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Learning to live with being a physician

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This paper draws on the results of an eight-month research project designed to foster reflection and professional growth in an intergenerational group of medical students, residents, and newly practicing physicians. Over a period of several months, participants individually read books written by physician authors of their experiences in clinical practice. After each book reading, the group met and engaged in a tape-recorded and researcher-facilitated discussions about the book. Reading followed by discussion was chosen as a process to promote increased self-reflection amongst the participants. Participants reflected on the readings and on their own experiences of moving through professional education in the process of becoming physicians. There were eight meetings. A thematic analysis of the eight transcripts of group meetings identified twelve overarching themes. Nine are discussed in this paper. The three additional themes address the participants' experiences of the process and are described elsewhere. The nine themes range from the 'image of super doc' to 'learning from patients'. Several themes contained sub-themes. The themes resonate with other findings in medical education about the experience of becoming physicians. The themes are discussed in relation to other research on designing spaces for reflective growth in medical education. Insights into the benefits of an intergenerational group experience are discussed.

Study context[1]

Schön's (1983, 1987, 1991) work on professional knowledge has been taken up across disciplines to highlight the place of professional growth through various approaches to reflective practice. Drawing on the evolving understanding of professional knowledge of teachers (Schön, 1983; Clandinin & Connelly, 1995) this study shifts the focus from student teachers' and teachers' professional growth to the professional growth of medical students, residents and newly practicing physicians.

Within medical education in recent years there have been several interventions aimed at fostering reflection. Henderson and Johnson (2002) describe a course for medical students designed to encourage the development of professional identity both within a workshop experience and later in a course evaluation and email communication with group facilitators. Henderson and Johnson, drawing on Schön's

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work, state that the workshops enabled the students to reflect in action, while the writing and dialogue with a facilitator, promoted reflection on action. A safe learning climate was built with group rules about confidentiality. Neither the workshop or course evaluations were tied to summative student evaluations.

The success of this intervention is in contrast to another where students were apprehensive of the required submission of their written reflections around a critical incident or significant event analysis (SEA). Henderson *et al.* (2003) found that medical students experienced both internal and external conflict when asked to write an SEA. Internal conflicts included feeling intruded upon and external conflicts concerned their feelings of being vulnerable within the medical hierarchal system.

Other medical educators approached reflection indirectly. Instead of expecting learners to volunteer their experiences at the outset they found that reflecting on the expression of others' experiences in the humanities can trigger reflection. Charon (2001) encourages the use of literature as a way to encourage reflection. She believes reading literature can help physicians understand the illness experience and hone clinical skills necessary in diagnosis, ethical clinical decision-making, and management. She also stresses the value to the person of the physician that results from increasing self awareness and providing meaning. Lazarus and Rosslyn (2003) also used literature as part of a special study module with medical students. The module's overall aim was to use the study of the arts to enhance students' understanding of the illness experience. One objective was to encourage medical students to reflect on, 'how the experience has affected their own personal and professional development'. Many of these interventions in medical education occurred during clerkship years. However, Bolton (2005) uses several humanities-based methods to promote reflection in physicians at various stages of their professional development.

In our study, discussion of the optimal developmental stage of adult learners (Cross, 1982) shaped our decision to recruit medical students, in, or about to enter, clerkship and first-year residents. Novice family physicians were also included. Participants at diverse stages professional development highlighted the potential for mentorship within the group. The research was a joint study between the Faculties of Education and Medicine and Dentistry at the University of Alberta. Approval was obtained to recruit learners in both the medical school and the family medicine residency program. Ethics approval was obtained from the Faculties of Education and Extension Research Ethics Board. It was then ratified by the Faculty of Medicine and Dentistry Health Research Ethics Board.

Participant recruitment

Participants, medical students, residents and novice physicians, were recruited, through snowball sampling, from contacts known to one of the researchers (Cave). These individuals were advised of the formation of a narrative and medicine group for the purpose of reading and discussing literature about the lives of physicians and their experiences of practice. It was explained that this was to be a professional development opportunity designed to foster reflective conversations about practice.

Table 1. Narrative medicine booklist

Session	Book title	Author
1	*The call of stories: teaching and the moral imagination*	Robert Coles
2		
3	*The anatomy of hope: how people prevail in the face of illness*	Jerome Groopman
4		
5	*Playing God*	Glenn Colquhoun
6		
7	*When the body says no*	Gabor Mate
8	*Limits to medicine*	Ivan Illich

Participants were advised the group was also a research study, and that writing based on the inquiry would be submitted for publication. After receiving this information those who continued to express interest were invited to an initial meeting and given a copy of the first book, selected by the researchers, to read in advance of the first meeting. Seven participants were recruited. See Table 1 for a list of books read.

Method

At the beginning of the first meeting participants were given an information letter about the study and asked to sign the consent form. Participants were advised of their role in the study, including a confidentiality clause and promise of anonymity in publications and of an opportunity to read and provide feedback on drafts of papers in advance of publication.

All eight meetings were held on campus, in a family medicine location, over suppertime, and were one-and-a-half-hours to two hours in length. Light refreshments were provided. Each was tape recorded—except for the last 10 minutes when participants and researchers wrote immediate reflections about their experiences of the meeting. Written reflections were collected after the eight meetings were completed. Attendance was recorded at each meeting. One male resident was unable to attend the first session. He attended the second session and signed a consent form but did not return to subsequent sessions. Further members were not recruited so the meetings continued with six (female) participants.

Participants were involved in the selection of readings. At the end of each session, a group decision, from a limited range of options, was made about what to read for the next session. The two researchers attended each group meeting as facilitators. Their roles as facilitators were to encourage all participants to engage in the conversation, to offer affirmation when they felt it was necessary, to encourage response rather than judgment to stories and ideas, and to share their own stories and ideas when appropriate. They also kept time limits, signaled starting and ending times, and handled the tape recorders.

Data included transcripts of group conversations, individual written responses and transcripts of exit interviews with each participant at the end of the eight meetings. Data were collected over approximately a one year period. The two researchers read all transcripts, sequentially in detail, identifying transcript segments from the text which suggested repeated or emphasized points. These points were summarized and grouped into themes. A theme was defined as 'a statement of meaning that runs through all or most of the pertinent data, or ... one in the minority of data that carries a heavy emotional or factual impact' (Ely, 1991, p. 150). As the themes were read and reread, some themes became sub-themes under overarching themes. This paper discusses nine themes with 14 sub-themes (see Table 2). Three themes that related to participants' experiences in the group are not discussed in this paper but are discussed elsewhere (Cave & Clandinin, in progress). Whilst the researchers facilitated group discussion when necessary, their contributions to the discussion are not included in the thematic analysis.

In this paper, we do not link the themes directly to the specific books read. Many thematic topics came up repeatedly triggered by the complexity of the doctors' life stories in the books read. For example, the image of the super doc occurred in conversations after reading Coles, Groopman and Colquhoun.

Table 2. Themes within learning to live with being a physician

Theme	Theme	Sub-themes
1	Super doc image	1. Not living up to super doc image 2. Affirmation/Recognition for doing a 'good' job 3. Seeking approval
2	Images of practice	
3	Tension between self and job	
4	Tensions around multiple boundaries	
5	Resisting the imposed script/asserting self	
6	Denial of doctor's experience	1. Oppression by patients 2. Not having a language to talk about their experiences 3. Tension between certainty and uncertainty 4. Conspiracy of silence
7	Not recognizing self in practice	1. How medical education was shaping them as people and professionals
8	Learning from patients	1. Story vs. diagnosis: 2. Denial of patients' experiences 3. Listening to patients 4. Presence in relationship with patients 5. Quality *vs.* quantity of time
9	Defining a role for self as physician	1. Reflecting on their purposes and motivations

Conversation themes

Theme 1: a super doc image

One theme related to learning how to live with, and up to, their images of an ideal doctor, or what we termed their image of a 'super doc'. Learning to practice and to sustain themselves as physicians often occurred within the range of what they saw as ideal practice, that is, within the parameters of their images of being a super doc. Sub-themes were: not living up to the super doc image; seeking affirmation/recognition for doing a 'good' job; and seeking approval.

Images of 'super doc' were formed in medical school as participants observed, and heard stories that crystallized into images of ideal doctors who were 'not allowed to express anger' (2, 306[2]), who were 'always going to be kind and gentle' (3, 1327), and 'never tired' (4, 673), who were able 'to spend ... the emotional energy being with the patient, even if it doesn't take very long' (4, 690–691), who 'should be able to just take it and go' (5, 229) without feeling anything, and 'to work 14 hours a day, six days a week, seven days a week' (8, 996). These images of a super doc lead to their concern about being 'found out for the fraud' (5, 833).

A sub-theme revolved around the things/events that caused them to feel like they were not living up to their images of super doc. Frequently, patients' responses such as 'rejection' (3, 929), of feeling 'bombarded with people who want more and more and more and more' (7, 1674), and of patients who 'are so frustrated when I don't have a cure for their cold' (6, 1069–1073) caused them to feel they were not living up to the ideal. Other events that caused them to feel not quite good enough were responses from other physicians who said it was inappropriate that a physician may 'react physiologically to something' (7, 1397) or that they were causing a shortage of physicians because they were women (8, 991–997). Sometimes the feelings were triggered by recognizing that 'we know we're not practicing the way we want to, we know we're making choices that we could make differently' (2, 302–303). The feelings that were triggered in these times were 'shame' (2, 184), 'guilt' (3, 857; 4, 695, 700), 'angry at ourselves' (3, 862), 'resentful' (4, 671), 'selfish' (5, 227), and 'really angry at my patients' (7, 1562).

A second sub-theme related to affirming and sustaining themselves as, if not super docs, then good physicians. These affirmations varied from acknowledging 'somebody's kind word can be the thing that keeps you going' (3, 1548–1550) to acknowledging 'I did a good job, this is one person that I'd helped and, you know, no expectation of anything else' (3, 1613–1615). These feelings around sustaining themselves sometimes acknowledged that:

> ... there were 'different' rewards. You don't have the reward of happy, smiling, good outcomes. But you have the reward of knowing for that moment you were with that patient, he made a connection and that it mattered, that what you did mattered. (4, 483–486)

Sometimes these rewards involved 'the patients that we remember, their stories that keep you going' (3, 1579–1580).

Theme 2: images of practice

Another theme pointed to experiences or people that served as images or exemplars of practice. Over the eight sessions participants tried to figure out who they were learning to be as physicians from interacting with practicing physicians. These experiences seemed to serve as guides to who they might become as physicians. As distinct from theme one where an image of super doc was formed as a kind of composite physician held before them, these images of practice were composed as they met and worked with physicians.

For example, we heard accounts of a physician who 'was great with his patients in terms of sort of being in contact with patients and teaching them ... he would engage with them on a very personal and basic level and they loved him' (1, 319–323). The image of this physician was that ' he didn't spend more than two or three minutes with a patient but he made those two or three minutes count' (1, 377–378). This image of practice was one that resonated with their images of a physician who was seen as 'definitely going above and beyond' (4, 1069–1070), and of a physician who said 'if we stop crying, then we shouldn't be doing this job' (1, 535–536).

These images were less frequently mentioned than ones where physicians and residents were resented for taking time away from practice to have children (2, 1148–1149), where physicians were seen as not wanting 'to know the patients' (2, 1391), where the physicians who were admired were the ones 'who give it all up for the sake of the profession. I mean that's still what we hold out to be the ideal' (2, 1441–1442), and where physicians 'hide behind the science' (3, 194). While they were drawn to the images of practice described in the first examples, they recognized that physicians who practiced in these ways were not 'rewarded' (1, 383).

They struggled to find ways to express how they saw physicians' lives and used metaphors such as 'if you've seen a gerbil on one of those running wheels, that's exactly what medicine is like, you're just constantly running' (2, 1227–1228) to try to represent what they saw and felt. They used examples such as 'people who give up their family life in order to study 100 hours a week' (2, 731–732), physicians who spoke of being too busy and who belatedly realized they had 'forgotten to have children' (2, 1028), physicians who used survival metaphors to describe medical training (2, 1386), and physicians who were made to feel uncomfortable because they nurtured passions outside of medicine to give a sense of the context in which they lived and worked and within which they were trying to create a way to practice meaningfully.

They spoke frequently of the importance of finding ways to work through the complexities of learning to practice amidst what seemed, at times, to be conflicting images. Sometimes they found spaces with colleagues 'you know it was such a relief to talk to someone that you work with so closely about all this stuff' (2, 201–203). Sometimes colleagues shared their strategies for remembering why they wanted to be physicians and how they wanted to practice such as 'he has things that he just looks at and it takes him out of the office and he remembers' (2, 435–436). They spoke of how spaces such as the one created in the research project also helped.

The tension of negotiating these complexities 'starts from the moment we walk into medical school, it goes all the way through and its always this constant conflict about who we thought we would be when we were doctors' (2, 1210–1212). One participant said:

> And every lecture you go to there's always a compromise. You hear something that you think, 'Boy, is this who I want to be? Is this the way I want to be? Is this the way I want to practice medicine?' So it's constant. (2, 548–553)

In clerkship, as they were offered images of practice, they said 'teachers have feet of clay' (2, 577), and were 'modeling behavior ... shocking to you as a learner' (2, 586–587).

They described themselves as 'pretty self-aware and pretty careful about what we're wanting to do. We want to practice consciously so that ... we're in the present when we're with a patient' (2, 185–186). Even as they sought a way to be attentive to each patient they spoke of the complexities of trying to practice.

Theme 3: tension between self and job

A third theme coalesced around expressions of tensions as the participants spoke over time about the tensions they felt between who they were and the job expectations and requirements. 'I think it happens to us all the time' (2, 116) expressed a sense of tensions that surfaced around a patient's story and her doctor's identification with it (2, 114–117). When asked whether she was speaking about the patient's or her own tension between self and job in this expression, the participant replied, 'there's not a day goes by where I don't do something which I think is in conflict with who I would kind of prefer to be' (2, 125–127). Tensions such as these reverberated through the sessions.

Participants voiced such tensions as they spoke of the conflict between feeling sad for themselves and 'feeling bad' because they were not the 'ideal doctor' (2, 471–474). However, they usually worked to ignore these tensions as they behaved as the 'ideal doctor', meeting patient and cultural expectations. Participants also described the tensions they experienced as they realized they were giving patients advice that they themselves needed to heed (2, 1043–1044). They spoke of their own unhealthy practices while they pushed themselves to the limit.

Tensions between self and job emerged as they spoke of the medical culture and the way they learned, in that culture, to seek approval. Those recently in practice noted, rewards are less frequent. At the end of long days, they often felt drained. 'Today I do not want to be a doctor, I mean I have one of those once a week' (5, 454–459).

One participant, however, tried to attend to these tensions rather than to ignore them. When at her limit, she took time out. She called in sick (7, 1378–1381). On her return to work she noted that no one enquired after her health (7, 1541–1543).

Participants were naming these tensions as they recognized that this was a silence among their colleagues. They spoke of colleagues who would never take a day off (7,

1566–1569) and about the expectation to work long hours. They described how specialists blamed women doctors for seeking a balanced life (8, 994–997). They said the medical culture prevented them from expressing their values. 'So basically they'd prefer if I sacrificed my own health and life and buy into the whole thing. I mean that's what we try to tell people not to do' (8, 997–1001). Participants also spoke of excessive work as denial or avoidance of personal issues, perhaps a way to avoid acknowledging the tensions.

They spoke of learning that expressing distress at work is taboo. 'I had tears in my eyes. And I remember getting these incredulous looks from people, and it's just so, someone just died here and someone else is dying downstairs' (3, 424–425). For some the tension between an empathic response and the job expectation to be clinical, was difficult (7, 582–583).

Gender issues also became apparent within this theme. Tensions between the struggle to be a good mother and 'ideal doctor' (2, 988–993) were addressed. There was tension over the loss of personal time 'I gave up so many things' (3, 1406). They also expressed concern that these tensions would continue, as one noted:

> ... more people I talk to don't want to take on a practice when they get out because they want to take some time off at some point and they're afraid ... to get locked into a practice. (8, 1269–1271)

Tensions also emerged as they spoke of the lack of confidentiality and of being in the sick role when they are known as a physician.

Theme 4: tensions around multiple boundaries

Another set of tensions emerged as the participants spoke of learning to name, recognize and negotiate boundaries. One set of tensions emerged from their concern around the doctor–patient boundary. One participant said, 'But where does the boundary get blurred? Like it's, it's, nobody is able to tell that and I always worry that I'm crossing it' (1, 482–484). As one participant related the following experience with a patient she made explicit the tensions she felt around boundaries.

> I just went and I gave him a hug ... and he, for one moment just, he hugged me and he bawled. And I remember thinking ... and then I bawled ... and then I was thinking, 'Oh my god' ... what am I doing and then eventually I think when you're sharing in someone's pain like that you just have to do it. (1, 561–569)

She also noted that another physician left quickly, noting 'good x-rays' (1, 570) and not acknowledging the situation and that too caused her to reflect on boundaries.

There was also a sense that physicians did not have complete control over establishing these doctor-patient boundaries. While they acknowledged that doctors 'choose the boundary and it changes with every patient as well because there will be some patients you cannot hug' (1, 486–487), they also noted that 'patients have a way different idea of boundaries' (1, 502) and that not all patients like to be 'patted or touched'.

They also acknowledged the complexities of doctor–patient relationships because some 'who are friends, on a superficial level maybe or, you know, just in the context

of the clinic' (3, 307–308) and some who have 'something special about them, something that connects you' (3, 311–312) raised further uncertainties for them. While they noted that 'the nature of the doctor/patient relationship means that you can't really cross over to truly be friends you know' (3, 335–337), they still struggled with boundary issues. The issues became more complex when they realized they had 'people in our practice who are friends ... people come to you that you've known before ... co-workers ... nurses that I work with and they truly are friends' (3, 341–344). As these boundary issues emerged and reemerged in the conversations, they realized that it took 'a lot of courage to take that leap' (1, 1110) 'from just purely patient/doctor' (4, 1111). They realized there were 'some risks' (4, 1217) and that 'once you cross that line you can't go back' (4, 1282).

Boundary issues also occurred as they considered their own relationships with their family doctors and they thought about their own needs for care (7, 845–847, 866–867). 'Boundaries are, are blurred all over the place and ... I don't know what the right answer is' (7, 1026–1027).

Theme 5: resisting the imposed script/asserting self

There were several examples of asserting the self by taking time out to reflect and regroup. For example, one participant described a moment in medical school when she decided, in the middle of a semester, to leave town to visit a sick grandmother, without first giving notice to the undergraduate medical education office. It was a huge decision but she described it as being the only thing to do, in order to live with herself, to be a good person (2, 822–826). In this and in other instances participants described they were convinced of the rightness of their decisions as they quietly resisted the imposed script (2, 824–825, 1066–1068).

To gain a place in medical school is so difficult that these actions were viewed by peers as both 'insane' (2, 1068–1069) and 'courageous' (2, 1076). Some other participants admitted, now, to being jealous. Another participant described trying to find space for herself in order to 'you know, claw back some time' (3, 1419). However, such actions remained exceptional.

Participants also spoke of resisting imposed scripts as they began to realize they too had choices. One participant who was encountering a difficult spouse of a palliative patient considered telling him to find another doctor (8, 1142–1149). In the end this did not happen, but knowing it was an option may have helped her make an assertive choice.

Theme 6: denial of doctors' experience

One theme, denial of doctors' experience, also included four sub-themes: oppression by patients; not having a language to talk about their experience; the tension between certainty and uncertainty; and a conspiracy of silence. Beginning in the first session, a theme around the need to acknowledge the stress physicians experience both in training and in practice and the lack of time and places to deal with the stress emerged

(1, 181–187, 669–674). The theme centered around time to think about what they were experiencing (8, 1031–1043). They realized that the group conversation allowed them to name something they felt, that is, that practicing medicine was more than 'simple physiology' (7, 1203).

One participant spoke of a loss of empathy and the ensuing guilt. 'You have no more empathy left to give and at that point I feel I'm doing very bad medicine' (1, 151–153). When they were swamped, participants spoke of becoming 'someone that you didn't want to be' (1, 208–210). This sense of oppression by patients was identified as Sub-theme 1. They described patients who were endlessly demanding, even after being told of a recent bereavement in the doctor's family.

Even more difficult was they felt they had no language (Sub-theme 2) for expressing their feelings about their experiences (2, 159–173). They felt they were without a language to talk about feelings of frustration (2, 172) but also their feelings when, for example, a baby died.

The approved way of coping with stress and emotions was to deny their feelings. In training, physicians learned to suppress their needs, even their own thoughts. One participant stated:

> I think it's probably the first time ... anyone's really asked me how I was doing with being in medicine. ... We don't talk about it. Like nobody talks about it. ... There's not the security and space to talk about the uncertainties or talk about the intangible ways that affected you ... (1, 156–170)

This tension between certainty and uncertainty was identified as Sub-theme 3. Even when one participant spoke of having 'a very good group in residency', she noted 'sometimes we all held back too because it's too overwhelming' (1, 669–671).

Participants said 'you're not allowed to express it' (2, 306), and 'we can't talk to somebody about it' (2, 315). This was identified as a conspiracy of silence, Sub-theme 4. In final sessions they made reference to taboo subjects such as physician suicide, alcoholism and drug use. They experienced dissonance as they were sending patients for procedures they would never have themselves (7, 762–766). They expressed fear around confidentiality when speaking particularly of seeking help for clinical depression (7, 776–779). Ultimately several participants expressed, at different times and in different ways, their belief that as physicians they are not allowed to react or behave in a 'normal human way, with the result that it just gets stuffed down there' (8, 1104–1106, 1115–1161).

Theme 7: not recognizing self in practice

As the participants spoke of how they were practicing and what they were feeling, they often seemed to experience a disconnection between who they were in their stories of themselves and who they were in their practice. We named this theme 'not recognizing self in practice'. A sub-theme within this theme was their recognition of how medical education was shaping them as people and professionals.

Some of the experiences around not recognizing themselves occurred around death as they said 'and to my shame ... I denied I had reached the point where people die and I don't care. ... And you pronounce people and then I'd go and eat my dinner' (1, 612–613, 621–622) and as they confronted the responsibility of pronouncing death:

> ... but to be kind of conceded the power to pronounce death ... this is the time of death and not until then and that very odd feeling of like what, but I don't have that power. Like what am I, I can't pronounce life, like I can't, I can't change what's happened so how can I pronounce death? (5, 1439–1444)

Other experiences where they were unable to recognize themselves in practice was when 'you have no more empathy to give' (1, 740), 'when I hit my empathy limit then every other patient after that really doesn't get the complete me because I just, you run out' (2, 426–427), when they stopped seeing people and 'you just see their veins' (5, 1380) and 'the deeper level too of when you, when you're not relating to people as a whole' (5, 1390–1391). When they found themselves unable to recognize themselves in practice, they spoke in the following ways: 'how awful you feel when you recognize that you're being someone you don't want to be' (2, 181–182); 'and I really was becoming somebody I didn't like' (2, 1259).

Sometimes they spoke of making a conscious decision not to be themselves and 'you do what you're supposed to do. But you don't, you're not conscious, you're not present' (2, 406–407) and 'then I start feeling bad about myself' (2, 414). They spoke of trying to learn how to keep themselves practicing in ways that made them recognizable to themselves. One participant noted:

> ... like you know it's just happening again and having to seriously remember like you said, why you went into it in the first place and trying to find the space to be healthier about it and step back and put it in the big picture again because you'll lose that through medicine. (1, 253–256)

Theme 8: learning from patients

Five sub-themes grouped together within this theme: story *vs.* diagnosis; denial of patients' experiences; listening to patients; being present in relationship with patients; and quality *vs.* quantity of time. One participant described an interaction between herself as a student and a patient (1, 233–234) that a supervising resident thought was an inappropriate interaction. The supervising resident also described the patient's story as 'irrelevant' (1, 236–237). As the participant described her experience, she said she initially 'felt bad' but then realized 'I was starting to be programmed into not really taking patients' experiences and learning from them (1, 239–241). Participants spoke of the value of learning from patients (1, 286–288) but said, 'You don't learn that in medical school. You're told it is irrelevant and it is not until you're out later that you realize "hey, it wasn't irrelevant at all. That was completely relevant"' (1, 288–290).

A sub-theme, story *vs.* diagnosis, led them to say that listening to a patient's story also validates their experience 'even if we can't write very much down clinically' (1,

63–64). Listening was seen as important when learning of the patient's knowledge of the illness (3, 743–747). The sub-theme of listening to patients' stories as different from diagnosis was connected to a sub-theme of denial of patients' experiences. The importance of attending to patients' stories and of listening to them was explained as:

> ... a progression of technology through ages ... we got more and more sophisticated, we put more and more reliance on these elaborate tests until we finally realize the really important thing is listening to the patients. (6, 374–378)

The sub-themes of not denying the patients' experience but of listening to patients came up as one participant noted that it helps 'in a fast practice to see the chart before going into the room but you miss so much' (8, 195). Many stories were told about denying a patient's experience.

Being with a patient facing a poor prognosis was described as difficult (3, 724–725). As these stories were told, another sub-theme emerged, that of the importance of presence with patients. They discussed the harm of keeping patients at a distance (1, 330–332; 5, 118–123) and of the recognition that listening and being with a patient is therapeutic (5, 113–123). The importance of presence, of being with each patient in the relationship, occurred across the sessions. They spoke of the potential of connections, of communication, of taking the few minutes to be in the relationship, of just being a witness.

Presence was often linked to the sub-theme of quality *vs.* quantity of time. While sometimes they saw time as 'time to get together and just talk like this' (1, 199–200) and time to 'check in' with themselves (1, 214), they realized that it was not only how much time but the quality of time they spent with patients.

Theme 9: definition of role

Comments about the definition of the physician's role surfaced early in the sessions. In session one, a participant spoke of senior physicians who modeled a mechanistic approach to the patient (1, 298–301). She described these physicians as seeing their jobs as addressing physical complaints, paying no attention to a patient as a person. She offered an example of one of her new patients who, as she expressed her distress around the illness experience, described her previous physician's dismissive response (1, 305–307).

The group offered frequent examples of their own opposing values to the mechanistic physician role (1, 541–542, 782–789). Participants suggested that to resist the pain, many doctors erected barriers and became the mechanistic physician (1, 595–596).

The group acknowledged strategies to cover their emotions (2, 309–311) and their relief when a patient needed only a prescription refill (2, 394–407). The regular experience of patients facing the end of life led some to question their subdued reaction to death or sad news (3, 405–412, 495–496). One participant explained, 'If we got upset every single time someone died ... maybe it is a protective thing' (3, 414–416).

Participants identified a tension when their own thoughts and feelings about a patient's predicament led to paternalistic behaviors (4, 159–151, 193–200). One participant, instructed to deliver bad news, described a preceptor's avoidance of the responsibility, failure to mentor and indifference to the patient (4, 333–351). In later sessions participants formulated their duty to the patient—'to cure rarely and comfort always' (4, 851–853) and 'to empower' (7, 293–296). They spoke of supporting their patients to move forward when there was no cure (7, 393–311). Participants talked of the importance of hope and realism (7, 322–332). One participant emphasized the physician's role as supporter and facilitator of the body's capacity to self-heal.

As they sought to define their own role, a major frustration was their experience of patients' choosing not to recognize their role in maintaining their health, placing the responsibility on the doctor (8, 674–680, 856–861). They realized that this responsibility, if assumed, could cause great stress in physicians (8, 850–852). As they worked to define who they wanted to be as physicians, they spoke of a physician's duty to respect patients' autonomy and the shift towards partnerships between patients and physician (8, 848–849).

A sub-theme began to emerge within the theme where the participants sought to compose their own definitions for who they were becoming as physicians as they reflected on their purposes and motivations. One participant noted 'we all went in with this, you know, hearts on fire ... view that we can help people and make a difference' (4, 463–465), but as we talked over the eight sessions they spoke of hope, spirituality, holistic approaches and environmental issues in relation to health. In these conversations they wondered about their purposes and motivations as physicians.

Discussion

This study is unique in that there have been no other teaching interventions which have used literature written by doctors about their lives to promote reflective conversations in a group of physicians at various stages of professional development. However some of the themes identified in this paper have been previously recorded in literature on physicians' lives (McCue, 1982; Fox, 1995) and in narrative medicine teaching and learning interventions which focus more on writing than reading physician's stories.

The theme of 'super doc' has been previously identified by Myers (2001) where he expresses the concern that, 'medical student role models range from academic superstars ... to committed clinical teachers who are at the hospital seven days a week' and he adds, 'many of these heroes lead lives that are desperately out of balance' (p. 2).

The participants in this study acknowledged that images of 'super doc' can lead them to fearing 'being found out for a fraud', a feeling previously described in the literature as the 'imposter phenomenon' (Oriel *et al.*, 2004, p. 248). One third of family medicine residents in Oriel's study scored as 'imposters' on Clance's imposter scale. Those who had high scores also struggled with depression, anxiety and self-esteem.

A further group theme was the participants' struggle with 'images of practice'. Reflection on examples of physician behavior in practice evoked positive and negative emotions. However it is interesting that at no point did the discussion within the group acknowledge that the same individual physician preceptor might offer conflicting images of practice at different times.

In the theme, tension between self and job, participants recognized the importance of self care and taught it to their patients but from the moment they began their clinical training they were obliged to deny their own needs, their own bodies. This theme is described as 'disembodiment' by Das Gupta (2003) in a description of a narrative medicine group for second year medical students. Das Gupta noted that 'rituals of medical education reinforce this type of disembodiment in both men and women, ignoring the reality of all physician bodies in the privileging of physician minds' (p. 244). Das Gupta's group was perhaps the closest to our study group in that all the participants were women. In a report of a humanities seminar series offered to second year medical students, Das Gupta describes how the specific six week seminar series above attracted only women students although it was designed for a broader audience. The impact of gender on the life of the emerging physicians was a theme which ran through several of our meetings and it is worth considering a further argument presented by Das Gupta, that women physicians in training occupy the margins of the medical culture, which is 'persistently masculine-centered' (p. 244). The female medical student is in 'a place on the power spectrum closer to the patient than the male medical student' (p. 242) and that the woman physician along with other medical trainees marginalized by, for example, ethnicity or 'an impoverished economic background' is well placed to understand and observe the practice of medicine (p. 242).

We wonder how many of the themes around physician identity mentioned by our participants and Das Gupta's group, resonate for male physicians in training. Would these themes emerge in a mixed gender group? Trust and confidentiality were an integral part of both our and Das Gupta's group ground rules. Safety and a supportive environment are critical. It was perhaps even more important in Das Gupta's group, as although self selected and reading the stories of women patient's experiences, participants were also required to do a weekly assignment, a piece of reflective writing triggered by the readings and the discussion. These reflections were then read aloud to the group. It is a measure of the safety in the group that these one page pieces of empathic writing became reflexive essays. A unique finding amongst Das Gupta's participants was that all were dealing, secretly, with an illness. Aside from the burden of illness these women students were resisting being identified as patients because:

> As learned from the first day of anatomy class, patients are predominantly defined by their bodies whereas physicians were defined by their scientific minds. What lies beneath the physician's white coat is irrelevant; if it becomes relevant it is a threat to the physician identity. (Das Gupta, 2003, p. 244)

The rigors of medical education are compared to military boot camp. 'Indeed as military boot camp transforms the individual from civilian to soldier ... so too are

these rigors of medical education designed to "transform an ordinary person into a doctor"' (Das Gupta, 2003, p. 244). Our participants would likely recognize much of what is written here.

Apart from denial of the body, emotional needs went unmet as the themes clearly showed. When describing, for example, distress at the death of a patient, participants acknowledged that to express their sadness was taboo. Charon (2001) describes sociological studies in the 1960's in which physicians were observed as practicing medicine with 'detached concern' (Charon, 2001, p. 1899) and she goes on to say, 'Somehow this field observation became a normative prescription and physicians for decades seemed to consider detachment a goal' (p. 1899). She suggests that recent use of narrative disciplines together with reflection practice is presently encouraging physicians to practice engaged concern.

Most of the narrative medicine groups described in the literature were part of a pre-clinical medical curriculum and, as such, some of the themes identified in this study have not previously emerged. However, in Hatem and Ferrara's (2001) study, as early as the beginning of the clinical clerkship year, in a creative writing elective course students were described as 'trying on the intensity and emotions of an overworked intern' (p. 19) and one student wrote that having delved into the personal lives of patients 'she wouldn't recognize them if she ran into them in the grocery store' (p. 19). As realization emerges she asked herself 'what have I become?' (p. 19). This lack of recognition of self regularly emerged in our sub-theme 'denial of doctor's experience' when participants spoke of becoming 'someone I don't want to be'.

This paper addresses the themes about the emerging physician's struggle to grow into her professional identity. Several researchers and commentators on narrative medicine speak of the value of narrative processes in fostering reflection and reflexion in this aspect of professional development. 'They [physicians] can reflect upon their relationship with themselves, their own feelings, thoughts, ideas and spirituality as well as those of the patient' (Bolton, 2005, p. 177). Charon (2001) proposes that 'the physician's most potent therapeutic instrument is the self' (p. 1899) and that using narrative processes physicians can reflect and self examine which will benefit patients and also help physicians 'make sense of their own life journeys' (p. 1899). Physicians are both story and story teller (Vergehse, 2001). Through narrative they can claim:

> ... my own, unique experience of being a doctor—no more or less important than a dozen disparate others, but one belonging to the whole ... as individuals when we say 'This but not that, is what I think and feel', or 'This but not that, is who I am', we widen the truth about who we are as a group. (Scannel, 2002, p. 781)

In many of the previous narrative interventions employed to foster reflection in emerging physicians the participants spoke of the challenge to find the time to write their stories and this challenge became greater as they entered full time clinical practice. Providing a safe space to reflect on the writing of other physicians and recounting their own stories is a good beginning.

Conclusion

We did not find other studies that included an intergenerational professional group, that is, that included medical students, residents and beginning physicians. The results of our study echoed some of the earlier findings with medical students. The themes were similar to themes found with medical students as various researchers worked with them to engage them in reflective practice and then asked them about their experiences in the reflective practice activities. While in other studies, participants were asked to identify their struggles and issues with becoming physicians, we identified the themes using a thematic analysis from the transcripts of the group conversations. It was while the participants engaged with reading the physicians' stories in the books and then as they engaged in conversations with each other that they identified their own struggles and issues and identified ways they were coming to live with them. In the reflective conversations the participants learned to look reflectively at their own lives and experiences and to name and identify, for themselves, their own processes of living their lives as physicians.

Notes

1. Funding for the study, including the purchase of books, was obtained from the Scott McCleod Memorial Family Medicine Fund—a fund instituted to promote research and education around physician/patient relationship.
2. The first number signifies session numbers, the other signifies transcript line numbers.

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Dr. Jean Clandinin is Professor and Director of the Centre for Research for Teacher Education and Development at the University of Alberta. She is a former teacher, counselor, and psychologist. She is co-author with Michael Connelly of four books and many chapters and articles. Their most recent book, *Narrative*

Inquiry, was published in 2000. She has also authored two other books; the first one was based on her doctoral research and the second was based on research from an experimental teacher education program. She is currently co-authoring a book on several years of her research with children and teachers in inner city schools. She is part of an ongoing inquiry into teacher knowledge and teachers' professional knowledge landscapes. She is past Vice President of Division B of AERA and is the 1993 winner of AERA's Early Career Award. She is the 1999 winner of the Canadian Education Association Whitworth Award for educational research. She was awarded the Division B Lifetime Achievement Award in 2002 from AERA. She is a 2001 winner of the Kaplan Research Achievement Award, the University of Alberta's highest award for research and a 2004 Killam Scholar at the University of Alberta.

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