Emotions and identity in the figured world of becoming a doctor

Tim Dornan,1 Emma Pearson,2 Peter Carson,3 Esther Helmich4 & Christine Bundy5

CONTEXT There is little room in clerkship curricula for students to express emotions, particularly those associated with the development of a caring identity. Yet it is recognised that competence, alone, does not make a good doctor. We therefore set out to explore the relationship between emotions and identity in clerkship education. Our exploration was conceptually oriented towards Figured Worlds theory, which is linked to Bakhtin’s theory of dialogism.

METHODS Nine female and one male member of a mixed student cohort kept audio-diaries and participated in both semi-structured and cognitive individual interviews. The researchers identified 43 emotionally salient utterances in the dataset and subjected them to critical discourse analysis. They applied Figured Worlds constructs to within-case and cross-case analyses, supporting one another’s reflexivity and openness to different interpretations, and constantly comparing their evolving interpretation against the complete set of transcripts.

RESULTS Students’ emotions were closely related to their identity development in the world of medicine. Patients were disempowered by their illnesses. Doctors were powerful because they could treat those illnesses. Students expressed positive emotions when they were granted positions in the world of medicine and were able to identify with the figures of doctors or other health professionals. They identified with doctors who behaved in caring and professionally appropriate ways towards patients and supportively towards students. Students expressed negative emotions when they were unable to develop their identities.

CONCLUSIONS Critical discourse analysis has uncovered a link between students’ emotions and their identity development in the powerful world of becoming and being a doctor. At present, identity development, emotions and power are mostly tacit in undergraduate clinical curricula. We speculate that helping students to express emotions and exercise power in the most effective ways might help them to develop caring identities.

Medical Education 2015: 49: 174–185
doi: 10.1111/medu.12587
Discuss ideas arising from the article at www.mededuc.com discuss.

1Department of Education Development and Research, Maastricht University, Maastricht, The Netherlands
2Manchester Medical School, University of Manchester, Manchester, UK
3University of Liverpool, Liverpool, UK
4Department of Evidence-Based Education, Amsterdam Medical Centre, Amsterdam, The Netherlands
5Institute of Inflammation and Repair, University of Manchester, Manchester, UK

Correspondence: Tim Dornan, Department of Educational Development and Research, Maastricht University, PO Box 616, 6200 MD, Maastricht, the Netherlands. Tel: 00 31 43 388 5726; E-mail: t.dornan@maastrichtuniversity.nl
INTRODUCTION

A wish to care for other people motivates young people to become doctors. Learning how to care exposes them to patients’ and their families’ emotional reactions to wellness, illness, death and recovery. Medical students can experience strong emotions as a result. In order to care, they must become competent. MacLeod found it was hard for students to show themselves as both competent and caring. Displays of emotion were associated with a caring identity, but the type of competent identity most valued in medical school was an unemotional type. The net result, according to Shapiro, is that medical education blunts rather than sensitises students to emotions. Shapiro and others have called for emotions to have a more explicit place in the process of becoming and being a doctor, and hence we will begin by reviewing what is known about emotions in medical education.

Emotions are intimately involved in any sort of learning because they help students apply what they learn in socially and morally appropriate ways, which is self-evidently relevant to medicine. Emotions influence information processing and academic achievement. Becoming a doctor elicits positive and negative emotions. A single situation can elicit both types of emotion and therefore students are required to resolve emotional conflict. Research publications have mainly emphasised the negative emotions associated with becoming a doctor, which result from being abused by teachers, experiencing patients’ suffering, and remaining professional in challenging situations. Students learn more about suppressing than acknowledging, expressing and managing emotions, which confounds their development as emotionally sensitive physicians. A recent review by McNaughton represents an important milestone in our understanding of emotions in medical education. She identified three discourses of emotion that interpret emotions as, respectively, physiological responses to educational experiences, skills to be demonstrated when communicating with patients, and social, political and cultural mediators.

Having previously observed that emotions were related to medical students’ identity development, we wanted to better understand how emotions and identity relate to one another, which led to the research question: how do emotions experienced during workplace learning relate to medical students’ identity development? Like previous authors who have researched the complex interactions among emotions, identity development and professional behaviour, we located our research within McNaughton’s socio-cultural discourse. The purpose of answering the question was to explain everyday clerkship occurrences in ways that might inform education research and practice.

METHODS

Research ethics approval and protection of participants’ identities

Approval was granted by the University of Manchester Senate Ethics Committee. The authors were conscious that students’ emotions and identity development are very sensitive topics. We describe below how the anonymity of participants was protected scrupulously at every stage.

Conceptual orientation

Critical discourse analysis

Both McNaughton and MacLeod used a form of critical discourse analysis derived from the work of Michel Foucault, which has tended to dominate discourse research in medical education (e.g.). Other fields such as mathematics education, however, have made good use of alternative discourse traditions. Those other traditions use the term ‘discourse’ in a manner that differs from its use in the Foucauldian tradition. Gee, for example, defines discourse as ‘any instance of language in use’ as well as ‘characteristic ways of saying, doing, and being’.

Bakhtin fathered a discourse tradition in the same post-revolutionary Russian ferment that stimulated Vygotsky to originate socio-cultural theory. Central to Bakhtin’s thinking was ‘dialogism’. This assumes that language and other symbols and signs mediate all human perception. As language and culture are intimately related to one another, we cannot but perceive our world from the perspective of our own culture. As we go about our lives, we are addressed by the voices of other people. From a Bakhtinian point of view, we have no alternative but to respond to those voices. It is by ‘authoring’ our responses (choosing one response rather than another) that we create ourselves as individuals.
We create our identities by telling the stories of our lives. Therefore, discourse and identity are inseparable from one another. In the identity development of medical students, their speech acts (‘utterances’ in Bakhtinian language) are never truly original. However, such students develop different identities by authoring their responses to other people’s utterances, rather than being passively formed by the discourses they encounter. Adopting this conceptual orientation allows us to assume that conducting discourse analysis gives access to students’ processes of learning. How they author their responses to all the different voices they hear in medical school tells us how they create their identities.

**Figured worlds**

Figured Worlds theory is deeply rooted in the work of Bakhtin. It is an identity theory, which goes further towards linking emotions and identity development than other socio-cultural theories. It provides a socio-cultural platform for critical discourse analysis. From a Figured Worlds perspective, medical students hear the voices of deans, doctors, patients, peers and nurses speaking about being a doctor in dynamically changing and potentially contradictory ways. Students have agency (capacity to act in the world) to choose certain voices and other signs and symbols they have encountered in their learning environments to tell the stories of their own developing identities. Individuals – such as doctors with whom students have been (un)able to identify – become figures in students’ discourses.

Figured Worlds theory sees social processes like medical education as being influenced by hierarchy, power and privilege. The speech of doctors and other influential people ‘positions’ students in ways that make certain actions and, ultimately, identities (in)accessible. However, even when the scope for demonstrating agency is limited by the positions students are given, they can become ‘worldmakers’ in that they can use their imaginations and speak about worlds of future possibilities.

**Context**

The University of Manchester, which is a major academic institution in a large, traditionally industrial European city, provided a context for the research. Its large undergraduate-entry medical programme is strongly integrated and problem-based. The present research was conducted in one of its three main academic hospitals.

**Methodology and study design**

This study was a secondary analysis of an existing dataset. It used a constructionist methodology, providing answers to the research question by carefully and critically analysing learners’ speech.

**Sampling and recruitment**

We chose students in the first two of three clerkship years (Years 3 and 4 of a 5-year programme) as participants because identity development during the transition from predominantly theoretical to practice-based learning elicits strong emotions. We also thought junior clerks would be less fully socialised to the hidden curriculum of clerkships and therefore more critical observers of workplace practices than senior clerks. We sampled opportunistically because only interested participants could be expected to give the requisite breadth and depth of information.

Acknowledging the ethical sensitivity of the research, a neutral party (EP, a psychology graduate and PhD student, not involved in the curriculum) addressed all students in a cohort entering clerkships in the hospital. To avoid coercion, all prospective participants were sent an e-mail by a third party, which invited them to a short talk explaining the study and included an information pack containing the protocol, consent form and participant information sheet. It was made clear that non-participation or the withdrawal of participation would have no negative consequences on their progress through the medical programme. Attendees were sent an e-mail by EP asking if they were willing to participate and a reminder if they did not reply. All who agreed were included. The reward was a small sum of money, the receipt of which was conditional upon the completion of all study procedures.

**Data-gathering procedures**

Data collection started in the second semester of the first clerkship year and continued into the first semester of the second clerkship year. Three complementary procedures were used to generate a broad dataset; these included semi-structured interviews (SSIs), cognitive interviews (CIs) and solicited audio-diaries (ADs). The SSIs used the prompts in Table 1, which were followed by open questions to broaden and deepen participants’ responses. The CIs aimed for depth rather than breadth by asking participants to elaborate repetitively their accounts.
of individual events in order to illuminate emotionally salient occurrences. EP conducted all CIs following procedures outlined in Table 1. After the SSIs and CIs had been completed, EP asked participants to keep ADs. She showed them how to use a digital recording device and gave the AD instructions shown in Table 1, which asked them to record emotionally salient events for up to 40 minutes per day over 10 working days. We included this technique, introduced by Monrouxe, in order to obtain rich, contemporaneous, spoken accounts of people’s salient experiences.

Analysis

Each participant had a study number, the key to which was available only to EP so that no other researcher knew participants’ identities. To avoid the accidental identification of participants’ voices, other researchers did not listen to audio-recorded material.

Table 1 Schedules for interviews and prompts for audio-diaries

<table>
<thead>
<tr>
<th>Schedule for semi-structured interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you describe any experiences that have been particularly positive or negative with members of the clinical team?</td>
</tr>
<tr>
<td>Can you explain what you remember about the event?</td>
</tr>
<tr>
<td>How did it affect you emotionally?</td>
</tr>
<tr>
<td>How did it affect your learning experience at that time?</td>
</tr>
<tr>
<td>How do you think ‘good doctors’ show emotion?*</td>
</tr>
</tbody>
</table>

| Cognitive interview procedure (following Ginet and Verkamp)
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants were</td>
</tr>
<tr>
<td>Made to feel comfortable; rapport was established</td>
</tr>
<tr>
<td>Informed that they would be asked to report everything they could remember about their emotional experiences over the past 2 weeks, and asked to concentrate</td>
</tr>
<tr>
<td>Instructed: ‘I want you to tell me everything you can remember, even if you think some details may be unimportant or you aren’t quite sure about them’</td>
</tr>
<tr>
<td>Instructed: ‘Try to imagine yourself back in the place where the event happened. Close your eyes if you think this will help. Try to picture the surroundings and where you were, any others who were present, and any lights, noises and smells. Try to think about your mood at the time. How were you feeling? What were your reactions towards the event?’</td>
</tr>
<tr>
<td>Probed for additional information by means of free recall: ‘To help you remember in even more detail, can you repeat everything that you can remember once again, but concentrate on all the specific details that you can remember, such as objects or people present and your location. Don’t worry about repetition, as repeating yourself may help you to remember better’</td>
</tr>
<tr>
<td>Given detailed summaries of their accounts and invited to add or correct information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions for use of audio-diaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>We would like you to make some audio-recordings about your emotions and what has caused them during your working days for the next 2 weeks. You can make these recordings at any time that is convenient for you, but please try to make them as close to the event as possible so that you can tell us about the experience in as much detail as possible. If you wish, you can make short recordings at the time of the event and a further recording later on to fill in extra details when you have time. Please be discrete in your recordings and be sensitive to those who might be around you whilst you are making them. For each recording, we would like you to tell us:</td>
</tr>
<tr>
<td>The date and time</td>
</tr>
<tr>
<td>Where you were when the event occurred</td>
</tr>
<tr>
<td>Who you were with</td>
</tr>
<tr>
<td>The context of the situation (clinical or non-clinical)</td>
</tr>
<tr>
<td>A description of the event, why you chose to report it, and if you found anything valuable about the situation</td>
</tr>
<tr>
<td>Anything else that you feel is relevant</td>
</tr>
</tbody>
</table>

*Answers to this question were not included in the current analysis (see Methods).
Interview and diary contents were transcribed verbatim and identified only by study numbers. The approach involved identifying blocks of text representing emotionally salient episodes and first analysing the data by episode and participant in order to allow us to explore intra-individual as well as inter-individual patterns of response. After all of the materials had been closely read by three researchers, we used the following criteria to identify episodes for inclusion in the analysis. Accordingly, to be included, any piece of material was required to:

1. narrate a specific event rather than make a general statement;
2. report the occurrence of one or more expressions of emotion;
3. contain sufficient speech to allow the analysis of the situation in which a respondent found him- or herself and give the reason why the situation was emotional, and
4. refer to an experience of becoming a doctor.

To make those judgements and protect participants' identities, a senior medical student (PC) from a different medical school, who never met the participants, and an experienced clinician-educator (TD) at the University of Manchester, who remained blinded to participants' identities throughout, independently identified and then agreed that text fulfilled those criteria.

All such episodes were identified and the whole text of each episode was copied into a template, which structured the application of the Figured Worlds concepts described earlier. TD and PC independently analysed all episodes and reviewed each other’s templates, resolving differences by discussion and agreeing an interpretation. TD went through two further iterations of organising and condensing the data, communicating the findings to the other authors. The process moved from one of analysing data to that of synthesising a theoretically rich interpretation, which represented individual participants’ experiences and cut across participants. The data remained tagged throughout and we constantly referred back to raw transcripts, particularly when writing the final narrative of results. EH, a researcher from another country with expertise in socio-cultural emotions research, added an expert independent opinion. She critiqued every stage of the data analysis, which was amended in light of her criticisms. CB, a social scientist at the University of Manchester who had no current involvement with participants’ learning, read the texts and reviewed the interpretation. Finally, participants were given pseudonyms appropriate to their gender and ethnic origin. We use individual respondents’ stories to present the results of the discourse analysis.

**RESULTS**

One man and nine women completed all stages of data gathering. The number of extracts that fulfilled the inclusion criteria for discourse analysis was 43 (range: two to seven per participant). Fourteen extracts were sourced from ADs (range per participant: none to four), 17 from SSIs (range per participant: one to three), and 12 from CIs (range per participant: none to three).

The mixed emotions of identity development

Figure 1 presents an abbreviated version of text narrated by Emily, purposively selected because it exemplifies the main findings of the study and illustrates Figured Worlds concepts. This and the next two paragraphs link the origins of Emily’s emotions to her identity development. At the same moment, Emily experienced the negative emotion of feeling empathically sad and the positive emotions of camaraderie and feeling honoured to be taken into a patient’s confidence.

Consider how Emily’s spoken discourse authored the relative status of doctor and patient: she authored doctors as fortunate because they can develop relationships with patients. She authored the patient, by contrast, as ‘finding things really difficult to cope with’ because of her depressive illness. The patient was, we might say, unfortunate. That was why she needed a doctor to form a relationship with her. The net effect of Emily’s discourse was to give doctors status relative to patients. The word ‘honoured’, moreover, gave status to Emily herself. Her predominantly positive emotions resulted from having the status of a doctor-to-be.

According to Figured Worlds theory, people develop their identities by ‘orchestrating’ the discourses available to them. Like a composer orchestrating music, they draw different discourses together into a multi-voiced performance of their identities. Emily orchestrated fortunate doctors building relationships with patients as a dominant and emotionally positive voice alongside a non-dominant and emotionally negative voice of sadness towards patients. She was helped to do so by both the doctor’s and patient’s positioning of her as someone with the identity of doctor-to-be. The mixed nature of
'I was told to go and take a … history … and … [the patient] just opened up to me … I felt very humbled and honoured… and of course … as part of the medical team you have a kind of responsibility and obligation to help … I felt a bit sad for her but … not to the level where I’m grieving as well ... And also a sense of camaraderie. I felt like a doctor, it was a very, very positive experience. [I] presented the history to him … The doctor was very calm, and I thought what a very … fatherly figure and … if I was a patient and was approached with a face like that I would feel very comfortable … I thought he dealt with the situation really well and those were the moments when I thought that practitioners are very fortunate and they have good relationships with their patients.’(Emily,CI)

**Basic assumptions**

Figured Worlds is a discourse theory in that it assumes this utterance reflects Emily’s **inner speech**. What she said had its origins in the **social speech** of her learning environment. Social speech constitutes, and is constituted by, the **culture** of medicine. A fundamental assumption of **socio-cultural theory** is that participation in the activities of a practice equates with learning

**Figuring**

In the **world** in which Emily was learning, there was the fatherly **figure** of a calm doctor, whose face would make a patient comfortable, and who dealt well with an emotionally charged situation. The world was **figured**, also, by a patient, whose need for care brought her to the doctor. Emily, by participating in this clinical activity and identifying with the doctor’s ability to have a good relationship with patients, developed a **figured identity** in the world of medicine

**Positioning**

Emily’s utterance **positioned** the patient as someone towards whom Emily had responsibility and obligation because of the effects of illness. The doctor’s ability to care for this patient gave him **status**. The supportive behaviour of the doctor and being honoured by the patient’s willingness to tell her story gave Emily the **privileged position** of a medical interviewer and, as a result, the **positional identity** of a doctor(-to-be)

**Self-authoring and worldmaking**

Emily was not constrained by the **structure** of her workplace curriculum. She demonstrated **agency** (a capacity to act in the world) by **authoring** her identity. From the many voices around her, she **self-authored** the identity of a doctor in terms of humility, honour, responsibility and obligation to help. In fact, she authored an **imagined world** in which doctors have the identities of people whose good relationships with patients make them fortunate

---

Figure 1 Figured Worlds concepts. Bold font indicates words to which Figured Worlds and discourse theories give specific meaning (see Methods). CI, cognitive interview
Emily's emotions resulted from her developing the identity of a doctor in a world in which patients' misfortunes give doctors status.

Jane’s experience of attending a cardiac arrest, likewise, led to mixed emotions, this time of shock, fear, pleasure and sadness:

There was...a cardiac arrest... We were... shocked and... scared... It was really interesting because we were observing what each team member was doing so it was a learning opportunity as well... I was... curious and wanted to know more... and... whilst I was sad the patient hadn’t survived, I was also... pleased that I’d witnessed that event and... had that learning opportunity... Your first cardiac arrest is always gonna be a big thing... and now we can progress... if we see one another time. (Jane, SSI)

Whereas a lay person would have been asked to leave the scene of a cardiac arrest, Jane stayed. The status of a medical student positioned her within practice. Just like Emily and other participants not cited here, Jane authored her identification with the process of care as a cause of positive emotions. She also authored sadness, but her dominant emotion was positive because she was ‘making progress’ in a world in which cardiac arrests are ‘a big thing’.

Our interpretation thus far is that participants formed their identities in a world in which doctors, students and patients had different levels of status, made apparent by participants’ negotiation of their ambiguous positions and emotions. Their dominant voices authored positive emotions towards the empowered position of doctors-(to-be). Their non-dominant voices authored sadness towards disempowered patients. This is consonant with Figured Worlds theory, according to which people form their identities and experience emotions in fields of power. Doctors exercised power in positive ways (thus far at least) by, for example, making a patient very comfortable by being a fatherly figure (Fig. 1). The next section pursues the theme of power and emotions in relation to social position.

The emotions of positional identities

Positive emotions and being granted a positional identity

Actions by doctors, patients, peers and participants themselves granted positions in the world of practice. Gaining a position consistently caused positive emotions. Such a simple thing as sharing a joke did so:

So then, after [the patient] left, the GP [general practitioner] said, “Thank God you two were here because... he could have kicked off at me and... I had you two to protect me,” and we were like, “No, we would have just run out of the room as well” [laughs]. (Rashida, AD)

A resident’s behaviour positioned Lucy in practice and caused positive emotions:

One of the junior doctors... [who has]... been really... friendly and... helpful... asked me to... do a night with her... I was grateful that she’d asked me to do it... I just felt really important... She was giving me responsibilities... and... trusted me with the jobs she was giving me... It was exciting... at the same time... answering the bleep and running around to the different wards. (Lucy, CI)

Lucy’s story illustrates an important finding: being given a position was most emotionally positive when the participant felt that he or she was doing something that ‘mattered’ to patient care as well as to learning.

It was not just doctors who granted positions. A midwife who ‘explained everything well... allowed [Sonia] to do lots of examinations of pregnant tummies’, which made it possible ‘to get involved with newborn babies’. Likewise, a nurse built a relationship, which allowed Natasha to author a future in which she was a doctor who would work cooperatively with nurses:

I said “Is there anything I can do?” and she said [I could test] a urine sample... She said... there are some doctors who wouldn’t contemplate doing something like that... so it made me think about what I’d like to be like in the future and get that rapport going. (Natasha, SSI)

Patients positioned participants within practice by confiding in them. Like Emily (Fig. 1), Gemma found it:

...quite nice... that she [a patient] felt it was ok to just cry and just let it all out in front of me and... I actually was quite happy that she did it... it’s just strange how people will just tell you absolutely everything. (Gemma, SSI)

Patients’ needs created positions:

All the doctors are very busy dealing with quite a sick little girl who’s just come in so the running
of the ward has sort of been handed to us which has been absolutely excellent. (Sonia, AD)

In all of those examples, rather simple actions by other people in workplaces empowered students to participate in practice, which resulted in positive emotions. From a Figured Worlds perspective, participants experienced those emotions whilst authoring the identity of a responsible, trusted, involved person in whom patients could confide and who was able to run a ward.

**Negative emotions and not being granted a position**

Participants experienced wholly negative emotions and did not author their identity development when they were positioned unfavourably or granted no position in practice at all:

The junior doctors would shuffle about; they’d be like “who are you?” The nurses would be like “why are you in the way on our wards?” and get really narky with you. The junior doctors would say: “We’re really busy... we don’t have time for you.” (Sonia, SSI)

In the next excerpt, a participant’s discourse was of unmixed negative emotions, which resulted from being positioned as a helpless observer of a doctor who did not respond to a patient’s needs:

You could see in her eyes that... it was... a cry for help, she just needed someone to... talk to... (Robin, SSI)

Sometimes it was the sheer impossibility of helping a patient that led a participant to author negative emotions:

There was a child who is... quite severely handicapped and she’s blind in both eyes... I found it quite shocking and quite sad. (Sonia, AD)

These texts fit our emerging theory that participants’ empowered or disempowered situations led them to develop or not develop the identity of a doctor and to positive and negative emotions, respectively.

**Negative emotions and being unable to take up a position**

This interpretation is further supported by instances in which participants’ own negative reactions to clinical situations denied them positions. Fear disempowered Bryony:

It was quite scary... he was a big stocky man with a beard, in his mid 40s early 50s... the three [carers] finally managed to get him on the bed, and he was swearing and swearing and swearing, saying “I’m gonna spit on all your faces” and it was... really awful... It... makes you think: “How do you cope in that situation?” (Bryony, CI)

Sonia was disempowered by her disgust at a patient’s flesh rotting away, which made her feel guilty:

His legs were essentially rotting away so it smelt horrible and looked horrible. In the end, I got so stressed out by it all [that I walked] out... and burst into tears. ...I was quite disgusted by it, which is a horrible thing to say because... you’re supposed to be very open minded... but I did just find it all a bit too much. I did feel bad leaving because I know in 3 or 4 years time when I’m a doctor... there’s no way I’d be able to do that... It’s a sense that you’ve sort of let yourself down. (Sonia, CI)

Natasha’s emotions were shame and guilt:

I’d just examined her intimately and didn’t know much about her. It made me guilty and bad. I felt... ashamed of what I’d done... it was... a learning experience... I was stupid... because it’s something that’s drummed into us that we’re meant to do but I didn’t really take it into the context. (Natasha, SSI)

These three texts support the interpretation and further elaborate it by showing how participants were unable to author themselves as doctors-to-be when they were unable to handle their reactions to challenging clinical situations, which led to unmixed negative emotions.

**Figured identities**

**Positive emotions and authoring a figured identity**

Like Emily (Fig. 1), who was able to identify with the figure of a general practitioner, an ophthalmic surgeon and a scrub nurse were figures in Natasha’s world. She authored the identity of a future surgeon, experienced strongly positive emotions, and was motivated to study:

A consultant... was... really keen and enthusiastic... She gave every student the opportunity to do some suturing... The... scrub nurse...
commented on how good my suturing was… I was quite flattered by that cos… I’ve never sutured properly before… I told [the surgeon] I wasn’t really too keen on surgery but… she gave me… feedback that I might make quite a good surgeon… It opened up a few ideas… and it just sticks in my mind cos she was really nice and positive… I was feeling good about myself… so I made an effort to show my face around the department… and so it was also quite interesting as well so… I just put more work into that [placement] than my most recent one. (Natasha, SSI)

Senior doctors figured the discourse vividly as individuals, whereas residents, nurses, midwives and other professionals figured it more in terms of the possibilities they opened up for participants. Sometimes, rather than by one person, the world was figured by a whole team of people, such as a cardiac arrest team, the people staffing a particular shift, or an anaesthetist and anaesthetic nurses. The compassionate behaviour of clinical figures and the proficient way in which they did their work elicited positive emotions:

This GP [general practitioner] really inspired me… it’s really nice seeing how caring people can be and how you can still maintain compassion once you’re a doctor… I was… constantly motivated and engaged and I just sucked up knowledge… (Robin, SSI)

Participants identified with doctors who were supportive and who praised their clinical work:

He [the paediatrician] just immediately was in his office, had everything on the computer screen, had all the notes open, was running through everything with me, helped me summarise anything, answered any question I had… I think when… someone takes an interest in what you’re doing and sees you as someone who’s in the profession who wants to do a good job… not as an annoying student that needs help yet again… that is really positive and I think [one of] the main things is feeling valued. (Sonia, CI)

Identification with a figure encouraged participants to author the doctor’s specialty as a career choice and to study conscientiously. An exception to this occurred when, despite positive figuring, participants were unable to author themselves as agents in the figured world:

[A] consultant had to break… bad news to [a patient] and her daughter… [He] was really calm and… concerned… The [resident] was with us as well… He was saying how he’s not actually had to do this… it’s usually the consultants that do it… It just got me thinking… when I’m… a GP or a consultant or… even a junior doctor, I’m gonna be doing these kinds of things… I cry at the smallest things, and… I’m just gonna end up crying… It just made me think… “Can I imagine myself telling people bad news?” (Rashida, CI)

Negative emotions and being unable to identify with figures

Rashida was confused by staff issuing ‘do not resuscitate’ orders without first discussing them with patients (contrary to well-established ethical practice):

I just remember the DNR [do not resuscitate] form and thinking “Oh God”… During the four months I’ve seen my consultant filling out DNR forms, he only discussed one DNR form… with the grand-daughter of one of the female patients. At that point I remember asking him: “Should you not discuss these forms with patients?“ and he said, “No,” and I’m thinking… “I was at [a different hospital] and… we were told we should discuss them with… the patient or at least their family… At that point… I was really confused… thinking: “Well what would I do?” (Rashida, CI)

There were many instances in which participants experienced negative emotions when they could not identify with figures. Rashida, an Asian woman, felt sad, shocked and disappointed when a male Asian doctor objected to an Asian female patient wearing a veil during a consultation. A personal history of mental ill health made Robin angry and unable to identify with a physician who ‘shunned’ a mentally ill patient. Natasha experienced negative emotions when doctors broke hospital rules and increased the risk for patients becoming infected. Sonia could not identify with doctors and nurses who were irritable and unhelpful towards students and rude about patients. She authored an ‘imagined world’ in which, as a qualified doctor, she would behave supportively towards medical students:

I’m quite excited to see… if I just remain normal… or if everyone gets this bizarre god-like complex… if ever I see a medical student
looking lost . . . that medical student will benefit so much by you just talking your thoughts aloud.’
(Sonia, SSI)

The relationships among emotions, figuring and identity development in this final section seem quite simple: participants experienced positive emotions when they encountered figures with whom they could identify and when they could author their own identities. The reverse was also true.

DISCUSSION

Principal findings and meaning

Participants’ emotions related directly to their identity development. Having a position in the world of medicine and being able to identify with a figure generated positive emotions, and vice versa. Participants did not identify with every doctor, nurse or resident. They identified with figures who were supportive of students, behaved ethically or compassionately towards patients, were culturally sensitive, or were careful with hand hygiene. Critical discourse analysis uncovered something else important: participants developed their identities within a field of power. Doctors were relatively empowered. Patients were relatively disempowered. Participants’ net emotions were positive when they identified with doctors who used their power to the benefit of patients. Such figures occupied the most prominent places in participants’ stories of their emerging identities.

Strengths and limitations

The strengths of this research include our assembly of a research team that represented the perspectives of curriculum leads, doctors who teach clerks, medical students and non-doctors. We chose a strong, relevant theory, applied it rigorously, and layered a narrative of everyday clinical learning on top of it. The value of our interpretation has to be judged by its utility to other people in other places at other times. People who are, or have been, active participants in clerkship education as teachers or learners are, we suggest, the people who are best placed to read our findings reflexively and to benefit from them.

We see two main limitations. The findings were sourced from medical students who were willing and able to participate in such intensive data collection. There was a relative absence from the discourse of participants who were negatively positioned by clinicians’ abusive behaviour towards them. Perhaps the latter limitation is explained by the former – only positively disposed students volunteered for the study – or perhaps participants held back from saying things they feared might harm their careers. A limitation of the study, then, is that we have less to say about negative than about positive emotions.

Relationship to other research

According to Billett’s socio-cultural theory of relational interdependence, workplace learning is influenced by two main factors: the social possibilities afforded by workplaces, and learners’ uptake of those possibilities as they engage themselves in work. Our findings fit Billett’s theory because many of our participants described how behaviour on the part of doctors, nurses, midwives and other people made it more or less possible for them to engage in practice and learn from it. Thus, medical students’ identity development and emotions are influenced by, in Billett’s words, relational interdependence between individual and social agency. Our findings fit closely with those in an influential publication by Kasman et al., which showed how positive emotions resulted from connections with patients and colleagues, from being recognised for one’s efforts, and from the receipt of emotional support from others, whereas difficult emotions resulted from uncertainty, powerlessness, responsibility, lack of respect and a difference in values. Our findings, moreover, echo the observation of Kasman et al. that both difficult (sadness) and positive emotions can result from a single experience.

Although there is debate about the size of the effect, there is concern that medical students become less empathic as their education progresses. Causes include students’ vulnerability, inappropriate role models, distress and inadequate coping mechanisms. Our research shows that medical students experience many positive and negative emotions as they develop their identities among potentially conflicting figures and positions. Our participants responded empathically to patients’ disempowered conditions and identified with empathic figures. It is likely that other students may have responded non-empathically and may have identified with non-empathic figures, but they would be unlikely to volunteer for a study of this type.

Bleakley and colleagues have argued for a new medical education, which places patients at its centre and in which learners read patients as text. Although our participants read patients as text,
their identity development was influenced in important and positive ways by doctors whose capabilities our participants sought to acquire. Albeit that we agree that caring for patients is the goal of medicine, and learning to care for them is the goal of medical education, we would not want a sole focus on patients to distract from the vital roles of doctors and other people in medical students’ identity development. More recent work by Bleakley, which considers how medical students’ identity develops in ‘knotworks’, addresses this concern. The knotwork of social interactions involves all the individuals who deliver contemporary medical care, but a patient-centred orientation cannot be maintained if a ‘doctor knows best’ mentality prevails.

Implications for research and practice

The clearest implication for educational practice is that we should explore how it can be made legitimate to talk about physicians’, residents’ and medical students’ emotions, and how those emotions link to power and identity development. Making the discourse of emotions explicit in medical curricula is not, in fact, a new idea because it is an essential component of the Balint approach to intervision among physicians. One UK medical school has helped large numbers of its medical students learn about emotions in medical practice by offering them opportunities to participate in Balint groups. Other medical schools might follow its lead and all must consider giving emotions a more explicit place in their discourse of curriculum.

Contributors: TD supervised EP’s PhD, including the collection of these data and their preliminary analysis. He reanalysed the data, applying Figured Worlds theory to them, and wrote this paper. EP collected the data and participated in their reanalysis for this paper. PC reorganised the data for reanalysis and worked closely with TD to interpret the data and apply Figured Worlds constructs. EH provided an independent opinion on the analysis, reviewed the original data, commented on successive stages of the data analysis and contributed to reflexive discussions about the data interpretation. CB co-supervised EP’s PhD, including the collection and preliminary analysis of these data, and participated in their reanalysis. All authors contributed to the review and revision of successive drafts of this paper and approved the final manuscript for publication.

Acknowledgements: the authors acknowledge with thanks the help given to them in writing this paper by Deirdre Bennett, Emily Bate, Elspeth Hill, Yvette Solomon, Joanna Bates and Kathryn Steven.

Funding: EP won a University of Manchester strategic studentship, which paid her a stipend and tuition fees.

Conflicts of interest: None.

Ethical approval: The work was carried out in accordance with the Declaration of Helsinki including, but not limited to, there being no potential harm to participants. The anonymity of participants is guaranteed and their informed consent was obtained. Approval was granted by the University of Manchester Senate Ethics Committee and endorsed by the local Health Service Ethics Committee.

REFERENCES


32 Pearson E. Investigating the Psychological and Contextual Factors Affecting the Experience of Emotion by Medical Students in the Clinical Workplace. Manchester: University of Manchester 2010;297.


40 Ginet M, Verkampt F. The cognitive interview: is its benefit affected by the level of witness emotion? Memory 2007;15:450–64.

Received 1 April 2014; editorial comments to author 2 May 2014; accepted for publication 1 August 2014