RESEARCH ONLINE

Current Narratives

Volume 1
Issue 1 *Narrative Inquiry: Breathing Life into Talk, Text and the Visual*

Article 5

1-1-2009

# Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries

Lynn V. Monrouxe
*Cardiff University, UK*

Follow this and additional works at: http://ro.uow.edu.au/currentnarratives

Recommended Citation
Monrouxe, Lynn V., Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries, *Current Narratives*, 1, 2009, 41-59.
Available at:http://ro.uow.edu.au/currentnarratives/vol1/iss1/5

Research Online is the open access institutional repository for the University of Wollongong. For further information contact the UOW Library: research-pubs@uow.edu.au

RESEARCH ONLINE

# Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries

**Abstract**
The successful development of a professional identity is paramount to becoming a successful doctor. This study investigates medical students' professional identity formation over time through the analysis of their narrative accounts of events recorded during their first two years of medical school using longitudinal audio diaries. The data was analysed for underlying narrative plotlines. Six dominant discourses from societal narratives about doctors and medicine were found within the students' narratives: The Privilege narrative, the Gratitude narrative, the Certainty of Medicine narrative, the Good Doctor narrative, the Healing Doctor narrative, and the Detached Doctor narrative. A further two narrative plotlines were identified as emerging narratives that contest master narratives and which are frequently found in the current culture within a modern medical school: the Informed Servant narrative and the Uncertainty of Medicine narrative. Following an overview of these narrative plotlines identified within medical students' audio diaries, a single event narrative is presented in full, in order to provide a deeper understanding of how these are played out as medical students try to make sense of the events they experience and of their own development as a doctor.

This journal article is available in Current Narratives: http://ro.uow.edu.au/currentnarratives/vol1/iss1/5

# Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries

**Lynn V Monrouxe**
**Cardiff University**

**Abstract:** *The successful development of a professional identity is paramount to becoming a successful doctor. This study investigates medical students' professional identity formation over time through the analysis of their narrative accounts of events recorded during their first two years of medical school using longitudinal audio diaries. The data was analysed for underlying narrative plotlines. Six dominant discourses from societal narratives about doctors and medicine were found within the students' narratives: The Privilege narrative, the Gratitude narrative, the Certainty of Medicine narrative, the Good Doctor narrative, the Healing Doctor narrative, and the Detached Doctor narrative. A further two narrative plotlines were identified as emerging narratives that contest master narratives and which are frequently found in the current culture within a modern medical school: the Informed Servant narrative and the Uncertainty of Medicine narrative. Following an overview of these narrative plotlines identified within medical students' audio diaries, a single event narrative is presented in full, in order to provide a deeper understanding of how these are played out as medical students try to make sense of the events they experience and of their own development as a doctor.*

## Introduction

Along with the assimilation of knowledge and skills, the successful development of a medical professional identity is an important aspect of becoming a doctor. Professionals are required to successfully embrace a professional identity for ethical reasons. The internalisation of professional ethics facilitates the process of the self-regulation by professionals (Friedson 1994). Indeed, professional self-regulation can be conceived as a dynamic continuum from individual through to work groups and finally the professional standards bodies (Irvine 1997). Individuals who do not successfully develop their professional identity as a doctor, therefore, can compromise this process. Additionally, professionals are required to develop a strong professional identity for practical reasons. For example, holding a strong identity as a doctor will facilitate individuals to practice with a 'professional demeanour' that enables patients to trust their doctors, and collectively for society to trust the medical profession in general (Freedman & Holmes 2003). So we can see that even if a medical student assimilates the knowledge and skills required of them during their medical training, they will find it hard to be successful as a doctor unless they have also developed their professional identity (Costello 2005).

Developing an identity as a doctor is achieved through the process of *identification*: a two-way, internal and external process whereby we define ourselves (who I think I am) and are simultaneously defined by others (who I think that you think I am) through talk and the use of symbolic artefacts (Jenkins 2008). Identity is embedded in language and interaction, and identification comprises the cognitive and social processes through which we make sense of our world.

**Narrative Identity**

Identities are negotiated as we interact with others, and with ourselves, through sense-making activities. The telling of stories is an everyday social occurrence and is one such activity. Storytelling happens in many ways. From the 'big stories' of our autobiography to the 'small stories' of events that interject ordinary conversations, our stories are the fundamental way in which we make meaning in our lives: recalling, editing, describing, highlighting and evaluating events (Bamberg 2006; Georgakopoulou 2007). Indeed, it has been argued that it is through narrative that we construct our identities both for ourselves and for others (e.g. Diaute and Lightfoot 2004; McAdams 1993; Ricoeur 1992). 'Telling stories configures the "self-that-I-might-be"' (Riessman 2003: 7). Furthermore, narratives are interactively constructed, drawing upon 'the well of past stories and flows into future stories' (Ewick and Silbey 2003: 1343) and always with a particular audience in mind and within a specific context. Thus narratives are produced *retrospectively* from other narratives and *prospectively* for an audience. Therefore, by attending to the way in which medical students narrate their everyday experiences as they negotiate their way through medical school – how they make sense of events from their own personal view of the world – it is possible to gain an understanding of the process of identification and of how aspects of their experiences impact on their successful development of a professional (medical) identity.

The analysis of narratives, however, can take many forms, and researchers who agree on the premise (as outlined above) may be deeply divided on a number of theoretical and methodological issues. Moreover, these issues not only change across individuals, but perspectives can shift within the same scholar over time (Smith and Sparkes 2008). While it is beyond the scope of this article to go into details, I will briefly comment on the perspective adopted here before going on to discuss the research in more detail.

The process of narrative identity formation places an emphasis on identity as *performed*. This performative aspect, whether conscious or unconscious, is continually present. Indeed, Bourdieu (1990) argued that through repeated rehearsal, our presentation of our self is influenced by acquired unconscious patterns of thought and behaviour (habitus). Thus we internalise aspects of our self that we might at first consciously play out. Furthermore, narrative identities are culturally and historically situated and constructed through interaction with other people within institutions and organisations (Jenkins 2008). So the notion of *positioning* is important when we consider narratives and identity: that is, the relationships we adopt through the language we use (e.g., pronouns that suggest a level of commitment, such as *we*, and difference, such as *they*) and the engagement we take up with our social, cultural and ideological worlds. Tied in with aspects of positioning and the process of identity formation is the notion of an individuals' self-agency and how this is inscribed within narratives. So, how individuals position themselves with respect to their relationships with social and institutional

bodies to comply with, or to counter, dominant practices, discourses or master narratives. The narration of these relationships gives insight into the ways in which individuals understand their present experiences through a reflection on ideologies of widely held conceptions of roles and identities (such as what it means to be a doctor) and therefore sheds light onto their evolving interpretation of their new identities (de Fina, Schiffrin and Bamberg 2006).

**The study**

A three-year longitudinal audio diary research project began in October 2005 to consider the following questions: (1) What is the nature of medical students' epistemological talk during medical school? (2) How do medical students narrate their developing professional identity? This paper considers aspects of the second question by focussing on the plotlines identified within medical students' narratives of everyday events as they progressed through medical school.

*The Setting*

The context of this research is a new medical school in England which was developed according to UK policy documents such as Tomorrow's Doctors (GMC 2003). Additionally, the development of the curriculum was informed by educational theory, utilising a problem based learning (PBL) method with a strong emphasis on self-directed learning. Students spend the majority of their first two years of the 5-year curriculum learning at one of two geographically dispersed university sites. Clinical contact begins early in Year 1 and becomes more frequent over time: in Year 2 students are attached to a General Practice (GP) surgery, with periodic day visits throughout the year, during Years 3-5 students are predominately based across five main hospital sites. Ethics approval for this research was obtained from the medical school ethics committee.

*Participants*

An invitation to participate in this study was sent out via e-mail to all first year medical students at the beginning of Year 1. Seventeen students across the two university locations agreed to participate. The students were introduced to the study and the researchers (Lynn Monrouxe & Kieran Sweeney) during group meetings at each locality (see Table 1 below for participant demographics).

**Table 1: Participant demographics**

| | | Male | Female | Total |
|---|---|---|---|---|
| | | 11 (65%) | 6 (35%) | 17 (100%) |
| **Ethnicity:** | **White** | 8 (47%) | 5 (29%) | 13 (76%) |
| | **Asian** | 2 (12%) | 1 (6%) | 4 (18%) |
| | **Other** | 1 (6%) | 0 (0%) | 1 (6%) |
| **English First Language** | **Yes** | 9 (53%) | 5 (29%) | 14 (72%) |
| | **No** | 2 (12%) | 1 (6%) | 3 (18%) |
| **Prior Academic Level** | **A-levels** | 10 (59%) | 5 (29%) | 15 (88%) |
| | **Degree/PhD** | 1 (6%) | 1 (6%) | 2 (12%) |

*Data collection methods*

The process of data collection was as follows: participants were requested to record an audio diary of their experiences (via a freephone hotline that recorded messages, or recorded on a personal Dictaphone provided for participants), catch-up one-to-one interviews were also held once or twice a year and group meetings were held annually. Audio-diaries were used as the primary method of data collection as a way of minimising researcher influence and in order to capture participant's sense-making in action as they told their stories both to the researchers and to themselves (Monrouxe 2009). In order to further facilitate the capturing of everyday sense-making and to enable participants to set the agenda for the content of their narratives we gave them one request: "Please tell us a story about something that has happened to you since the last time you left a message and how it has affected the way you think about yourself now and your future role as a doctor."

Although the frequency of contact differed both across and within individuals, fifteen participants regularly used the audio diary to record messages. Some participants made regular weekly recordings whereas others left longer intervals between recordings, often making more than one recording in a day. One participant withdrew from the study at the end of the first year as he was required to re-take the year and felt unable to continue. However, he was happy for the stories already recorded to be used in our analysis. At the end of the second year, one further participant withdrew as she felt she could not give the time to the study due to work pressures. She also was happy for her stories recorded so far to be used in the analysis.

We defined, a 'diary entry' as 'a recording or group of recordings by any one individual participant in a single day.' Two hundred and eighty four diary entries (comprising over 60 hours of recordings) were made over the first 24 months (15/10/05 to 15/10/07). These recordings varied in length: from 10 seconds, to longer, discursive recordings (up to 27:24) with a mean of 7:58. This data is rich with a diversity of narratives of events that these medical students experienced, providing insights into their ongoing emerging professional identities.

Only the first two years of audio diary data are included in this analysis. All audiotapes were transcribed and anonymised. Following a period of data immersion and familiarisation, coding of plotlines from the audio diaries was undertaken independently by the author and co-researcher Dr Kieran Sweeney. Their codes were then compared for consistency and any differences were negotiated. The data were then comprehensively coded using Atlas.ti (Visual Qualitative Data Analysis) by a third researcher.

## Results and discussion

This section comprises two parts. The first part will provide an overview of the narrative plotlines (narrative types) identified within the data along with brief examples from the audio diaries. Following this, I will present a longer excerpt from a single diary entry to demonstrate how these play out in the narrative sense-making process as one participant talks about his experience at a GP placement which runs counter to his previously held conceptions of what it is to be a doctor.

Six dominant discourses reflecting societal ideologies about doctors and medicine were found within the students' narratives. These are narratives of what it is to be a doctor (or training to be a doctor) that are common in the participants' own culture and the current culture within medicine: (1) The Privilege narrative, (2) the Gratitude narrative, (3) the Certainty of Medicine narrative, (4) the Good Doctor narrative, (5) the Healing Doctor narrative, and (6) the Detached Doctor narrative. A further two narrative plotlines were identified as emerging narratives that contest master narratives and which are frequently found in the current culture within a modern medical school: (1) the Informed Servant narrative, and (2) the Uncertainty of Medicine narrative.

It is important to note that although some participants' narratives demonstrated a propensity for certain narrative types, no one participant used any narrative type exclusively within their narratives. Indeed, with the longer, discursive narratives, frequently more than one narrative type appeared in participant's sense-making process: sometimes complimentary narrative types were present and seemed to back-up the main message within the story, other times opposing narrative types were played out as participants struggled to make sense of their experiences. We will now consider each narrative plotline in turn with brief examples from participants' audio diaries.

### *The Privilege Narrative*

The Privilege Narrative is about being in a privileged position of being a doctor – or doctor to be (Mueller 2006). As participants narrated events they experienced they often marvelled at the trust patients gave them and of the privileged position in society that they were adopting. Rather than taking this for granted, our participants were frequently taken aback by this aspect of their new self. They used terms such as *blessed, lucky* and *honoured*: 'when people share their secrets with you I think you have to look on it as an honour- they're trusting you with something like that … ' (Katie, 14th April 2006).

Participants did not take this aspect of their developing identity lightly, and understood that it was a constantly evolving part of their new position that could be compromised. Indeed, as we see in the following excerpt, some participants realised that 'playing the

part' of a 'trustworthy person' was integral to their developing 'professional demeanour' (Freedman & Holmes 2003):

> [1]I had my placement just over a week ago now which was really good- again I felt very trusted by the patients ... and it made me feel very privileged ... obviously trust is a very important thing in every relationship and particularly in a relationship where- such as a medical relationship that you're having to share a lot of very personal information and often having to do very personal things- such as examinations, it did make me feel very empowered as such and also very responsible- but it also made me very aware that I needed to use this responsibility and use this trust very carefully, because trust is very easy to break down, and then very difficult to rebuild so obviously maintaining that trust and giving patients reason to trust you was very important and I think this is something that has to become more natural because thinking about it too much can- can mean that things breakdown because you're thinking too much about it and over analysing situations, and that means that the patient becomes aware of this and becomes aware that you're uncomfortable and if you seem uncomfortable with that trust then the patient wonders why and then will start to not trust you. . . (Henry, 29th November 2006).

*The Gratitude Narrative*

The Gratitude narrative is about the feeling of gratefulness for one's health (both physical and mental) in the face of illness. Participants' narratives were rife with comments about how others were worse off than themselves in terms of health. Along with gratitude, participants talked about being *lucky* and *fortunate* to be in good health. However, for some, being confronted with illness was, at times, particularly distressing, especially when they felt that there was nothing they could do to help:

> So yeah I had a placement the first Friday back which was at a Special School which was really enjoyable ... it was- I don't know it was quite *difficult* really, I haven't really had very much experience with children with special needs so I suppose it was quite *tough* really in some ways, it was kind of (2.0) don't know, made me realise how lucky I was. . . I just felt like there was something- something I wanted to do but I couldn't really, couldn't really do anything to help them, it was a bit frustrating . . . some of them were quite *profoundly* disabled- communication was very- very difficult, I just kind of stood there and didn't really know what to do which was quite *tough* ... (Danny, 23rd January 2006)

At times, however, participants acknowledged a different perspective. In expressing our feelings of being *lucky*, we are implicitly suggesting the other is somehow *unlucky* and this value judgement might not always be appropriate. Consider this excerpt from Natalie's narrative where she tells us of her encounter with a teenager who had arthritis:

---

[1] Transcription notes: . . . ellipses = edited section; (1.0) = pause (to nearest second); Dash at end of word- = running-on-speech; *italics* = emphasis in talk; ((double brackets)) = additional comments; [square brackets] = general information on anonymised talk

> I suppose it makes me feel quite lucky that I don't have anything wrong with me- but maybe she would feel unlucky not to have it because it would be a different life for her, if you see what I mean (1.0) I don't know, maybe she doesn't feel lucky that she's got it but maybe she would feel different about it if she didn't have it . . . (Natalie, 2nd February 2006).

*The Certainty of Medicine Narrative*

This narrative reflects the ideology of authoritative certainty which characterises the dominant discourse in medicine: the use of medical terminology, objectively describing physical symptoms, and the classifying illnesses within the biomedical model with the doctor (who has medical skills and knowledge) having legitimate authority over moral issues (Mishler 1984). There were many ways in which this narrative infiltrated students' stories, including the objective way in which students talked about patients' bodies. And this objectification began very early on in participants' narratives: 'there was a woman, well a lady who came in who was pregnant- heavily pregnant if fact she's er-er due next week and we were allowed to er- touch uh well feel for the- for *the* fundus of *the* uterus and *the* baby and you could actually feel...' (Andy, 21st October 2004).

Another way in which this narrative played out in participants' audio diaries was the ideology that in order to be a doctor, one must know everything. This caused some students to worry about their own abilities to become such a person. Consider this excerpt from Paul's audio diary as he narrates an event encountered at his GP placement. Note how Paul refers to the patient as *the migraine* – this objectification is intimately tied up with medical terminology and effectively reduces this patient to a biomedical event. Furthermore, his pre-understanding that doctors should know everything lead him to deduce that the GP on his placement is such a doctor:

> ... got me thinking that there's just *so* much to learn and I'm barely scratching the surface of it all as it is- you know being a second-year- and it's quite scary in fact- you know you kind of think "I'm two years in, you know, three years to go- I'll be sorted" but actually there's just *so* much and the GP was- I was fairly impressed by the way he- he kind of knew all the different presentations of every condition that came in- the migraine- all of this- he was very- I mean I know what a migraine was but I- would- I wouldn't be able to tell you exactly all the different presentations that the migraine comes in with and he said "migraine was this, this and that" and then I looked into the into the Cheese and Onion book- the clinical medicine book that I had, and basically every single presentation- clinical presentation that he described was actually in the handbook and you know- that was basically just a 10th of one page of the handbook so, if that GPs knows basically everything in that handbook is quite impressive and its- you know it's almost- it's almost slightly scary- well it is scary- and I'm thinking you know "how am I going to be able to in the future learn absolutely everything- be able to recall it to that depth?" (Paul, 5th November 2006)

*The Good Doctor Narrative*

This narrative is about the idealised notion that all doctors are good and that they should not possess personal qualities (opinions, behaviours, etc) that are negative. Doctors should only have positive qualities (e.g. enthusiasm, precise sense of ethics) and should always be motivated. Furthermore, while there were strong assertions that sometimes these characteristics were innate, generally, they were considered qualities that could be learned. Participants' narratives reflected these notions both in the admiration they held when they encountered *good doctors* and in the shock and dismay they narrated when the doctors they met acted counter to their expectations. Sometimes participants recorded narratives that focused on their own personality 'flaws', how they became suddenly aware of these in light of their new developing identities and how they might address these aspects of themselves. Therefore many participants storied how they were developing these idealised notions of a *good doctor* in their own lives. Consider the following excerpt from Andy. The event he is narrating is his experience during a Special Skills Module during which students are required to produce an oral presentation for their group. However, Andy turns this everyday (general) educational event into an opportunity to demonstrate how, through this, he is specifically learning to become a good doctor. He begins by linking the skills of presenting to an audience, to the skills required of a doctor when explaining to a patient about their illness and treatment options. He then goes on to bring in other skills required of a good doctor, skills that he now claims to be developing:

> I think it's just- I mean it is very difficult- I don't think anybody can ever do it- but to actually be able to listen to a large majority of what's being said I think is a really important duty- a duty and a skill for a doctor to have- you know- because at the end of the day as doctors were going to be seeing things- oh God you know- especially if you're a GP or anything else- you going to be seeing the *same* things over and over again . . . and I think that's essential and it shows you know the difference when you go to see a doctor and he's just an alert and wise- he's quick and he sharp and he's enthusiastic about it- or he can help- or- you know, you've *got* to have that to all your patients otherwise- you know you're dealing them a bit of a shoddy hand really if you're not really there listening- you're just thinking "Oh God you know, it's almost 5 o'clock I can go home after this thank God" you know- I think that's essential, anyway so that's my presentation and certain skills I think- you know- were practiced- and essential to become a good doctor (Andy, 6th January 2008).

*The Healing Doctor Narrative*

This narrative is about the ideological belief that the role of the doctor is to cure the sick. We saw how this aspect of what it is to be a doctor impacted on Danny as he narrated his experience when he came into contact with children who had special needs. Not only was Danny grateful for his own health, but he told us of a sense of frustration as he was unable to help, or even communicate with these profoundly disabled children. This Healing Doctor narrative also provided a tension within participants when patients die, or when there was no clear diagnosis or treatment as is at odds with the idea of living with an illness (Monrouxe and Sweeney, in press). Indeed, of all the narratives

we identified, this narrative appeared to cause tensions within the students' reflections as they tried to reconcile this dominant discourse of the Healing Doctor with the events unfolding before them. We will see an example of this later, when I present the longer excerpt of Rory's narrative concerning his experience of attending a 'checkout call' on his GP placement recorded in February 2007. It seems, however, that for some participants, the Healing Doctor narrative is so culturally embedded that it is extremely difficult to re-story, perhaps because it is one of the key motivating factors that lead some people into medicine.

Consider the following narrative recorded by Rory in May 2006. Within this narrative we get a sense of Rory's personal need for the Healing Doctor narrative to be 'true,' if not now, but sometime in the future. Common with other participants' stories, in this audio diary entry Rory chooses to narrate a personal event that is of great significance to him as he develops his identity as a doctor. Although this is not the focus of the current paper, it should be noted that this aspect of identity formation is important: becoming a doctor necessitates the negotiation of individual's shifting roles within their own family relationships as well as their relationships with peers and society in general.

The following excerpt has been highly edited, for reasons of expediency. What has been edited out is Rory's assertion that, technically, there is a way to re-grow brain tissue (albeit morally wrong). What remains of this narrative, however, is the overarching notion that, for Rory, being a doctor is about healing the sick:

> A major impact on my Easter holidays is that my grandmother is becoming increasingly sick, she's had a series of strokes ... I think she's on the way out ... I obviously haven't told mum this or anything- or spoken to anyone about it- it's just- it's just hollow ... and again bringing it back to patients and things, how do you deal with that when the person opposite you basically describes symptoms of cancer and you know they know they've had the blood in their stool- they've had the weight loss- huge amounts- they've got all their nodes up and you think "this person's got metastatic cancer, there's no way they're going to survive this, I'm talking to somebody who's dying" ... and to be able to have the control over that step would be phenomenal- to be able to treat people and help them and take them from that stage of "look you've got this- this is inevitable" to being able to help them- I mean that would be fantastic- to be able to cure strokes and things ... I could just imagine doing that though, being able to not look at this person and think "that's it you're gone" but to be able to think "that's it right- this is what you've got, we can help you like this" it would be phenomenal, I think that's what medicine is about and that's what's impacted me from ... I think that's the major impact from Easter but I hope it's an impact that goes on through my whole career because that is really important to me- that's what it's about (Rory, 13th May 2006).

Before I leave this section, and this powerful narrative, it is important to note how Rory aligns himself with the medical profession – 'we can help you' – and how that alignment solidifies for him the Healing Doctor narrative as a *truth* to attain, and one that he openly commits to.

*The Detached Doctor Narrative*

The Detached Doctor narrative encompasses how participants feel that they need to, or that they should, separate themselves from their clinical practice. Only parts of 'themselves' should be brought to their work. Their attitudes, opinions and emotions should be detached. This incorporates the notion that this is the right thing to do and that it serves to be self-protective (Madill and Latchford 2005). However, when encountering death, for example, this aspect of a doctor's identity can be contested: even if it is the 'right' thing to do, whether it is desirable is open to question. The following excerpt has been taken from a much longer diary entry by Kath, recorded only 6-months into her medical degree. In this excerpt Kath uses the evocative metaphor of detachment as the summit of a mountain. The full excerpt of Kath's narrative about her first experience of witnessing someone dying is reproduced elsewhere (Monrouxe 2009). However, even this highly edited excerpt clearly demonstrates the difficulty some participants have as they attempt to make sense of events they encounter in light of the current dominant discourses they hold about what it is to be a doctor:

> ... other members of my family who work with death a lot, like they work with patients who are like [disease] sufferers and stuff like that- one of my [family], she's a doctor . . . obviously she sees a lot of people with [disease] and stuff like that and the high mortality rate on her ward, and I see with her, even her she's worked for the best part of 25 years and like- well 20- 25 years [softly laughs] sorry better flatter her, but it doesn't seem to get any easier for her- it's just- it's like as if I want to be climbing this mountain that I'm not sure that I'll ever be able to fully reach the top and, then again would I ever want to reach the top? would I ever want to accept death that much that I'd be so desensitized to it but- I just- wouldn't be totally affected (Kath, 3rd March 2006).

Interestingly, in this excerpt from Kath's narrative we see how she displays a reluctance to develop emotional detachment (and so, metaphorically, join the doctors at the summit). She locates herself away from these detached doctors, appearing to draw legitimacy for this by referring to another family member who is a doctor. She effectively positions herself within this other group of doctors – doctors who accept their emotions within the clinical encounter – and with whom she has an attachment to.

*The Informed Servant Narrative*

The Informed Servant Narrative asserts that the doctor acts predominantly as expert resource, not expert professional, setting out the alternative therapeutic strategies, having framed the patient's dilemma. This narrative clearly comes from early influences at medical school reflecting the new ideology of relationship-centred, rather than doctor-centred, care. Thus it contests the dominant Certainty of Medicine narrative, in which biomedical knowledge is privileged above all other types of knowing. In addition to these aspects, this narrative requires the narrator to consider their own ethical and moral positions, which might run counter to those of the patient. The following excerpt demonstrates how one participant narrated his development towards becoming this 'new kind' of doctor. In addition to his realisation of the shifting role of doctors in society,

this excerpt is interesting as we can see how, after 6 months at medical school, this participant is already developing a strong identification with the medical profession, shifting his opinion on moral issues, and beginning to identify himself as a doctor as he talks about '*my* patients':

> ' ... in making us consider the patients it has also helped me think about myself and how I would react in such a situation- this has meant that several of my values and beliefs, particularly on topics such as abortion have changed dramatically- at the start of the year I was very much against abortion in nearly all situations, however, having considered the many different reasons that people ask for abortions I've become much more liberal towards the subject- and also- understand the patient's right to choice, I was worried that this meant that I had begun to lose my morals, but I now think that I've just changed my opinions and my morals on a subject in a way that's very beneficial to myself and my patients' (Henry, 6th May 2006).

*The Uncertainty of Medicine Narrative*

The Uncertainty of Medicine narrative reflects the way in which doctors of tomorrow are being educated, particularly within modernised medical education curricula. It reflects the culture of students' early years of medical education and contests the dominant Certainty of Medicine narrative frequently found in the clinical environment. This narrative is interesting due to the evolution in society's thinking about the role of medicine and doctors, an evolution moving from deferential acceptance to active consumer-based critique. The uncertainty narrative explores the epistemological basis informing and supporting that role: what comprises knowledge? It requires the narrator to accept uncertainty in both the limits of their own knowledge and in the body of knowledge that medicine draws from. Interestingly, many participants accepted this discourse relatively early on in their studies, only later, when students had more clinical experience, did they begin to question this. The following excerpt is part of a longer diary entry within which Rory narrates his present difficulties around the conflicting messages he is receiving from medical school, family and teachers within the clinical setting:

> 'Right got a genuine medical one for you now ... it was unusual that I'd never thought about how much faith people press on you just because you know more about their body than they do, so you do have to be good at what you do- there is no-you know- no matter how much [medical school] try to convince us that right and wrong don't exist, that even if you know you make the wrong choice- as long as you've tried your best you know there isn't a wrong- you know if you don't have the evidence ... it's hard to explain- they tend to paint a picture of a nice cuddly version of medicine where you try very hard, you should find the right thing and you should get there but it's not right, in the real world people die, if you make the wrong choice or don't actually know what you need to do … ' (Rory, 3rd February 2007) .

*Putting It All Together*

I have presented a number of smaller excerpts from medical students' audio diaries narrated over their first two years at medical school that demonstrate the six master narratives and two contesting narratives identified within the data. These excerpts were highly edited for expediency. Additionally, detailed comments on performative aspects of these narratives have not been possible for the same reason. The full narratives, however, provide a rich and powerful resource through which to consider medical students' professional identity formation at a number of different levels. In order to provide a flavour of this, a significant excerpt from one single event narrative recorded as part of a diary entry is considered as a narrative whole. While continuing to be brief, I will now comment on both structural and linguistic aspects of this narrative in order to bring out salient aspects of Rory's sense-making process. The event concerns Rory's first experience of witnessing a 'check out call': whereby a general practitioner visits an elderly person in decline to assess whether anything can be done to help. I now present a narrative extract lasting 4:23 (the full recording lasts 5:02). At the time, Rory was twenty-years-old and had been at medical school sixteen months. The excerpt has been parsed according to Labov and Waletzky's 1967 narrative framework: a summary of the narrative's essence (abstract), the time, place, people etc. (orientation), the events (complicating action), the speaker's subjective meaning of the events (evaluation) and a return to the present situation (coda, which is absent from the narrative presented).

***Rory's Narrative: the 'Check out call' – 3rd February 2007***

ABSTRACT
1 I wanted to tell you about my placement Tuesday, that's right.
EVALUATION
2 Placement was fine, I love the placements they really show us what medicine is
3 like and what we should be doing which is perfect, I love, love, love doing it,
4 but I had a very- very odd experience that was almost- I've talked about it in
5 Jigsaw and I think I really struck a chord with a couple of people because it's-
6 it's the weirdest thing I've ever sat with
ORIENTATION
7 I went with a doctor and we went to a nursing home on [name] and did what
8 he called a check out call which is where he went into to see this nice elderly
9 lady- she was a bit-she's a bit demented- a bit far gone and he just did a general
10 check- checked her power on both sides, pulses, blood pressure- just generally
11 looked at every aspect, checked in her mouth and everything
(SIGNIFYING SENTENCE)
12 and then he stood back
COMPLICATING ACTION
13 and he turned to the nurse and he said "yeah she's just going downhill" and
14 what he'd done was checked that she wasn't ill- she hadn't had a stroke- she
15 didn't have an infection-
ORIENTATION (WITHIN COMPLICATING ACTION)
16 and they'd- they'd rung up and they'd said "look this woman is going downhill
17 will you come and take a look"
COMPLICATING ACTION
18 and then he went in and just said "yeah, yeah she's going downhill, this is
19 completely natural, there's nothing we can really do, we'll start these couple of
20 meds just so it's painless for her but she'll be dead in a week"

EVALUATION

21 and that was it- that was- that was all he did, he was totally helpless. It was like
22 pronouncing her a week in advance. But it wasn't- it was the way he did it and
23 it was also what it meant. It was total failure. He just looked at her and he said
24 "yeah, that's it" and I don't think I've ever realised that before- I mean I've seen
25 in all the programmes people being rushed with crash carts and things and you
26 know, you know people die but they seem to be fighting right up to the last
27 minute and that's the bit of medicine that I like, the fighting against the disease,
28 working out what it is and stopping it, or at least knowing what it is when it
29 can't be stopped and still rushing to try and help this person as much as
30 possible and just being pipped at the post by- the cancer or whatever. But this
31 was just like standing back and saying "yeah it is a fact, people do die. And it's
32 natural for them to die" and that was- and he just- it was- he's such a chirpy
33 bloke normally and the way he just sort of stood back, stood up and it was
34 almost like dusting his hands and saying "right yeah that's it. Thanks very
35 much for playing but that's time out." It was very, very unusual. I-I don't think
36 I can describe how- what effect it had on me to see- uh- to sort of see death
37 coming but just to bla- to just bluntly say "oh yeah there's nothing we can do
38 about this but, you know, at least we know it's not anything like an infection
39 that we could have done something"

COMPLICATING ACTION

40 and the nurse just sort of nodded as well

EVALUATION

41 as though to say "yeah that's what I was expecting" I mean they must see it all
42 the time but it was just so, so helpless, he couldn't do anything, check the
43 mattress was fluffy- make sure she was comfortable, don't let the nurses- you
44 know- treat her like she's already gone because she's got a few more days left-
45 It was just a total "that's it." And, it was a very weird feeling but I suppose it's
46 something you have to get used to, is the fact that people are gonna die. They
47 do die. It's natural for them to die- and all you do really, is not so much slow it
48 down but, but, well yeah slow it down-[*laugh*] what total crap I'm talking. It's
49 because I don't know how to tell you really what it meant, the sort of sit back
50 and that's it we can't do anything- I- I never want to have to do that to
51 somebody- say "You're just dying. This is it. Your body's finally clocking out."
52 I mean surely there should be something we can do at that point- you know
53 whatever it is. I don't mean finish them off early so it's painful. But, death's a
54 natural part of life in the end isn't it? So, you know, when do you reach the
55 point where we're holding back nature's course? It's a hard decision to sort of
56 make and probably a massive ethical one.

Rory begins his message with a note that this is the last message of the evening and goes on to discuss his GP placement. His opening statement regarding the status that placements have for him is clear: they are a window into the reality of medical practice which is welcomed by the narrator (lines 2-3). Stories about events that happen during placements can therefore be seen as the narrators' sense-making of what it is to be a doctor, and thus have the potential to strongly influence the future practice of the participant. Rory concludes his initial evaluation by announcing that this event was indeed significant to him. He signifies this by announcing it was 'very- very odd' (line 4). Before going any further, Rory legitimises his story to the hearer by claiming that

other medical students in his Jigsaw group[2] also understood the significance of this event (lines 4-5). In telling us this, we know that this is not the first time Rory has told his story; his analysis of the event has already been co-constructed within the group setting of a Jigsaw session. Following a typically Labovian structure, he then goes on to provide an orientation for his story, and as he does so, draws on cultural stereotypes: medical student and doctor, at a nursing home, visiting a 'nice elderly lady' who was a 'bit demented' (lines 8-11). In doing so, Rory omits any association of himself to the action though his lack of pronoun use 'and did' (rather than 'we did' or 'he did': line 7). Furthermore, Rory positions himself as an onlooker to the event (rather than as an active participant) through his use later of the personal pronoun *he* (meaning the doctor) purposively placing the action firmly in the hands of the clinician rather than the student-clinician team.

Rory then utilises a signifying sentence (line 12) as he approaches his telling of the complicating action (lines 13-15). In doing so, however, he provides further background information by way of a second orientation (within the complicated action: lines 16-17) informing us, through the use of direct reported speech (DRP: Holt and Clift 2007), that it was the nurses who had requested the doctor to call. He then seamlessly returns to the complicating action, summarising events through the use of an extended DRP from the doctor, repeating his earlier account, but with the omission of the clinicians' clinical check, and adding a prognosis on the timing of the woman's death (lines 18-20).

Rory then takes his narrative into a long evaluative phase during which he tries to make sense of the apparent failure of medicine to save the woman's life (lines 21-39). What is interesting is Rory's use of DRP throughout this phase. He repeats the same 'event' (the doctor proclaiming that the patient would die soon) using DRP, yet each time the doctors' words change in form from previous reporting: 'yeah, that's it,' 'yeah it is a fact, people do die,' 'oh yeah there's nothing we can do about this.' Each one can be seen as a further sense-making act, with the use of the doctors' DRP to facilitate the notion of truth. Within his evaluative talk, we can see how Rory draws on dominant ideologies of what it is to be a doctor: The Healing Doctor narrative – whereby the role of the doctor is to cure the sick. For Rory, this event ran counter to his expectations. His repetition that there was nothing that can be done (lines 36-38) along with his earlier use of the phrases 'he was totally helpless" (line 21) and 'it was total failure' (line 23) suggests a strong tension within Rory between this dominant discourse and his real life experience on a placement.

At this point of unease, Rory returns to the complicating action within his evaluative talk. With this addition, he brings us full circle by concluding the logical cycle of events within the complicated action: (1) the nurses, worried the patient is in a decline, call the doctor; (2) the doctor checks out the patient and confirms this fear, adding that there's nothing that can be done; (3) the nurse adds her own confirmation to the proclamation of the patient's imminent demise, thus further legitimising the outcome. What is notable here is the lack of a linear temporal structure within Rory's reporting of the

[2] These meetings provide an opportunity for students to share experiences and dilemmas from the clinical setting and to work collaboratively to explore the stories and clarify the underlying issues.

complicating action. This non-linearity suggests a personal tension within Rory and evokes a strong feeling of sense-making in the moment.

Rory ends with further strong evaluative talk. Once again his direct experience of being on this placement and witnessing the event has strongly challenged the validity of his previous culturally derived ideology of what it is to be a doctor as he tries to come to terms with human mortality.

**Conclusion**

Medical students' professional identity formation is a complex process. The solicited audio diary methodology appears to open up new insights into this process, shedding light onto key factors involved in the way medical students make sense of their experiences as they tell their stories to one another and to themselves. From the analysis and narrative excerpts presented in this paper we can make a number of observations, both processual and methodological.

Firstly, on a methodological note, through the use of audio-diaries it has been possible for us to capture important elements of medical students' sense-making processes as they tell their stories both to the researchers and to themselves (Monrouxe 2009). In doing so it is the students themselves who select from the experiences they have and what those experiences meant to them as they decide which story to tell and how to tell that story. In itself, this brings an element of surprise (for the researcher) to the content of participants' stories and the ways in which they are constructed, which in turn has ethical and practical issues. It is beyond the scope of this paper to discuss these in depth and they have been taken up elsewhere (see Monrouxe 2009), the main point I wish to make here, however, is that the stories told by our participants signify important events in their lives as medical students as perceived by them, rather than as a response to prescriptive and directive questioning by researchers.

Thus, the audio diary method gives participants relative freedom to make sense of their experiences: as they try to explain their meaning to another, they simultaneously explore meanings to themselves. Thus we see from Rory's narrative how the audio diary method afforded space for participants to tell their stories without interruption and with key elements of classical structuring (i.e., abstract, orientation, complicating action and evaluation: Labov and Waletzky 1967). Furthermore, aspects of these narratives reveal an element of conversational mindfulness unfolding in a nonlinear manner within this broad narrative structure. Such nonlinearity reflects the spontaneous and recursive nature of sense-making in practice. So we see Rory's narrative contains embedded additions to the complicated action within evaluation talk. Other narratives in our data show recursivity in a number of ways. Capturing this process gives a deep and unique insight into identity formation: this discursive think-aloud process provides unintended, yet profound insights into an individual's sense-making activity.

So we see that prior to their arrival at medical school, medical students appear to hold a number of ideologies derived from society that influence their understanding of medicine and what it means to be a doctor; these include the Good Doctor, Healing Doctor and Certainty of Medicine narratives. As they go through medical school, however, these students encounter events that challenge these discourses: the very discourses that might have brought them to study medicine in the first place and which

will have structured students' understandings of the selves they might be as they developed into doctors. Additionally, during their formal learning within medical school, these students encounter new discourses that further challenge their existing dominant narratives. Indeed, narrative accounts can function as challenges and forms of resistance to master narratives so it is interesting to consider how participants positioned themselves to their ideological worlds. For example, the Healing Doctor narrative was strongly challenged as students came to see that, rather than healing the sick, the role of the doctor seemed to be more about managing illness and ultimately death. Consider Rory's narratives presented earlier. The first brief excerpt, presented to demonstrate the Healing Doctor narrative was recorded by Rory in May 2006, eight months into medical school. In this narrative he firmly aligns himself with the Healing Doctor ideology in strict opposition to the event he narrates. The second, much longer excerpt was narrated by Rory nine months later. Towards the end of this narrative, while he maintains an allegiance to the Healing Doctor ideology, his resistance to accepting the alternative – that doctors manage illness and death, and one day he will be such a doctor – appears to be waning as his discursive positioning takes on less force than before, appearing to be more reflective than defiant.

The way in which participants positioned themselves within their narratives though linguistic forms such as the definite article *the*, and pronouns such as *my* and *I*, gives further insights into their ongoing identity formation. For example, we saw how Andy and Paul (Certainty of Medicine Narrative) positioned themselves with respect to patients through their use of *the* when referring to patients. So, Andy referred to '*the* fundus' rather than '*her* fundus,' suggesting a need for him to distance himself from the person when he is using her as an object for his own learning, adopting an air of clinical detachment. We can also see how participants positioned themselves as active participants in the process of medicine as they identified themselves a doctor (referring to '*my* patients') or when they distanced themselves from certain types of doctors, preferring to use the personal pronoun *I* as a claim to self-agency in their own development (e.g., the excerpt from Kath's narrative; Detached Doctor narrative).

Appreciating that medical students arrive at medical school with understandings derived from master narratives within society about medicine and what it is to be a doctor is profoundly important for those involved in the teaching of medical students, many of whom will have long since developed their own identities and particular discourses of doctors and medicine. Indeed, these medical educationists, many of whom are clinicians themselves, may well have forgotten their earlier struggles against these idealised notions (Coulehan and Williams 2001; Lown 1996). This study has demonstrated that some students do struggle with their future roles in light of new experiences; and these struggles against their inherited ideologies continue during the first two years of medical school (and possibly beyond), having a profound impact on students' identity formation. Educating medical students with sensitivity to these discourses – a sensitivity that for these students some discourses hold a reality that they strive to maintain – is a challenge for educationists. Medical students need space within which to explore experiences which appear to uphold or challenge their understandings of what it is to be a doctor, telling their stories to others, negotiating their meaning, and at times, re-storying medicine and 'the doctor'. Consider Henry's 'Informed Servant' narrative presented earlier. Henry begins by setting the scene for us when he says about the medical school 'in making us consider the patients,' he then goes on to tell us about his

dramatically changing values and beliefs around abortion and the concerns he had that he was losing his morals. However, the core message within his narrative concerns the way in which he was able to reframe his negative 'loss of morals' story into a story of an emergent 'new doctor' – a story of self improvement as he positions himself within his developing identity as a doctor.

One final point I wish to make here is that I have only reported narratives recorded by medical students during their first two years of medical school. However, in order to understand how students negotiate their identities throughout the completion of their studies until they become practicing doctors (and beyond) will be essential if we are to understand more fully how these dominant and contesting discourses are played out in students' narrative sense-making process, and how other potentially contesting narrative emerge as they encounter new and potentially challenging events.

## Acknowledgements

I would like to thank Kieran Sweeney (Peninsula College of Medicine and Dentistry, Universities of Exeter & Plymouth, UK) for his helpful comments on earlier drafts of this paper. I would also like to thank all of the medical students who participate, and who have participated, in this research for giving their time and sharing their stories. Finally, I extend my thanks to the Nuffield Foundation and Support for Science for their financial support for this research.

## References

Bamberg M 2006 'Stories: Big or small: Why do we care?' *Narrative Inquiry* 16: 139-147

Bourdieu P 1990 *The logic of practice* Polity Cambridge

Costello C Y 2005 *Professional identity crisis: Race, class, gender and success at professional schools.*: Vanderbilt University Press Nashville Tennessee

Coulehan J and Williams P C 2001 'Vanquishing virtue: the impact of medical education' *Academic Medicine* 76: 598–605.

Cutting J 2000 *Analysing the language of discourse communities* Elsevier Amsterdam.

Diaute C and Lightfoot C 2004 *Narrative analysis: studying the development of individuals in society* Sage Publications Thousand Oaks.

De Fina A, Shiffrin D and Bamberg M 2006 *Discourse and identity* Cambridge University Press Cambridge

Ewick P, and Sibley S 2003 'Narrating social structure: Stories of resistance to legal authority' *American Journal of. Sociology* 108 (6): 1328–72

Freedman D P and Holmes M S (Eds) 2003 *The teacher's body: Embodiment, authority and identity in the academy* State University of New York Press Albany

Friedson E 1994 *Professionalism reborn: Theory, prophecy and policy* Chicago University Press Chicago

General Medical Council 2003 *Tomorrow's doctors: recommendations on undergraduate medical education* GMC London

Georgakopoulou A 2007 *Small stories, interaction and identities* John Benjamins Publishing Company Amsterdam

Holt E and Clift R 2007 *Reporting talk: Reported speech in interaction* Cambridge University Press, Cambridge

Irvine D 1997 'The performance of doctors: professionalism and self regulation in a changing world' *British Medical Journal* 314:1540.

Jenkins R 2008 *Social Identity: Third Edition* Routledge London and New York

Labov W and Waletzky J 1967 'Narrative analysis' *Journal of Narrative and Life History* 7: 1-38

Lown B 1996 *The Lost Art of Healing: Practicing Compassion in Medicine* Houghton Mifflin Boston

Madill A and Latchford G 2005 'Identity change and the human dissection experience over the first year of medical training' *Social Science & Medicine* 60: 1637-47

McAdams D 1993 *The stories we live by* The Guildford Press New York

Mead G H 1934 *Mind, self and society* Chicago University Press Chicago.

Mishler E G 1984 *The discourse of medicine, dialectics of medical interviews* Ablex Publishing Corporation Norwood, New Jersey

Monrouxe L V 2009 'Solicited audio diaries in longitudinal narrative research: a view from inside' *Qualitative Research 9*: 81-103

Monrouxe L V and Sweeney K (in press) 'Contesting narratives: Medical professional identity formation amidst changing values' In Pattison S, Hannigan B, Thomas H, and Pill R (Eds.) *Emerging professional values in health care: How professions and professionals are changing*

Mueller C B 2006 The privilege of caring: An open letter to medical students everywhere' *Bulletin of the American College of Surgeons* 91 (5) 20-21

Ricoeur P 1992 *Oneself as another* University of Chicago Press Chicago

Riessman C 2003 'Performing identities in illness narrative: Masculinity and multiple sclerosis' *Qualitative Research* 3 (1) 5-33.

Smith B and Sparkes A 2008 'Contrasting perspectives on narrating selves and identities' *Qualitative Research* 8 (1) 5-35