LIVERPOOL

Health and Life Sciences Research Ethics Committee (Human participants, tissues and databases)

16 October 2019

Dear Dr Joynes

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	5356
Project Title:	How do medical educators and current students respond to stories of unprofessional medical students?
Principal Investigator/Supervisor:	Dr Viktoria Joynes
Co-Investigator(s):	Dr Susannah Brockbank, Dr Marina Anderson, Prof Vikram Jha, Prof Jude Robinson
Lead Student Investigator:	-
Department:	School of Medicine
Approval Date:	16/10/2019
Approval Expiry Date:	Five years from the approval date listed above

The application was APPROVED subject to the following conditions:

Conditions of approval

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

D Prescott

Health and Life Sciences Research Ethics Committee (Human participants, tissues and databases)

edreseth@liverpool.ac.uk

0151 795 4358

UNIVERSITY OF LIVERPOOL

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Title of Research Project:	*How do medical educators and current students respond to stories of unprofessional medical students?*
Researcher(s):	Dr. Susannah Brockbank, Dr. Viktoria Joynes, Professor Vikram Jha, Dr. Marina Anderson, Professor Jude Robinson

	Please tick box
1. I confirm that I have read and have understood the participant information sheet (V4 or V5) dated September 2019 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐
4. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
5. I understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the purposes of transcription and analysis.	☐
6. I agree to take part in the above study.	☐

Participant Name	Date	Signature
Researcher	Date	Signature

Lead student investigator:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Supervisor:
Dr. Viktoria Joynes
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7949785
vjoynes@liverpool.ac.uk

UNIVERSITY OF LIVERPOOL

Participant Information Sheet

Title: ***How do medical educators and current students respond to stories of unprofessional medical students?***

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your colleagues if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Aims and purpose

Recent General Medical Council (GMC) guidance about unprofessional behaviour in medical students recommends that students who are identified as behaving unprofessionally should be supported by their medical school in order to demonstrate that this behaviour has been addressed. Current understanding of students who have behaved unprofessionally is, however, very limited. This makes planning remediation for unprofessional students challenging. With this in mind, I have conducted a study aiming to explore the identity of students who have behaved unprofessionally using in-depth interviews. This study presents the results of this study in the form of vignettes organised around the themes that emerged from analysis of the interviews. This is intended to ensure that these stories resonate with your experience as a medical educator and generate ideas for how unprofessional behaviour could be approached in these cases.

Why have I been chosen to take part?

You have been identified as a medical educator engaged in managing unprofessional behaviour. You have therefore been selected as someone valuable experience of unprofessional students and current remediation to share. You may have been identified as a contact of a member of the research team or by your medical school as someone with interest and experience.

Do I have to take part?

No. Participation is voluntary and you may withdraw at any time.

What will happen if I take part?

This study involves taking part in a workshop. These workshops involve discussion of some stories of unprofessional behaviour that emerged from a previous study. We anticipate these workshops lasting approximately two hours, though this will depend on the length of the responses and the number of participants. These workshops will be audio recorded and anonymously transcribed for the purposes of analysis

Expenses and / or payments

No reimbursement is being offered.

Are there any risks in taking part?

No risks are anticipated.

Are there any benefits in taking part?

This study ultimately aims to improve the practice of remediation of unprofessional behaviour in the United Kingdom. The results will be shared to provide you and your institution with materials to support this process.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr. Susannah Brockbank (sbrock@liverpool.ac.uk) or Dr. Viktoria Joynes (vjoynes@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

Yes. Audio files will be stored securely on the University of Liverpool server prior to transcription. Transcripts will then be anonymised and stored securely in password-protected files on the University of Liverpool server. Original audio data will then be deleted to ensure your confidentiality is maintained. You will not be identifiable in either the thesis or any publications that may result from this study.

What will happen to the results of the study?

Results of this study will form part of my PhD thesis and any resulting publications. If participants wish to be informed of any publications of these results, they should inform the investigation team via email (sbrock@liverpool.ac.uk), allowing the researcher to generate a separate list of interested participants. Your responses will not be identifiable in any publications.

What will happen if I want to stop taking part?

You are not under any obligation to participate in this study and there will be no adverse consequences if you choose not to be involved. However, once your responses have been deidentified, you will not be able to withdraw from participation in this study.

What if I become distressed as a result of participating?

You have access to staff support services at your university. You can get in contact in the following ways:

Email – [email address]

Telephone – [number]

In person – [address and opening hours]

Who approved this research?

This study was approved by the University of Liverpool Committee on Research Ethics (reference no. 5356).

Who can I contact if I have further questions?

Principal investigator: Dr. Susannah Brockbank

Tel.: 0151 794 8759

Email: sbrock@liverpool.ac.uk

Postal address: Cedar House

University of Liverpool

Ashton Street

Liverpool L69 3GE

UNIVERSITY OF LIVERPOOL

Participant Information Sheet

Title: ***How do medical educators and current students respond to stories of unprofessional medical students?***

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your colleagues if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Aims and purpose

Recent General Medical Council (GMC) guidance about unprofessional behaviour in medical students recommends that students who are identified as behaving unprofessionally should be supported by their medical school in order to demonstrate that this behaviour has been addressed. Current understanding of students who have behaved unprofessionally is, however, very limited. This makes planning remediation for unprofessional students challenging. With this in mind, I have conducted a study aiming to explore the identity of students who have behaved unprofessionally using in-depth interviews. This study presents the results of this study in the form of vignettes organised around the themes that emerged from analysis of the interviews. This is intended to ensure that these stories resonate with your experience as a medical student and generate ideas for how unprofessional behaviour could be fairly approached in these cases, based on your experience of medical education.

Why have I been chosen to take part?

You have been identified as a medical student and therefore someone with current knowledge and experience of medical education. You have therefore been selected as someone with valuable insights into unprofessional behaviour that occurs and how your medical school approaches this.

Do I have to take part?

No. Participation is voluntary and you may withdraw at any time.

What will happen if I take part?

This study involves taking part in a workshop. These workshops involve discussion of some stories of unprofessional behaviour that emerged from a previous study. We anticipate these workshops lasting approximately two hours, though this will depend on the length of the responses and the number of participants. These workshops will be audio recorded and anonymously transcribed for the purposes of analysis.

Expenses and / or payments

No reimbursement is being offered.

Are there any risks in taking part?

No risks are anticipated.

Are there any benefits in taking part?

This study ultimately aims to improve the practice of remediation of unprofessional behaviour in the United Kingdom. The results will be shared to provide your medical school with materials to support this process in future.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr. Susannah Brockbank (sbrock@liverpool.ac.uk) or Dr. Viktoria Joynes (vjoynes@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

Yes. Audio files will be stored securely on the University of Liverpool server prior to transcription. Transcripts will then be anonymised and stored securely in password-protected files on the University of Liverpool server. Original audio data will then be deleted to ensure your confidentiality is maintained. You will not be identifiable in either the thesis or any publications that may result from this study.

What will happen to the results of the study?

Results of this study will form part of my PhD thesis and any resulting publications. If participants wish to be informed of any publications of these results, they should inform the investigation team via email (sbrock@liverpool.ac.uk), allowing the researcher to generate a separate list of interested participants. Your responses will not be identifiable in any publications.

What will happen if I want to stop taking part?

You are not under any obligation to participate in this study and there will be no adverse consequences if you choose not to be involved. However, once your responses have been deidentified, you will not be able to withdraw from participation in this study.

What if I become distressed as a result of participating?

You have access to student support services at your university. You can get in contact in the following ways:

Email – [email address]

Telephone – [number]

In person – [address and opening hours]

Who approved this research?

This study was approved by the University of Liverpool Committee on Research Ethics (reference no. 5356).

Who can I contact if I have further questions?

Principal investigator: Dr. Susannah Brockbank

Tel.: 0151 794 8759

Email: sbrock@liverpool.ac.uk

Postal address: Cedar House

University of Liverpool

Ashton Street

Liverpool L69 3GE

Example recruitment email – faculty

Dear …,

As a medical educator involved in professionalism, you have been identified as a potential participant for a study entitled "how do medical educators and medical students respond to stories of unprofessional medical students?". I am attending your medical school on [date] at [time] to present the findings of a previous study that involved in-depth interviews with unprofessional medical students. This study involves you participating in a workshop following this presentation to discuss your reaction to stories I share. The aim of this study is to better understand how we can identify unprofessional behaviour and support students through the process of investigating and addressing this behaviour. This workshop will take an estimated total time of two hours (including presentation) and we would be very grateful for your time. Students at your medical school will also be invited to participate in this study but this will be a separate session.

If you are interested in participating in this study, please attend the scheduled meeting and read the participant information sheet (attached).

Thank you for your time,

Dr. Susannah Brockbank

PhD Candidate and Clinical Research Fellow

Student researcher:
Dr. Susannah Brockbank
5.19 Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7948759
sbrock@liverpool.ac.uk

Principal Investigator:
Dr. Viktoria Joynes
Cedar House
University of Liverpool
Ashton Street
Liverpool L69 3GE
0151 7949785
vjoynes@liverpool.ac.uk

Example recruitment email – students

Dear …,

As a current medical student, you have been identified as a potential participant for a study entitled "how do medical educators and medical students respond to stories of unprofessional medical students?". I am attending your medical school on [date] at [time] to discuss the findings of a previous study that involved in-depth interviews with unprofessional medical students. This study involves you participating in a workshop following this presentation to discuss your reaction to stories I share. The aim of this study is to better understand how we can identify unprofessional behaviour and support students through the process of investigating and addressing this behaviour. This workshop will take an estimated total time of two hours (including presentation) and we would be very grateful for your time. Members of faculty at your medical school will also be invited to participate in this study but this will be a separate session.

If you are interested in participating in this study, please contact me via email (sbrock@liverpool.ac.uk) and read the participant information sheet (attached).

Thank you for your time,

Dr. Susannah Brockbank

PhD Candidate and Clinical Research Fellow

Student researcher:
Dr. Susannah Brockbank
5.19 Cedar House
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Question schedule for workshops

1. What is your first reaction to this story?
2. What does this story tell you about this person?
    a. What does this story tell you about their lived experience?
    b. What about their experience of medical school?
3. What do these stories tell you about 'unprofessional' students?
    a. In the context of professionalism lapses, what dilemmas does this story raise for you?
    b. Is there anything that you feel should have been done differently?
4. What do these stories tell you about managing 'unprofessional' students?
    a. How do you think this student's professionalism lapse would be dealt with here?
    b. What should medical schools do?

Appendix 4 – Analytical audit trail

In this section, I present examples of anonymised coded transcripts from the narrative study of unprofessional student identities. As a point of reference, the table below demonstrates how codes were clustered into themes and subthemes. Importantly, these codes represent the final outcomes of the analysis following multiple iterations and thus some of the original codes have been revised, rationalised or removed. Codes were initially grouped together under subheadings expressing common meanings and these are shown in the table below to illustrate the journey from interpretive coding to overarching themes. Following this table, there are excerpts from two transcript demonstrating how some of these codes relate to the original text, as well as illustrating the narrative structure aspect of the analysis.

Theme	Subtheme	Codes (*subheadings in italics)*
It's not what it looks like		*Explaining it away* Actions misinterpreted Justifying their actions in retrospect Faculty seemed unconcerned about professionalism Unprofessionalism as positive Professional ideals open to interpretation Rejecting or minimising concerns Making excuses Unintended consequences Compensated failure It could be worse Downplaying their own challenges Appearances can be deceiving Covering up struggles State of denial Someone is on their side
		Reflections on their former self Misjudged someone Youthful indiscretions Impulsive decisions A dawning realisation Admissions of guilt or failure Self-sabotage Critique of self Innocence and naïveté Learning from their mistakes Oblivious to problems at the time Lacking awareness Embarrassed or ashamed Unable to face people Nostalgia for something that's lost

		Playing the system Using the right words Apology fatigue Attempts at humility Honest about challenges and shortcomings Building a case for the defence Behaving as expected Following the process
		Inconsistent narratives Vague about the details Contradicting themselves Too much information
I'm not like the rest of them	Because this has been harder for me	*Doesn't fit in* Sitting on the periphery Not a typical medic Cause of consternation Uncertain of their place Not able to pass unnoticed Set apart by medical school
		Needing something extra Asking to be treated differently In need of support Needing to understand why Needing external validation Desperate to prove themselves
		The struggle to where we are now A difficult journey Academically falling short Additional barriers Sacrifices for medicine Relationships falling apart Slipping out of control Traumatic experience Not just a normal problem Broken dreams False starts Dealing with turbulent times Object of pity
	Because I don't want to be	*Straining against convention* Hatred of hierarchies Challenging authority Difficulty conforming Distaste for constraints Not able to stay quiet Craving freedom Craving a challenge Rejecting the medical habitus
		Seeing the world through a different lens Woke to the world

		Unique insights Professional ideals open to interpretation Toxic masculinity Toxic femininity Being a cultural chameleon Cultural superiority Aware of their own privilege The wisdom of the community Interesting life experience Dispassionately curious about own experience Unconventional friends Power structures and dynamics
		Their own ideas about how the world should be Better ways of training Critique of parenting Critique of peers Critique of the system Critique of faculty or clinicians Finding fault Alternative approaches to medicine Open criticism of (medical) school Faculty declining to take responsibility Lacking continuity Open minded Speaking out for everyone
		Superior intellect or skills Developing special skills Functioning on a higher plane Expressions of admiration Driven by desire to understand Boasting about prowess Intellectually stimulated Not just a doctor Fascinated by the unknown
I think a doctor is what I'm supposed to be		*Pushing forwards* Struggling on A work in progress Keep calm and carry on
		Being the hero Bridging societal divides Heroic acts Supporting friends or family in need Protecting someone they care about
		Societal structures that have brought them here Not free from familial or cultural expectations A conventional family Pride in their history or background Power structures and dynamics Professionalism as a threat Name dropping

		Struck lucky Blind to their privilege
		Expressions of negative medical/societal structures Derrogatory language or views Judgements about lifestyle Toxic masculinity Toxic femininity Patients as objects
		Finding the doctor identity Using medicine as a yardstick Comfort with the doctor identity Doing medicine at home Why medicine or specialty Competing for opportunities Paying your dues Reaching for the medical identity
		Desperate to be a doctor Work or study as therapy The dream that won't die Being a doctor is everything Blind pursuit of a goal Medicine commands respect Enduring desire in spite of everything
	I'll get there eventually	*Citing evidence for being a good doctor* Busting a gut Striving to be the perfect student Academically capable Desire to reach professional ideals and values Acknowledging why it's important Confidence in abilities Satisfaction in success The magic touch Affinity for the patients (especially elderly) Doing better than the doctors Some things come easily
		Doing it for themselves Wanting to make changes Wanting a clean slate Taking control of the future Emotional labour Trying to fill a void Rejection of pity Fight for survival Forging their own path (Doesn't enjoy being) forced to rely on others Wanting to keep control Wanting to keep some things to themselves Selective honesty
		Attempts at self-care

		Ways of coping Self-medicating More to life than medicine Switching paths Medicine isn't that hard really Ringfencing time Finding time for rest Giving themselves a break Hedonism and escapism Emotional labour Keep calm and carry on A social being
I'm not sure where I fit	I can't make sense of myself	*The identity tightrope* Not (yet) comfortable with being a doctor Competing interests or priorities Tension between medical and non-medical worlds Power shifts Fitting into the hierarchy Finding their niche
		Being a doctor or a patient? Medicalisation of problems Addiction or dependence Psychological distress Self-medicating
		It wasn't what I thought it'd be Disavowed of idealistic notions Disappointment in the healthcare system Mismatch between expectations and reality of medicine
		Becoming a grown up Parents as mortals Supporting themselves Being the responsible adult Enforced responsibility Making pragmatic choices Medicine as a transaction
	I'm not sure I can do it	*The future might not be bright* A long way left to go Being a medic makes doing life hard Planning for the worst Hoping for the best
		Can't stand the heat Totally overwhelmed Crumbles under pressure Not having the right words Foxed by the unexpected or uncertain Unexpected reactions
		Lacking self-belief

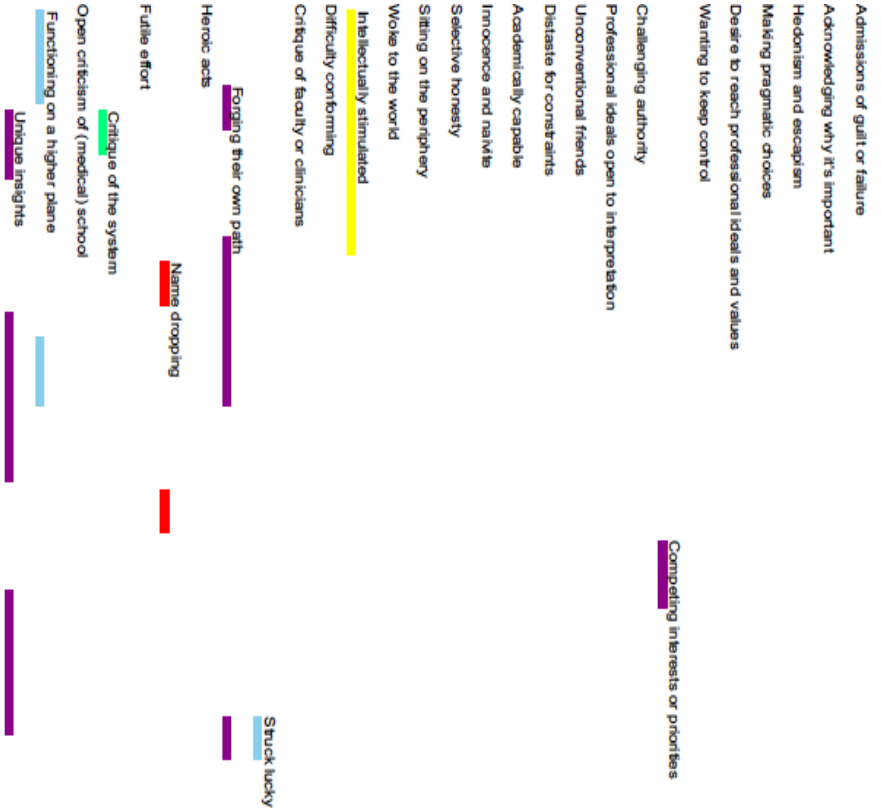
		Tempering their own success Expecting to fail Lacking faith in themselves
		Medicine is part of the problem Medicine causing psychological distress Pressure to plough on Being a medic makes doing life hard
		Difficulty getting back on track Cycles of failure Getting back under control In need of direction Struggling to move forwards Stuck in limbo Struggling to make sense of it all
It feels like the world is against me		*Externalisation of responsibility* Betrayed by someone Someone else is to blame Unfairly treated Denied an opportunity Disadvantaged by good behaviour Punished for doing extra Tarred with the same brush Futile effort Persecuted for difference Caught in the crossfire Unfair expectations Not given due time and consideration Missed diagnoses
		Adversaries or antagonists Victimised by the world Persecuted for difference Victimised by an individual Doubted and underestimated
		No one is helping Let down by the people they need Fell through the cracks Unhelpful help or false reassurances Empty consolations In this on their own Misguided assistance

Table A4.1 – A summary of codes, groups, themes and subthemes

Example coded segments

Here I present two examples of coded anonymised transcripts. The first of these is taken from the transcript of my interview with Henry.

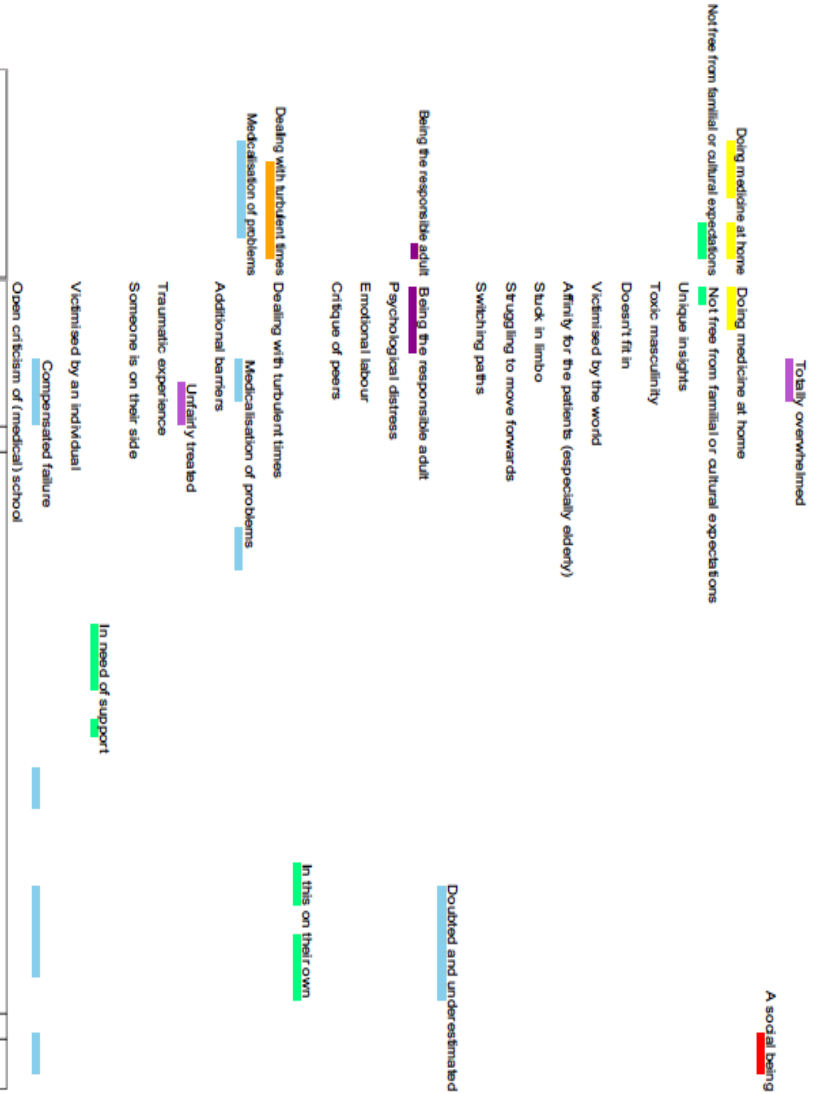
Narrative structure		
Abstract Orientation Complicating action Evaluation Resolution Complicating action Evaluation Orientation Evaluation		got very interested in...erm...models of symbolic healing in, in other cultures? Er, and different medical paradigms, erm...became very interested in, er, for instance, medical paradigms involving trance states? Er...which are, by and large, either induced by some form of deprivation – of food or sleep or...sex or sensation or whatever – or by the use of drugs. Er, and...from a surprisingly...academic and non-experiential viewpoint for an undergraduate, I became very interested in the latter category. Erm, and started a society at the university for, er, sort of, psychedelic studies. Erm, I'd read a lot about, erm....the sort of renaissance in the field of psychedelic-assisted psychotherapies. It had become very clear to me that...er, the psychological treatments available at the time were pretty impotent for a lot of patients. Having seen that up close. Er, and this fascinated me because...it seemed to be a way of, erm...under...a situation of relative safety, engaging with levels of, of, of the psyche and, erm...with certain, er, types of psychological material that...were entirely inaccessible. Erm, in that space and time at least. By any other, er, er, means of psychological therapy. And, er, the data...seemed to be...suggestive of that having a, erm, er, a real clinical effect. Not that we really know that yet, 'cos...phase III is still going on. So, erm, then that turned into, er...I ended up organising a conference, er...in my last year of university, which ended up being huge. It was the largest one that the university had ever held. And, er, that was with a couple of faculty members and, er, a professor of psychology from [institution] and, erm...a psychiatrist from [institution]. And then, after that, we started a charity and we've been doing this conferences ever two years since. By and large on the...on the topic of, erm...psychedelic-assisted psychotherapies. But from a very multidisciplinary angle, because, er, my interest in that and, in general, has always really been, er, trying to figure out...the nature of psychological illness and the, the types of discursive model best suited for engaging it and, and manipulating it. Erm...and, er...yeah, this, er, this, sort of, conference on...altered states, which has...sociologists, anthropologists, criminologists... psychiatrists, psychologists, artists, musicians, er...literary theorists, historians...quantum physicists, all sorts, really. There's, there's all the... disciplines one can imagine coming together and...trying to get to the, the heart of the...deep philosophical questions surrounding the nature of consciousness. The nature of he, of health and wellbeing and self and mind. Er, within that.
Abstract Orientation Evaluation Complication action Orientation Complicating action Resolution Coda	Henry	Erm...and then, I started working for, erm...er...an interesting organisation up in Oxford? [Me: okay] Run by a woman who, famously... trepanned herself when she was 27. Erm...quite an eccentric lady. Erm...that became...problematic. Not, I mean...some people are difficult to work with. Er...this particular individual has quite a reputation for...erm...staff turnover? Er, and I ended up with the option of staying and working for her after my degree or going to, er, Singapore with my girlfriend at the time. And trying to find work out there. Er...so that's what I did and I ended up doing...two years of, erm...immunology research. [Me: mhmm] Er...so...well it's not very, it's not very interesting, really. It's about T cell senescence. Er...there's a particular subset of the T cell that re-expresses naïve markers but they're...terminally differentiated. Er, they've got very weak avidity. They're old and they're shagged out and, to compensate, they've...all these...biochemical things have happened to give them the appearance of, of youth. So the telomeres get extended and stuff. And it's this, sort of, compensatory reaction, er, for a, well we think, compensatory reaction that results from, erm...repeated subclinical reactivations of...viruses like CMV throughout the lifespan? Erm...anyway...so...came back from Singapore and applied for medicine. I only applied for [university], because of the [research institute]. Er...and got onto it. Which was very fortunate. Onto the graduate course. Erm. And have been trying to...trying and struggling to identify as a medical student ever since, really. Erm...so yes. That is the journey of...[me: okay] how I ended up at med school. Doing this.
	Me	And then...so that brings us to the point where you came to medical school. You've been here for, what, three years now?
	Henry	Yeah, this is my fourth year.



Narrative structure		
	Me	Yeah, that's it. Tell me a little bit about that journey.
Orientation Evaluation	Henry	Er...the first year. Erm. On the graduate programme is, is the two...academic years rolled into one. Erm. Which was...er...fine, really? I mean, surprisingly, looking back on it...erm, that was the year I think that I had...the least...the, well the, yeah...the slightest degree of, erm, of sort of identity crisis. [me: okay] Er...because it was just studying? It was just learning. Er...there wasn't really much of what it meant to be...a doctor at that point. There was a certain, sort of, dissociation from...erm...I didn't feel hugely connected to the rest of the people on that programme who are all very driven by medicine. Er...they're there at nine and they go home at five and then they spend...three hours revising and they talk about medicine and all the medical people hang out together in the social sphere and I never did any of that. Or felt moved to and still don't but have got used to that. Erm. But I think it wasn't really until...er...the clinical years that, that...I started to really find, kind of, imposter syndrome. Erm. Because almost all of...medicine...interests me but doesn't move me? Erm. I've got my sights so firmly set on...psychiatry that, if something doesn't...seem particularly relevant to that, er, and it's a choice in my head between...engaging with that or engaging with something else that I think is going to be more conducive in the long run? I find it *very* difficult to win that battle. Erm...and by win that battle, I mean...devote my attention to the medical stuff. Erm...so, yeah, my engagement with core medicine has always been a bit lacking. Erm...it's not...terrible: I'll pass the exams, I'll be a fine, y'know, I'll be a...I'm not going to be an exceptional F1 or F2 by any stretch, I imagine. But, er, I'm not going to be a dangerous one either. Erm. I'll know enough to get through but...I dunno. The whole thing really does just seem like an extended initiation. Er. A, sort of...something that I've just gotta do to get to where I'd like to get. And a lot of the stuff that I'm learning, it feels like I'm learning it to forget it? Erm...because...it won't be...*relevant* for most of my professional career. Erm...and...although one can become a consultant psychiatrist now without...ever having studied...anthropology. Or the philosophy of science. Or the philosophy of mind. Er...that seems completely...nuts to me. Erm...and, er...to me those...there are...there's a huge...er, panoply of disciplines that seem to me to be...essential for understanding how the mind works. How relates. How it expresses itself. How people understand themselves, er, how people...you know, relate to the kinds of sensations and experiences they have. Why people develop...particular reactions to things. Erm...so... I've kind of gone off track there. Where was I going with this? I don't really remember... erm. I think I'm just repeating myself about...general disengagement with the course? Er...yeah. Erm. So that's where I'm at, really. Erm...getting progressively more impatient to start doing what I really want to do. Having been in universities for 10 years now. And...still being years away from actually being able to get into...what I want to do. It's frustrating. Erm...and because so much of my extracurricular life has been...getting as involved in all of that stuff as I can...er... organising conferences and...writing books and...putting lecture series on and volunteering wherever I can. That...the allure of that is always stronger than sitting at home and reading about intestinal inflammation. Erm...which I know is a...a shitty attitude and one that I've tried very hard to...adjust. But haven't yet found a way of making it stick.
Abstract	Henry	Er...I didn't do...I haven't really thought about this interview prior to today but I did look up earlier, er, some definitions of professionalism.
Orientation	Me	Okay
Abstract	Henry	And, erm...er, there was one by a journalist. That was, er, 'the definition of professionalism is, erm, doing your best work on a day where you really don't feel like it'. Erm. I'm not great at that. Er...but, erm, yeah. So...shall I talk about my run ins with...professionalism, then?
	Me	If you feel comfortable talking about that?
	Henry	Yeah, that's fine. I don't mind that. Erm...if I did...this would be a bit of a waste of time! Erm...

This second example is taken from my interview with Sarah.

Narrative structure		
Abstract Orientation Complicating action Evaluation Complicating action		Because, erm...so last year in January, my sister who lives in [city], which is where my family live, erm, she said she wanted to come visit me, erm, here, so I said "yeah, that's fine" and nobody told me and she had no insight but she was actually going through mania and I didn't know until she got here. Erm...and she just, she had all these ideas of, kind of, delusions of grandiosity of "I'm going to study in [city]...I want to do a really good degree and get a good job and I will live with you..." and none of it had any basis in reality. Erm, and instead she was spending all her money in one go, she had no money left. And then she was getting into taxis having...with no money and offering to pay 'through other means' in her words and, kind of, all the symptoms you might expect from mania. Erm, not sleeping, talking excessively...so, erm, I had to spend a lot of time taking care of her, chasing her round [city] trying to make sure she's safe and then eventually, erm, I...got in touch with the
Resolution Complicating action Evaluation Complicating action Evaluation		mental health team here and we worked together at first through Community Care Team but it wasn't working 'cos she wasn't taking her medicines and she wasn't sleeping. So, erm, eventually they admitted her at [name] Hospital for about 6 months and I was the nearest relative, so, I was involved in finding out...finding accommodation for after she left and her finances... So that all led up to my exams last year...and then, erm, somehow I managed to pass all of them except OSCE because, there was one station...the mental health station. It was...it was a female with mania who, the situation was, like, practically *identical* and I just froze and I just couldn't. I think it was just emotional exhaustion. And, I failed the OSCE by 1%, which was, urgh, very...difficult to accept but...so now I have to resit the year but just for the OSCE.
	Me	Mmm
Coda	Sarah	So...that's where I'm at now....
Evaluation Complicating action Evaluation Resolution		Erm, and I think actually, resitting, at first it does feel horrible and you feel like a failure and your self-esteem takes a major hit. I wouldn't come out of my room for a good few weeks. But, I think actually, now I'm glad. I think I needed this time because, emotionally I was exhausted and I don't think I'm ready for fifth year where you do all the shifts they expect you to do and then...start working in less than a year's time, so, I think it was the right thing for me and I'm feeling much better now, so...
Orientation Evaluation		And I'm seeing Dr. [surname], [full name]. Who's just, sort of, helping me through with my family issues and, kind of making me aware of the bad dynamics that developed in terms of, she thinks that I've always taken on this caring role and people throw their problems on me. And, erm, I'm not kind of used to establishing boundaries and...maybe I do do a bit of that, but...I think her input has been really helpful. Erm... because, I mean in hospital it seems fine. I don't get so heavily involved to the point where I make myself unwell but, outside of hospital, it seems to affect me differently so, yeah, she's helping me to figure through all that stuff so my exams aren't affected again....
Resoluition		
Abstract Orientation		Erm...in terms of the...the situation with the professionalism? Erm...I think this was in my third year...and... I think from my point of view, it was just a big clash of...personalities between myself and the other staff at [hospital]... So it was in [name] Hospital and...erm...I think they're very perfectionist. They...they have very different standards to the rest of the hospitals and I think they expect students to be very expressive if they have issues or if you're feeling unwell or if anything is getting on top of you, I think they expect you to communicate this in a very articulate way and be on top of it and...tell them before you're scheduled in for something, which is...it's fair enough, but I wasn't so used to telling people about my problems and...erm...I've always just thought I have to deal with them myself. So...I think on the professionalism form they wrote a couple of things... Erm, one which was my body language in front of staff appeared uninterested, like yawning. Erm, not asking a lot of questions, but I think it's...I remember at that time it's...if I feel down, maybe you can see it all over my face but I'm not one to say it out loud or go seek somebody out and tell them, you know, what actually..."my mind's in a different headspace". I just, kind of...like to just sit with it and figure it out in my own time...
Evaluation Orientation Complicating action Evaluation		
	Me	Mmm
Complicating action Evaluation	Sarah	And I think some of the other reasons were...erm....register signing in. I...signed in for my friend, who was going through a really hard time and she was worried about her attendance...erm, 'cause she was missing quite a few days. So I told her I would sign her in and...I mean, it was...it's



Narrative structure		
Complicating action Resolution Orientation Complicating action Evaluation Orientation Complicating action Evaluation Resolution Orientation Complicating action Evaluation Resolution Complicating action Orientation Complicating action Resolution Evaluation		stupid, looking back, but I think...I just felt for her, having known what it's like to be depressed and anxious. I sort of just wanted to help her, and then, they found out so that was another reason....and...erm...I'm trying to remember the other reasons.... I think to my knowledge, that was it...it might have been more possibly but I can't remember now. But there were, aside from what was on the professionalism form, erm, there were a lot of clashes, where, erm, for example I was very anxious the day before the formative OSCE. And on the day I felt like I might have an anxiety attack, so I found one of them and I said "I don't know if I can sit this formative OSCE right now...erm...I just, I feel extremely anxious and..." Usually if this happens to me, all I need is a bit of support and my mindset will, kind of, rapidly change. You know, if I'm just kind of comforted that it doesn't matter, you know "just try your best", but I think their approach was very different to what I'd been used to with the communication skills people at the university and the [hospital], who I was with before, who were more sort of, supportive and comforting. The group at [hospital] instead turned around and said "well, look, if you don't sit the OSCE then we will send a Cause for Concern form about you. So, it's your choice..." Which didn't really help with anxiety, [laughs] with my anxiety. Erm, and...yeah, that, I think those are the sorts of situations which made them...doubt me, maybe? And some of the comments that some of the staff made...I felt were...to me they were quite inappropriate...because they didn't know me very well and I remember one of them saying to me "I've met students like you before. You..." and he used the phrase "You're the type who slips through the net" and I wanted to say, like, "with my background, trust me, there's no slipping through the net". Like, I've had to work every step of the way to be here. Probably harder than a lot of people, who hasn't..haven't come from my background. Erm...and then...so comments like that, sort of, it makes you want to open up even less. So they didn't...they knew even less about what was going on with me and maybe that made them think "yeah, she's uninterested, she's lazy..." And so there were some misunderstandings but...I just wasn't used to staff being like this at all and, it just kind of made me retreat into myself... Erm, so yeah they sent the cause for concern form to, I think [name of student support lead], and...I mean, I find it really easy to talk to him. So, when he called me in, I...it was fine, I explained everything and it felt fine. Oh yeah, the other reason for the professionalism was, during the simulation day training....at [hospital].
	Me	Mhmm
	Sarah	Erm...[hospital] staff, they...purposely partnered you with people that they thought you would clash with. To give you experience of working with people you might not necessarily get along with. And they videoed...how you work together. And during mine and the...my partner's simulation, he made a comment, which, just...made, made me start laughing uncontrollably. Erm, and it's just one of those really bad laughters where once you start you can't stop. And they kept asking me "why are you laughing? Why are you laughing?" and every time they asked be that, I laughed more. Erm...and then they made me watch it through and pointing out when I started laughing and, I mean, all of this just made me laugh more and more. So they wrote in the cause for concern form that, the third reason...erm...laughing hysterically during simulation day training. Erm, which, I mean...sometimes that happens. I know they're worried that I'm going to laugh at patients but I would ***never*** do that, I think...subconsciously even, your brain will know to switch this off if it's a real patient. You're...and they're...in an emergency setting, the first thing that you will, you know, feel is, like, worry and empathy. You're not going to laugh. So, I think sometimes, in my opinion, they can go a little bit over the top. I mean, we all sometimes giggle in class and when I spoke to the, the therapist at the university afterwards, erm, they told me that it actually sounded like nervous laughter that, after a long time of...sort of, keeping in your issues, sometimes you can react just by

Example narrative positioning analysis

Conveying the process of narrative positioning analysis is somewhat more challenging. As described in Chapter 5, I worked from the original audio data and my field notes, taking detailed analytical notes, which I then grouped into roles and characters that seemed to express common meaning. In order to give a sense of this process, in the table below I present some of the descriptive notes that constructed 'The Medic' identity position. Importantly, this is just a sample, demonstrating how this role was assumed by each participant in their narrative. For each participant, there were further examples of this identity position.

Participant	Analytical notes
Victoria	• Characterisation of Father's unhealthy lifestyle, e.g. describing him as "extreme, excessive smoker". Aligning herself with medical norms about health. • Describes 'special' position of medicine within society, as well as medicine being a 'calling' not just a job, e.g. "I've been given this gift to serve humanity, serve community". • Reinforces medicine as a vocation by reflecting back to her childhood and this being the career she always wanted to pursue. Uses this to take a position of belonging – medicine is something she has wanted to do since she can remember. • Uses detached voice when talking about patients, e.g. "schizophrenic patients", "dementia patients", thus occupying the conventional doctor role in her own story.
Sarah	• Early experiences of hospital environment as an HCA felt 'natural', thus positioning herself as belonging within this environment. • Positions herself in the discourse of academic excellence being required to be a doctor, e.g. "I mean everyone's a top achiever…" • Unforgiving of others' perceived lack of respect for the medical profession, e.g. describing her simulation partner a "lazy student". Goes on to position herself almost as a gatekeeper to the profession, e.g. describes the idea of him being a doctor "ridiculous"
Laura	• Life choices positioned around wanting to be a doctor, e.g. had not got into medical school at age 18 but was 'sold' the idea of a medical genetics degree with possibility of switching to medicine after year one, thus positioning herself within discourse of sacrifices or difficult decisions being necessary to become a doctor.

	• Enjoyed second year of medical school more because she was learning about disease: "felt like what medicine should have been like". Playing into discourse about medicine being about healing the sick. • Frequently returns to discussion of academic rankings and comparisons with others, thus playing into discourse that medicine is academically competitive (and even cutthroat). • Describes enjoying placement experiences in terms of seeing patients as a good vehicle for learning for exams and remembering things. Positioning herself in medical discourses of people's illness being academically interesting. • Doesn't talk about patients in a very human way – uses them to learn rather than seeking to understand them as people • Talks about her uncle previously senior nurse – "although it's still nursing, because of the level he got to…". Seems to play into the narrative of nurses being inferior to doctors.
Hannah	• Returns to narrative of medicine being different to other degrees and the impact that this has on social life and ability to keep on top of chores. Clearly positions 'medics' as separate to and working harder than other undergraduate students. • Discusses having self-diagnosed health anxiety but expressly not seeking formal help. Explicitly discusses the perceived stigma of mental illness and even goes on to suggest that doctors cannot be unwell: "as a doctor, you need to be in good health to take care of your patients". Aligns with discourse that doctors must be well and there is no space for being less than 100%. • Tells a story of witnessing a patient 'refusing' to be discharged on placement – talks about this patient as 'bad', e.g. as she is continuing to smoke and therefore not passively receiving medical treatment. Aligning herself with tacit messages of patients being 'good' or 'bad' according to whether they follow medical advice.
Pete	• Medicine as a career for public service that brings 'happiness to people'. Aligning willingness to do this himself with discourses about doctors' self-sacrifice. • Openly expressed judgement about 'obese' guy who he looks up to for charitable works: stories obesity as a limitation and sign of laziness/poor character. Sits with dominant discourses about 'health' and individuals' responsibilities to their own health. • Discusses episode where he "performed CPR and saved a life or whatever" – downplays this as though it is normal, thus positioning himself as a member of the medical community who perform acts like this routinely.
Henry	• Discusses Quality Improvement Project that he did in terms of futility, e.g. "nothing that it offered as an assessment tool that was more insightful than clinical judgement". Positioning doctors (and himself by using the narrative of futility) as beyond the reach of structures/guidelines.

	• Openly talks about the 'identity crisis' he feels when around other medical students but don't feel like that when in the clinical environment: "when I'm actually on wards, I don't get that [identity crisis]"; "I do feel…not exactly like a doctor". Positions himself as naturally fitting into the role of 'doctor' in spite of feeling of difference from his peers. • Extols typical virtues regularly throughout his narrative: listening to patients well, treating them with respect and kindness, confidentiality, consent. Fitting himself within the dominant expectations of medicine.
David	• Discusses his process of being diagnosed with ADHD. After his initial testing, he states "not an official diagnosis, with a psychiatrist", thus positioning the doctor as the one to give the definitive opinion. • Medicalises his own tendency to crave sweet foods, seeking a pathophysiological mechanism to explain this behavioural pattern. Thus using medicine to explain many of his life experiences, placing himself within the community of medicine and privileging medical discourses. • Uses medical terminology even when talking about drinking coffee, translating caffeine into units, e.g."half a gram". • Discusses his experiences of anatomy teaching using typical medical terminology, e.g. refers to his tutor as "the anatomy person on our cadaver". • Talks about experience of meeting young patients who use wheelchairs who are happy: "I love patients like that". Positions these characters as 'good' patients who are resilient and get on with things. Thus positioning patients as individuals who should be grateful for the help they receive from medicine. • Discusses being seen as 'the medic' by friends and family, who come to him for advice/treatment. Stories himself as appropriately reluctant, using a 'not a doctor yet' narrative but also willing to give recommendations, thus positioning himself as on the cusp of a doctor career.

Table A4.2 – Example narrative positioning analytical notes