Entering medical practice for the very first time: emotional talk, meaning and identity development

Esther Helmich,1 Sanneke Bolhuis,2 Tim Dornan,3 Roland Laan2 & Raymond Koopmans 1

CONTEXT During early clinical exposure, medical students have many emotive experiences. Through participation in social practice, they learn to give personal meaning to their emotional states. This meaningful social act of participation may lead to a sense of belonging and identity construction.

OBJECTIVES The aim of this study was to broaden and deepen our understanding of the interplay between those experiences and students’ identity development. Our research questions asked how medical students give meaning to early clinical experiences and how that affects their professional identity development.

METHODS Our method was phenomenology. Within that framework we used a narrative interviewing technique. Interviews with 17 medical students on Year 1 attachments to nurses in hospitals and nursing homes were analysed by listening to audio-recordings and reading transcripts. Nine transcripts, which best exemplified the students’ range of experiences, were purposively sampled for deeper analysis. Two researchers carried out a systematic analysis using qualitative research software. Finally, cases representing four paradigms were chosen to exemplify the study findings.

RESULTS Students experienced their relationships with the people they met during early clinical experiences in very different ways, particularly in terms of feeling and displaying emotions, adjusting, role finding and participation. The interplay among emotions, meaning and identity was complex and four different ‘paradigms’ of lived experience were apparent: feeling insecure; complying; developing, and participating.

CONCLUSIONS We found large differences in the way students related to other people and gave meaning to their first experiences as doctors-to-be. They differed in their ability to engage in ward practices, the way they experienced their roles as medical students and future doctors, and how they experienced and expressed their emotions. Medical educators should help students to be sensitive to their emotions, offer space to explore different meanings, and be ready to suggest alternative interpretations that foster the development of desired professional identities.
INTRODUCTION

During early clinical exposure, medical students have many new, potentially emotional experiences, such as when they are confronted with death and dying, when they access the intimate, corporeal areas of life, when they build relationships with patients, and as they deal with uncertainty and role confusion.\textsuperscript{1,2} These experiences have been found to result in a broad variety of learning outcomes, such as greater motivation and the development of a positive state of mind, knowledge and clinical skills, which together constitute a professional identity.\textsuperscript{1,3,4} Although we know that entering medical practice for the first time can be confusing, daunting and overwhelming for young students,\textsuperscript{5} our previous research suggests that the emotional dimension of learning in workplaces tends to be ignored.\textsuperscript{6}

Emotions and the meanings attributed to them may help people make sense of themselves and their relationships with others.\textsuperscript{7} Through participation in social practice, and by constructing a narrative of their experiences, students learn to give personal meaning to their emotional states. This meaningful social act of participation may then lead to a sense of belonging and identity construction.\textsuperscript{8} Emotional experiences and identity development are involved in a two-way relationship: emotionally salient incidents in medical workplaces represent powerful stimuli for the development of professional values and identity,\textsuperscript{9,10} and identity development can itself give rise to strong emotional disruptions.\textsuperscript{11}

Identity development is an emotional, cognitive and social process that can be considered at individual or social levels.\textsuperscript{11} Students give meaning to their emotional experiences during early clinical placements within their particular personal and socio-cultural contexts. Through participation in work activities such as caring for patients and collaborating with colleagues, they begin to identify with their future roles as health care professionals. By telling stories about their experiences and trying to make sense of them, students shape and reshape their developing identities. An inquiry into medical students’ narratives of workplace experiences, then, may enhance our understanding of how identities are constructed and co-constructed within medical education.\textsuperscript{11,12}

In this study, we focused on medical students’ meaning making and their developing awareness of the socio-cultural contexts they are entering. We explored the individual experiences of students who were in the throes of becoming health care professionals in the context of social practice. We chose phenomenology as a methodology through which to interpret these processes in depth. Previous phenomenological studies directed at professional identity development are scarce, particularly within medical education. A phenomenological study aimed at understanding how nursing students made meaning of being with patients revealed the strong interrelatedness of emotions and meaning making, and identified fear of interacting with patients, developing confidence and becoming self-aware as main themes in students’ experiences.\textsuperscript{13} A recent study within medical education showed how Year 3 students gave meaning to their experiences of being with patients by learning to be receptive and responsible.\textsuperscript{14}

The aim of the present study was to broaden and deepen our understanding of the identity development that occurs when medical students enter practice for the first time. This directed us towards the ‘lived experiences’ of these young people and towards exploring the ‘essence’ of being at once a Year 1 medical student and a future professional, and the emotional turmoil that might result from entering a clinical community of practice as a doctor-to-be. We sought to establish how medical students narrate and give meaning to their emotions in a Year 1 attachment to nurses, and how that affects their professional identity development.

METHODS

Ethics

As educational research is exempt from requirements for formal ethics approval under Dutch law, we discussed the aims and design of the study with the main educators in the nursing attachment and sought approval from the education management team of our medical school. Participation was fully voluntary and kept confidential to ensure it had no consequences for student assessments at the end of attachments. As narrating highly emotional events may be difficult or challenging for students, we explicitly offered support afterwards. We were aware that participation in phenomenological studies might result in an increase of consciousness in participants, impacting on their future experiences and personal development. The researcher ensured that she was available to talk with students again about possible unanticipated personal changes that arose as a consequence of participation. Our institutional
The review board decided that no further measures for ethical approval were necessary.

**Context**

At Radboud University Nijmegen Medical Centre, all Year 1 medical students participate in a compulsory 4-week nursing attachment. They are allocated to a nursing home or a hospital ward, in which they work as assistant nurses. The main educational goals of this early nursing attachment are to familiarise students with patient care, to help them develop communication skills and empathy, and to stimulate reflection on professional behaviour. We considered this nursing attachment a particularly suitable context in which to examine the research question because of the opportunities it provides for students to participate actively in patient care.15

**Participants**

As students’ perceptions were previously shown to be related to gender, age, prior experience and place of attachment,16 we purposely selected respondents with different backgrounds. This sampling strategy led to the diversity of gender, age, prior patient experience and place of attachment shown in Table 1.

The first author sent students an e-mail that included a short introduction to the study and a request for participation. Additional oral and written information accompanied by an informed consent sheet was given to students who agreed to take part.

**Study design**

We adopted a hermeneutic phenomenological research approach, relying on the ideas of the philosophers Heidegger and Gadamer. The main aim of such an approach is to ‘describe, interpret and understand the meanings of experiences at both a general and unique level’17 Our goal was to ‘find exemplars or paradigm cases that embody the meanings of everyday practices’.18 As the construction of meanings and identities largely occurs through language or narrative, we decided to interview students and analyse their narratives of workplace experiences.

**Data collection**

In order to stay as close to students’ experiences as possible, the first researcher visited the students at their workplaces during their attachments. She then carried out individual in-depth interviews, using a narrative interviewing technique. Interviews started with the question: What is it like to be a medical...

---

**Table 1 Demographic data for respondents**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age, years</th>
<th>Prior experience</th>
<th>Place of attachment</th>
<th>Date of interview</th>
<th>Included in full analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
<td>Yes</td>
<td>Hospital</td>
<td>06/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>Yes</td>
<td>Hospital</td>
<td>07/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>Yes</td>
<td>Hospital</td>
<td>10/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>No</td>
<td>Hospital</td>
<td>10/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>Yes</td>
<td>Hospital</td>
<td>11/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>Yes</td>
<td>Nursing home</td>
<td>11/12/2010</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>Yes</td>
<td>Nursing home</td>
<td>14/12/2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>No</td>
<td>Nursing home</td>
<td>18/01/2011</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>No</td>
<td>Nursing home</td>
<td>20/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>Yes</td>
<td>Nursing home</td>
<td>20/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>No</td>
<td>Nursing home</td>
<td>21/01/2011</td>
<td>Yes</td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
<td>No</td>
<td>Nursing home</td>
<td>21/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>No</td>
<td>Hospital</td>
<td>21/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>No</td>
<td>Nursing home</td>
<td>25/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>No</td>
<td>Hospital</td>
<td>27/01/2011</td>
<td>Yes</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>Yes</td>
<td>Hospital</td>
<td>27/01/2011</td>
<td>No</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>No</td>
<td>Nursing home</td>
<td>28/01/2011</td>
<td>No</td>
</tr>
</tbody>
</table>
student on this ward? Throughout the conversation, the interviewer took care to remain attentive and open to what was being said. She asked questions as they seemed appropriate to seek clarification or reflection. Judicious use of prompts such as ‘Tell me about the most impressive event you have encountered’ and ‘What did you feel/think/do?’ helped students to stay focused on their actual experiences. The interviews lasted 45–90 minutes.

Data analysis

The interviews were audiotaped and transcribed verbatim. To maintain confidentiality, participants were given pseudonyms. After carrying out 17 interviews, we felt we had gained a rich sense of respondents’ experiences. Because phenomenological analysis can be adversely affected by volume of data, the first author carefully read all the transcripts, made ‘thick descriptions’, and purposively selected the nine that most clearly illustrated the range of responses for in-depth analysis. This involved choosing between the transcripts of comparable respondents to achieve a balance of hospital and nursing home placements and maintain a variety of emotional experiences and ways of giving meaning to these.

In the course of listening to audio-recordings and reading their transcripts, we undertook a narrative analysis, focusing on ‘what’ was happening in students’ stories and ‘how’ they narrated their experiences and constructed their identities.12 Two researchers (EH, SB) carried out a systematic analysis of the whole stories and of individual parts of the texts, and then compared these two interpretations, constantly moving back and forth between holistic and categorical meanings.17–19 Data reduction was carried out by selecting salient excerpts that captured essential meanings. In doing so, we were looking for explicit emotional talk or paralinguistic dimensions of emotions and instances of meaning making and identity development. The qualitative research software ATLAS.ti (ATLAS.ti GmbH, Berlin, Germany) was used to sort fragments and search for relationships and general themes.

Throughout the planning and conduct of the research, the first author kept a reflective journal, in which she explained the various decisions made during the different stages of data collection and analysis, and included written summaries of all interpretations. EH and SB discussed this process and the main interpretations in several consecutive research meetings with the other authors. We judiciously tried to bring our pre-understandings into consciousness, acknowledging that narratives and interpretations are always co-constructed.19 Through an ongoing process of writing and rewriting, our interpretations were further refined.

RESULTS

Outline of findings

The experiences narrated by respondents followed four main thematic strands: feeling and displaying negative and positive emotions; adjusting to or experiencing dissonance with the social milieu; finding or not finding a role, and participating or not participating in social practice. These plotlines refer to the emotional, cognitive and social components of meaning making and identity development. Figures 1–4 present excerpts of longer individual narratives exemplifying four distinct patterns of emotional talk, meaning making and identity development, and, respectively, representing four different paradigms. Other participants’ narratives are not displayed, but their experiences informed the analysis and resonated with the four paradigms.

Feeling insecure

The first paradigm is presented by ‘Nancy’, who is 19 years old and has no prior experience in health care (Fig. 1). She has been allocated to an oncology ward in the university hospital. Emotions: Nancy’s narrative is about not feeling ‘at ease’ (Fig. 1), feeling ‘not sure’ when she is faced with patients ‘at once’, and fearing being ‘too large a burden’. She does not know how to respond emotionally to the suffering of patients and contradicts herself about whether she thinks about them after she has left the ward.

Adjustment: Nancy mentions several times that she ‘needed to adjust’, that ‘everything is really different from what I had expected’ and ‘not easy’. Role finding: Nancy does not know how she ‘should behave towards patients’. Although she does ‘wear a white uniform’, she is ‘only a student’ and she wonders if talking with patients ‘fits my role’. Participation: Nancy had ‘expected it was easy to do some nursing stuff’, but she feels she is ‘not capable of doing many things’ and is ‘superfluous’. Being recognised by a patient ‘that I just work here’, she ‘really enjoyed’. She narrates her difficulties in ‘interacting with other nurses’ and explicitly states she is ‘not really part of the team’.

© Blackwell Publishing Ltd 2012. MEDICAL EDUCATION 2012; 46: 1074–1086

1077
(Nancy): Uh, yeah, yeah, it was, uh, I needed to adjust, yeah ((laughs)). Uh, all at once, you are faced with patients, which is, yes, yes different ((laughs)), yes, and also, uh, how I, uh, uh, should behave towards patients.
(edited)
(Nancy): I think, uh, they are not waiting for me, but, maybe, I do wear a white uniform and, yeah ((laughs)), yeah, in itself I can talk with them, yeah, so, uh, yeah, increasingly I do like it a bit more. Yeah, in the beginning, I didn’t feel at ease ((laughs)), you know.
(edited)
(Nancy): Yeah, sometimes I think it is, I think, wow ((sighs)). Yeah, there is a lot happening to them, so to speak, sometimes it is really severe, yeah [2.0]. Yeah, just that it is all of a sudden, that they, yeah, that the whole life of those people, it completely changes just at once, yeah, uh [4.0].
(Esther): Uh, yeah, that’s quite severe?
(Nancy): Yes, I think so. Yeah, it is not that I keep thinking about it when I leave here, but, yeah, you kind of keep it with you, uh, yeah [3.0].
(Esther): Kind of keep it with you?
(Nancy): Yeah, that I think about it and then, uh, yeah, you know, about, uh, that patient, that patient, but yeah, sometimes, patients go home and then, I don’t know [4]. In particular the patients you really see regularly, with them I empathise most, you see, because I, because you, yeah, you know them best, know them best, so to say, those patients, yeah.
(edited)
(Nancy): Yeah, but I do not talk about it that much, really. I don’t think about it, not really, uh, not that much, but sometimes, if you meet some somebody, uh, then, when I was on duty, then you see patients again, and then, yes, then you wonder, oh, how will it go, you know, or someone leaves, and yet I wonder, what, well, what will be happening next, you know. Yeah, actually I am quite engaged in, yeah, really, actually.
(edited)
(Nancy): But, it is not that I, that I then, uh, have to think about it very much, but it is neither that I leave here and do not think about it anymore, you know. So, I still do think about it, yeah. Yes, and it’s also, uh, everything is really different from what I had expected, you know.
(edited)
(Nancy): Uh, yeah, I really find it difficult to, uh, just, uh, really, go and talk with patients, yeah. I had thought about it as being quite easy, but it is, I am only a student, and then just walking in and saying "hi, can I sit with you for a while?", yeah, that is, one way or another, it is really a big step, you know. Yeah, and I, yeah, I don’t know, I think I had expected it would be easy to do some nursing stuff, but that is, it is not that easy, now and then ((laughs)).
(edited)
(Nancy): I do not do that [talking with patients] that easily, Uh, yeah, it’s just, because then I think, uh, actually they might not like it, although I, yeah, you do not always know that for sure ((laughs)). Some patients are only too glad to have a conversation, so, yeah, that is something I should weigh up myself ((laughs)).
(edited)
(Nancy): It is not [4.0], it is not that I think it is easy [4.0], but, yeah, uh, yeah, it is just, I am learning a lot, and also how I should behave a bit and, yeah.
(edited)
(Nancy): I just do not know if it fits my role.
(Edited)
(Nancy): Then, there was a man in the corridor and he started a conversation, like ‘hey, are you on duty again’, or something like that, you know ((laughs)). I knew that man from here [the wards], and, uh, yes, those people also see you, just like, as, yes that, that those, that I just work here, you know, yeah ((laughs)), I really enjoyed, yeah.
(Edited)
(Nancy): I was afraid here, that it, yes, would be too large a burden, or something, for that patient, to talk about it with me, yes, yes. It is not that I am really sure when walking around here, that’s not really the case, no.
(Esther): Uh, yes. And what makes you feel insecure?

Figure 1 The Insecure paradigm. Pauses of ≥ 1 second are indicated between brackets. Fragments of the transcript that are not displayed are indicated by (edited)
Complying

The second paradigm is represented by ‘John’, aged 18 years, who lives at home with his parents (Fig. 2). He is allocated to a nursing home ward, in which he is introduced to patient care for the first time. 

**Emotions:** John reports his experiences in quite an objective manner. John makes almost no paralinguistic expressions of emotions (sighing, laughing, pauses), even when describing situations such as ‘you discover the next morning that they have passed a motion, and that they have been in it all night’ (Fig. 2) or when someone who ‘was an energetic person’ is now ‘bedbound’. For John, it is difficult to remember specific, impressive or emotional experiences. He comments almost exclusively on structural and procedural aspects of practice, sometimes hinting at his emotions – ‘this is kind of pitiful’ – but quickly discounting them, declaring that ‘it really is for his [the patient’s] sake’.

**Adjustment:** In the nursing home, ‘it is not all that beautiful’, but as ‘such things may happen’ and ‘you cannot change the situation’, John believes you ‘should just offer help wherever possible’. 

**Role finding:** John would like to help people, but he does not know if he ‘can help them’. He repeatedly states ‘it is quite busy here’, which means that ‘you can only talk with patients in your spare time’ (and other edited parts of the text). 

**Participation:** John says that after a while ‘you are allowed to do things on your own’, but as ‘supervisors do act differently’, ‘working together sometimes is problematic’. He seems to give meaning to his experiences predominantly by complying with what he thinks is expected: ‘you need to give them [the patients] structure’ and when something ‘is not allowed’, ‘you should tell them’. Interacting with patients remains difficult as ‘some of them don’t want to talk’ and ‘you just need to pay attention to patients’ privacy’.

Developing

‘Sarah’, aged 19 years, represents the third paradigm (Fig. 3). She has just moved to ‘the big city’ in order to study medicine. Everything is new: Sarah is living on her own, making new friends, and is now receiving her first introduction to patient care. She is allocated to a rehabilitation hospital. 

**Emotions:** This narrative is saturated with emotions. Sarah found it ‘very difficult’ (Fig. 3) to go to the hospital because it is ‘not easy to talk to people’ and it is ‘really tiring’ to meet new people. She considers it ‘pretty difficult to really empathise with patients’ or ‘to be able to talk to them’, especially ‘when patients are sad’. She describes herself as being ‘always very uncertain’ and ‘afraid to do everything wrong’. At the end of the attachment she is ‘still very uncertain’, but she has gained ‘some more confidence’.

**Adjustment:** Sarah is wondering if and to what extent it is a good thing to ‘get used’ to ‘what happens to people’. Considering ward practices, she thinks it is ‘fairly good’ that nurses ‘talk to each other about what’s going wrong’ and hopes she ‘will be able to do this in the future as well’. 

**Role finding:** Sarah describes her role in rather developmental terms, stating ‘you should learn’ to communicate with patients ‘when you are in practice’ and that the first time this happens ‘there needs to be someone present’ because she does not dare ‘to do something new’ on her own. With respect to interaction with patients, Sarah says ‘it will take a lot of time’ ‘to develop that skill’. This ‘will be confronting’, but she wants to ‘open up to this’. 

**Participation:** Although being on the ward ‘is not easy’, Sarah says
Yes, it is, uh. It is just, uh, it is quite busy here. You can only talk to people, to patients, in your spare time. Because, yes, they have, they are having a meal. Then it is a bit difficult to talk when they are still eating. And straight after the meal there are these activities, so it is already, uh, yes. The mornings are the busiest, when you have to help people get out of bed. But, uh, in the afternoon, uh, yes, then there is not much to do here.

You just try to help people, right? But actually, here it is, that, yes, that people should do most things themselves. So it is a kind of conflicted feeling: yes here I am, I am a nurse and I’d like to help. Really help people. But yes, actually, they should be doing most things themselves. So that’s a bit difficult: can I help them or do they need to do it themselves? Yes, and, uh, yes, sometimes there are those cases, sometimes, that, uh, it’s different, but, yes, people who sometimes have red skin, all of a sudden, with scales. And yes, the stools, that’s something I am getting used to now. But yes, that’s still always, uh, yes, kind of dreadful, you know. You discover the next morning that they have passed a motion. And that they have been in it all night.

But, yes, it is, yes, it is kind of daily stuff I think, it becomes kind of a routine. But, uh, such things may happen, and yes, and I think, yes, you should just offer help wherever possible as you cannot change the situation.

Yes, it was, at first, it was, uh, the supervisors, they, they washed the patients and then you had to dry them. But now, it is, now it is, uh, now things are going better, you are allowed to do things on your own, and yes, there was that moment, I had forgotten to raise the bed. That is important; to raise it to the right height. And, uh, yes, I think when you, uh, when you won’t do that for a long time, then there are, uh, yes you will get into severe trouble. Yes, people sometimes are quite obese here, some of them. So, yes, then, uh, that is kind of difficult.

Yeah, patients here need a lot of structure. They have, uh, yes, some of them have, yes, so, uh, yes, yes, they just have psychological problems and they, uh, then you need to give them structure, because otherwise strange things might happen.

In particular when having meals. There are those people who are, yes, who are kind of overweight. And they ask for additional food, but that is not allowed. And then, yes, than you should tell them, actually.

Yes, you, you do not, uh, yes, you do not always have the same supervisor. So, yes, these supervisors act differently, you know. They have, yes, sometimes, one of them says “well, give her some food”, but the other says “no, don’t do that”. Sometimes it is still a bit difficult to reach agreement about this, you know. So, yes, it is, uh, working together sometimes is problematic.

Yes [5], sometimes you should, yes, it is not always, uh, not always, not all that beautiful, you know, in the nursing home. Not that you think everything is going well. Because, yes, it is, there are still a lot of problems, yes, here.

Mm but, yes, I can’t remember [any particular experiences], if it, uh, really, uh, things that were really funny or very special.

No, not really. It just sticks around a bit, a little bit, but not specifically.

Yes, maybe the interaction with the persons, uh, the patients. Because, yes, some of them don’t want to talk, actually. Sometimes, I heard supervisors saying “yes, actually, uh, I will help that patient myself, because that person has, uh, it is difficult to get help from new people.” So, yes, you just need to pay attention to patients’ privacy. Sometimes, that is, uh, quite difficult.
that ’at a certain moment it went quite well’. The people she works with ’are not colleagues really’, but as she consciously observes their behaviour, she is led to conclude that ’you join in naturally’.

**Participating**

’Rebecca’, aged 18 years, whose narrative presents the last paradigm (Fig. 4), has been allocated to a psychogeriatric ward in a nursing home. She lives with her parents. Her mother works as a nurse in a hospital; Rebecca worked in the same hospital as a nursing assistant during the previous summer break. *Emotions:* Rebecca loves ’having contact with patients’ (Fig. 4). Many experiences are ’nice’, but sometimes it ’is a pity’ that demented patients forget so much. She refers to ’difficult’ situations, when people are not able to talk anymore. This makes her feel ’powerless’ because she ’really want[s] to help, but [she] can’t’. However, overall Rebecca ’is really happy with this placement’, which she is ’enjoying very much’. *Adjustment:* Rebecca describes how she ’had to get used to’ nurses who were ’singing’ and ’joking’, but ’now you just join in’. However, she is also critical when ’you notice that things go on quite routinely’ and she emphasises that it is important to ’tell people what is going to happen’ and that ’sometimes they are not told’. *Role finding:* Rebecca easily fits in, saying she will ’walk by’ to ’ask if I can do something’. If there is nothing to do, then she will ’play games’ or ’get into conversation’. *Participation:* Rebecca explicitely makes the comparison with the hospital, stating that in the nursing home ’you have more opportunities to interact with patients’, that ’you are allowed to do many more things on your own’, that ’you are really participating’ and ’I really do like that’.

**DISCUSSION**

**Summary of main findings**

Medical students’ narratives of their first workplace experiences unfolded along four lines: feeling and displaying emotions; adjusting; role finding; and participation. This resulted in four different ’paradigms’ of lived experience characterised by large differences in emotional talk, meaning and identity: feeling insecure; complying; developing; and participating. Recognition of these four different student ’profiles’ may have important implications for the process of selecting and supervising medical students.

The first paradigm, *feeling insecure,* is characterised by feelings of uncertainty and fear of being too large a burden. We consider this paradigm to be representative of students who interpret these first experiences in the workplace as fearful and difficult, and who do not know what to do or how to behave in their new roles as future doctors. These students may try to avoid or postpone a confrontation with ’real life’ because this is difficult and scary. Not being able to connect with others prevents them from engaging in meaningful participation and thus limits their identity development. The paradigm of *complying* is characterised by the act of remaining largely detached. This paradigm represents students who comment almost exclusively on structural and procedural aspects of practice, try to stick to the rules and accept even negative features of the workplace in order to fit in. It does not embrace critical reflection, but only conformity and obedience. The development of an autonomous professional identity is thus largely foreclosed. The *developing* paradigm is characterised by active involvement in emotional exploration and personal development. Students who fit this profile may be afraid of doing things wrongly, but they are able to reflect consciously on their feelings of uncertainty and the support they need from others. They interpret their feelings of uncertainty as appropriate to their current level of expertise, which creates developmental space in which they can explore in real practice how they can best relate to patients and others in the workplace, and how they can build a professional identity. The last paradigm, *participating,* is characterised by active contribution to patient care, and the recognition and shaping of learning opportunities in order to enhance personal and professional development. Students who fit this profile are receptive to their own feelings and engage in an embodied and differentiated process of meaning making, which may lead them to develop a balanced professional identity, predominantly based on their relationships with patients and their participation in a given social practice.

**The personal and social in identity development**

Our paradigms show striking similarities to the identity status paradigms described by Marcia, whose use of the term ’identity diffusion’ corresponds to our use of ’insecure’; his term ’foreclosure’ corresponds to our ’complying’; his term ’moratorium’ corresponds to our ’developing’, and his term ’identity achievement’ corresponds to our ’participating’. We suggest that our findings may be considered as representing the actualisation of Marcia’s identity status paradigms within medical education. This identity status model has been critiqued because
(Sarah): Uh [1.0], yeah, it was very difficult for me to go [to the hospital], I don’t find it that easy to talk to people. To [1.0] dare to do that. So, this has felt really difficult, uh [1.0]. Yes, a lot of new people. I found it really tiring to, uh, yeah, to try to remember all those names. So at first, you, you are used to stay at home, to come to know and, uh, uh, just go to university and, with people you have come to know there, uh [1.0], to talk with them a bit. But now, it is talking, talking, talking all day ((laughs)). I am not used to it. So, uh, but everything is going quite nicely, actually.

(edited)

(Sarah): Yes, ((laughs)), for me, it is not easy, but that, uh, yes, at one particular moment it, uh, went quite well. Yes [5.0], it is not that I, that it goes smoothly, uh, if I do not need to, then I, yes, then I won’t do it ((laughs)), but when it’s necessary, then, uh [2.0], then I will.

(edited)

(Sarah): I am constantly being laughed at by one patient. Every time I walk by, then, uh, she has, uh, her eyes are brimming with tears ((laughs)) I don’t know why but, uh [1.0], apparently, I am very funny. I do not understand, but, uh [1.0], I can laugh a lot with her. So, uh [3.0], and, they, how do I call that, uh, my colleagues [1.0], they are not colleagues really, because I am here only temporarily, but uh [1.0], they [1.0], yes they also laugh at everybody, so then, at a certain moment, you join in naturally.

(edited)

(Sarah): For me it (communicating with patients) is quite difficult ((laughs)). Uh, I think you should learn that when you are in practice, and, uh [1.0], I think, I am not that good at it, yet, it is not that I already am able to, that I am the one to decide, uh, yes, I think it’s pretty difficult to really empathise with patients, you know. When patients are really, uh really sad or something, then, uh, to be able, to be able to talk to them about it. So that’s difficult. And, yes, keeping too big a distance, I don’t like that idea either, uh [1.0], being at too great a distance.

(edited)

(Sarah): I am always very uncertain, afraid to do everything wrong. So there needs to be someone present, saying “yes, you are doing well”. And then, uh, then, I am ready for it. But to do something new on your own, that, uh [2.0], I don’t care to risk ((laughs)).

(edited)

(Sarah): I think it might be natural, that, uh, yeah, for everybody who has new experiences, that it, when you are engaged in for a longer period, that you get used to. I think that’s a normal thing. Indeed, it is really awkward for people that all this is happening to them. And yes, I keep worrying about, why should this happen? But the end of the story is, well this is life, and we are able to help people cope with it, and so having this [a rehabilitation hospital] is quite a good thing. Looking at it this way getting acquainted might not be that wrong ((laughs)) [2.0]. But the idea that this happens to people, I don’t like that, and I think I will never get used to that.

(edited)

(Sarah): And interacting with patients, uh, yes, I think this will [1.0], this will take a lot of time, to develop, to develop that skill. And, uh, I think it might be difficult to [1.0], uh [1.0], to do that.

(edited)

(Sarah): I think this only develop by trial and error. That you will face many setbacks. That you will face many, many, uh, difficult situations. That’s what I think. That you will have to look in the mirror, that it will be confronting, but that, eventually, you will be able to [1.0], to learn a lot from it. That you might be able to develop and reach something, when you open up yourself [2.0], and that is what I would like to do.

(edited)

(Sarah): Of course I am still very uncertain about everything, but uh [1.0], I have gained some, some more confidence in [1.0], that I will be able to do this ((laughs)).

(edited)

(Sarah): I had to move. I did not know anything here and I needed, yes, I just needed to start over again. And I knew [1.0], yes, I needed to get used to, uh, to university and the people that were around. And, generally, that takes me an awfully long time. And, uh, [1.0], if it had been scheduled earlier [this early clinical experience], then this would have been loaded on top and then I don’t know if I could have endured it. Because it is, uh [1.0], for me it is really tiring.

Figure 3 The Developing paradigm. Pauses of ≥ 1 second are indicated between brackets. Fragments of the transcript that are not displayed are indicated by (edited)
it focuses predominantly on personal identity and largely overlooks other aspects of identity, such as social identity, as conceptualised by Erikson. Therefore, it may be particularly relevant to extend the current research in medical education to more explicitly take into account the social and cultural contexts in which students develop their nascent professional identities.

Our main findings are in line with those of other empirical work about medical students’ workplace learning, and show the importance of participation and social relations. Student–teacher relationships are key experiences that may be mirrored by students in their future relations with patients. Collaborative working relationships between students and patients may provide an important setting for identity development, which is exemplified in most of our paradigm cases. In general, learning from and with others in the workplace is central to many workplace-based learning theories.

We found large differences among Year 1 medical students in their abilities to enter into relationships on wards. In the ‘experience-based learning model’, the social context, including curriculum factors and supportive human interactions, is considered to comprise the main conditions leading to the participation of medical students. This is congruent with more recent suggestions about the importance of developmental space, which is also mainly conceptualised as a characteristic of learning environments. Our paradigm cases demonstrate how workplaces can influence students’ participation. In her narrative, ‘Rebecca’ explicitly refers to the differences between the hospital and the nursing home in terms of how they offer ‘opportunities to interact with patients’ or ‘to do things on your own’. ‘Sarah’ shows how, after ‘observing the behaviour of others’, ‘you join in naturally’. Participation or developmental space, however, can also be thought of as a negotiated or relational interdependence between social and personal factors. Learning in workplaces, then, is a result of the interaction between how workplaces afford participation and how individuals are able to engage in social practice. Our paradigms clearly show those individual differences. ‘John’ and ‘Nancy’ represent students who may experience substantial difficulties as they enter medical practice for the first time.

Two recent studies relying on, respectively, longitudinal audio diaries and narrative interviewing showed how students may struggle with contradictory formal and informal learning experiences; students in these studies used strong emotional talk to make sense of the dilemmas they encountered in medical practice. Students needed to reconceptualise their idealised notions of themselves and to balance different and sometimes contradictory discourses in medicine. We explored the narratives of medical students at their first entry into medical practice to provide more insight into the large differences among students in their experiences, in their degree of emotional talk within their workplace narratives, in the meanings they attach to their experiences, and in the impact of these experiences on their identity development.

Emotions and professional identity

Although emotions are known to be strongly related to professional behaviour and the development of professional identity, students in several recent studies have seemed reluctant to express their emotions. This has led to the suggestion that medical education still socialises students to suppress their emotions, and to a call for greater attendance to the emotions of patients, students and teachers in medical training. Although some of the students in our study freely expressed their feelings, they tended to minimise the impact of these feelings and emphasised that they did not need or like to talk about how they were affected, even explicitly stating that emotional reactions are something one just has to get used to. This tension between ‘charged emotional experiences and the detached professionalism that medical students perceive is expected of good doctors’ was reported previously.

Strengths and weaknesses

We adhered to the principles of hermeneutic phenomenological inquiry within a constructivist research paradigm, which afforded rich empirical findings. Although our conclusions are drawn from only one study representing one local context, we think they can inform the work of others. Students in this study were attached to nurses rather than doctors. This may be judged as a weakness in relation to the study’s focus on medical students’ identity development, but we note that students are increasingly offered interprofessional placements, such as attachments to the community or to palliative care units. The first researcher was known to students as a university teacher, which may have limited their disclosure; however, the richness of the students’ responses suggests that the interest we showed in our respondents’ stories empowered them to respond freely.
Implications for medical practice and future research

Most students, as exemplified by ‘Sarah’ and ‘Rebecca’, experience their first interactions with patients and future colleagues as highly positive and interpret them as rewarding and helpful for the development of a professional identity. Others, like ‘Nancy’ and ‘John’, have less positive experiences. Overwhelmed by feelings of uncertainty, they interpret their first patient experiences as fearful and difficult, which may lead them to be unable to deal with their own feelings or to engage in meaningful relationships with others. This may at least hamper the development of an embodied professional identity, but may even lead to detachment and cynicism. As medical educators, we should find ways to identify this group of students and help them to react in more positive ways.

Figure 4 The Participating paradigm. Pauses of $\geq 1$ second are indicated between brackets. Fragments of the transcript that are not displayed are indicated by (edited)
Future research should be directed at the further development of the paradigms outlined in the present study and at obtaining greater insight into the needs of different students. Longitudinal research that follows students through all their transitions, from entry into medical practice, to clerkships and, ultimately, to residency and beyond, may help to establish how these initial paradigms predict future development. As we have suggested, the interplay between the individual and social contexts in professional identity development requires further research. It also seems important to find out more about how students learn to deal with emotions as part of their future professional identity and behaviour.

CONCLUSIONS

This study reveals large differences among students in how they relate to other people and in how they give meaning to their experiences as they enter medical practice. Students differ in their abilities to engage in ward practices, in how they find their roles as medical students and future doctors, and in how they experience and express their emotions. Medical educators should help students to be sensitive to their emotions, offer space to explore and contest different meanings, and, if necessary, suggest alternative interpretations in order to foster the development of desired professional identities.

Contributors: EH, SB, RL and RK contributed to the conception and design of the study, and to the acquisition of data. EH took responsibility for data analysis and served as principal author. SB made important contributions to data analysis and interpretation, and to the writing of the manuscript. TD contributed to data analysis and to the critical revision of the article. RL and RK contributed to data analysis and to the drafting and critical revision of the manuscript. All authors approved the final manuscript for submission.

Acknowledgements: none.

Funding: none.

Conflicts of interest: none.

Ethical approval: not required.

REFERENCES


Received 25 January 2012; editorial comments to authors 21 March 2012, 24 May 2012, 11 July 2012; accepted for publication 23 July 2012.