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Analyzing the Construction of the Medical Professional Identity: How Do Doctors Learn to "Do Doctoring?"

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ANALYZING THE CONSTRUCTION OF THE MEDICAL PROFESSIONAL IDENTITY: HOW DO DOCTORS LEARN TO "DO DOCTORING?"

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I. Abstract

This study is a qualitative analysis of how primary care physicians within the first five years of practice after residency construct their medical professional identity. An open-ended interview schedule was used to collect data which revealed the main themes of observational learning, dealing with uncertainty, and the importance of communication and education in patient interaction. Each doctor's professional identity was ultimately a refined version of the image they attributed to doctors as a lay-person.

II. Introduction

Situated at the crossroads of innovative science and community service, medical providers have always experienced a unique demand to integrate the empirical with the intimately personal. The medical field requires members of the brightest academic and technical caliber who also retain the ability to mentor, educate, and treat the patients entrusted to them. The current culture in American medical schools does much to socialize its students beyond the academic knowledge expected of them; the environment of the medical school forges medical students into technically sound physicians while also introducing them into the hierarchy and traditions of medicine.

However, research has found that the current curriculum and attitudes within medical schools pays little attention to creating an environment which encourages open discussion about the stresses and emotions associated with a medical education. Students are expected to process and filter inordinate amounts of knowledge that even their professors acknowledge they will never retain all of, yet uncertainty is taboo and considered a sign of incompetency (Martinez, 2000, Beagan, 2001, Lingard, 2003). This stigmatized uncertainty, combined with a demanding workload and long hours, prompts students to disengage from both their emotions and their

patients (Madill 2005, Lingard 2003). Detachment can ultimately lead to dehumanization of the patients. Though medical students report guilt over this dehumanization, there are few or no resources available for coping with this guilt and other emotions. Indeed, historically medical professionals are trained or socialized to ignore their emotions rather than cope with them.

Although there is a significant body of valuable research already completed on the socialization experiences of medical students and residents (e.g. Becker 1961, Nuala 2003, Lopez and Dyck 2009, Began 2001) there is an apparent lack of research focused on doctors already in practice. The purpose of this study is to address this gap and identify and analyze the ways in which practicing doctors construct their professional identities. In order to examine this issue, I will draw on a series of semi-structured interviews with new doctors and focus on understanding the *continued* socialization of recently licensed doctors.

III. Literature Review

The following literature review describes some of the existing work on the socialization processes within the medical field. Because the majority of research conducted on medical socialization centers on medical students and residents, I focus on these accounts. I will begin by giving a brief overview of how modern medicine evolved and how this process cast the medical professional as an affluent, Christian male. I will then discuss the role of the university as the major socializing agent. I will focus on the tools it uses to transform lay-people into developing medical professionals and how it teaches these professionals what their expectations of their medical experience should be. The purpose of this literature review is to highlight the mechanisms of socialization in medical students and identify what they are being taught. This background will allow me to see how medical students learn their roles, what they learn, and how they come to understand themselves as student doctors. I will use this as a base to compare

and contrast these student-stage processes with the professional-stage processes I observe as I interview doctors.

The Making of a Profession

Bullough (1966) discusses the history of medicine in Medieval Paris and the factors which influenced its path to acceptance as a profession in *The Development of Medicine as a Profession*. Fifteenth century physicians were expected to project an image of honesty and authority through clothing and other adornments, which sociologists refer to as "symbols." This unified the appearance of the group, which was distinctly male, and made them easily recognizable as professional physicians.

Bullough (1966) also states that the establishment of a preliminary code of ethics was another major element of the maturation of the profession in the medieval era. Physicians were expected to be polite, pleasant, and concise during patient contact, with treatment being the only focus of interaction. They were instructed to establish rapport by maintaining patient confidentiality and exert authority by overstressing the consequences of straying from the physician's orders. The codification of ethics was prompted by self-interest and the need for a professional image to present to the public, which distinguished them from midwives, surgeons, apothecaries, and other healthcare providers. Bullough (1966) explains that this image was necessary to legitimize the group in a time when blood-letting and other grotesque practices were medical commonplace; it was in the physician's best interest to establish trust to convince patients of the necessity of these painful procedures.

As physicians gained authority in both medicine and society, medical faculty turned to the papacy to prevent the practice of "ignorant medicine." As such, the pope pushed other

officials to ensure that every practitioner was approved by a council of the medical faculty and the university. Notably, this established the faculty and university as the major agents of medical socialization, assigning them the authority to dictate what exactly a medical professional looked and acted like. Sanctions were enforced primarily on practitioners who fell outside the accepted, organized groups (i.e. those associated with the acting medical faculty), ostracizing them into "quacks" and defining them as incompetent. Through this process of othering, where the doctors reproduced and reinforced inequalities between groups (Schwalbe 1996), physicians—and their sanctioning institutions—created a cohesive identity and stronger bond.

Bullough (1966) also notes that because medical training occurred within the context of the university, it situated medical professionals near other power groups such as high clergy and lawyers, who came to view one another as equals and allies. Medical faculty succeeded in requesting legislation that mandated competency evaluations (by the master surgeons of the city) for the various subsets of medicine, particularly apothecaries, as the physicians were dependent upon them for drugs. Limits were also set on the types of drugs apothecaries could dispense. As much of the enforcement for the legislation regulating medical practice came from the Christian papacy, non-Christians were increasingly excluded from the medical profession.

In all, Bullough (1966) identifies six factors that shaped the development of medicine as a profession: the accumulation of an elite body of technical knowledge and utilization of Latin as a technical language, the institutionalization of said knowledge, the guarantee of exclusive rights to practice medicine, promulgation of a new codes of ethics, an increase in socioeconomic status, and the recognition of medicine as a high status occupation that members incorporated into their self-identification. These factors were facilitated by the university, whose governing role over

the profession had, and still has, the most significant impact on the socialization process of medical professionals (Bollough 1966, Becker 1961).

Becoming a Doctor

Expectations of the Medical Education

Interestingly, relatively little has changed in medical culture since the profession was established as a legitimate profession and medical schools became substantial institutions. Individuals still view physicians as all-knowing, authoritative figures. Physicians can trace the root of their authority to their medical knowledge; this is one thing that distinguishes them from the rest of society, and society regards their medical knowledge as a commodity which their health and proper function relies upon. In his classic study of the medical school experience, Becker (1961) notes that students bring their preconceptions of doctors as omniscient practitioners with them into medical school and expect to learn everything that is presented to them so that they may fulfill this role appropriately.

This notion of what a physician should be, however, is challenged as students progress through their medical education and negotiate how to best allocate time and effort to academia as they quickly realize that it is impossible to absorb everything they are being taught. Becker (1961) observes that the students consult each other in determining how to utilize time and energy and, together, assign value to the various intellectual tasks before them. During this process, students move away from their initial belief that in order to be a competent physician one must know everything to accepting that mastering everything that they are taught is impossible.

The Role of Medical School

The university, and by extension medical school, actively socializes students by guiding the development of their professional identity. George Herbert Mead (1934:158) theorizes that as individuals assimilate into new professions, they create identities based on the shared values, rules, and beliefs of the professional group. Coover and Murphy (2000:125) point out that these identities are constructed and continually recreated as individuals becomes aware of how they are defined by others and how they define themselves. Participants are actively engaged in this process as they choose to display qualities that they believe will help them succeed and avoid qualities they believe will be detrimental within their professional realm (Baumeister and Muraven 1996:405). In his classic study of the medical school experience, Becker (1961) asserts that not only is the "professional" role one of the most coveted statuses in society, but that it is a *role* which individuals must learn to *act* appropriately.

As illustrated at the outset of this literature review, historically medical school has been charged as a major agent of socialization for new doctors and prepares them by providing them with the bare scientific knowledge and skill necessary for clinical success. Becker, however, argues that one does not assume the identity of physician until they have become initiated into their role within the "drama of medicine." Becker uses this metaphor to illustrate that the practice of medicine is a coordinated act, a theatrical production of sorts, in which each "actor" learns their role and "plays" it according to a social script. In his 2003 study of the professionalization of medical students and residents, Nuala presents a similar argument. He asserts that students go beyond merely acting out this role and, instead, come to completely assume and embody it. Nuala (2003) asserts that although the medical community is becoming more consciously aware of their professional identity as a whole, it still does not sufficiently prepare its students for the active process of doctoring. He explains that the current focus of medical school lies almost

entirely on how to make diagnoses and practice scientific medicine; there are no classes teaching the actual *practice.*

Nuala suggests that this historical absence of the interactional clinical element of doctoring in medical school is addressed through role modeling and observational learning. He points out that as biomedicine became the professional standard, those within the field assumed that medical school admissions criteria were sufficient in selecting physicians of proper character (i.e., students with effective communication skills and moral standards). It was assumed that students entered medical school already possessing the full range of intellectual and interpersonal skills necessary for doctoring. However, the increasingly scientific nature of medicine complicated the moral and ethical issues surrounding it, and new doctors were provided no direct guidance in negotiating these emerging issues. The emergence of biomedicine also shifted the predominant criteria for admission toward intellectual capability with little regard for the capacity for appropriate relationships with patients.

Nuala (2003) advocates a renewed focus on medicine as an apprenticeship, where students actively participate in their learning and help to create the values and standards of the community. He asserts that standardizing this type of professional socialization will increase individuals' dedication to the community and promote longitudinal learning. It also has the potential to foster stronger professional relationships and encourage collaboration, which can benefit both the physicians and the patients.

In fact, Lopez and Dyck (2009) assert that the current teaching styles and expectations of medical school can be so intense and overwhelming as to actually de-professionalize the student doctors. The authors researched clinical settings to examine the relationship between empathy and professionalism. They discovered that rotations demand so much of the medical students that

they crumble under the pressure; students fail to adhere to professional standards of patient interaction because they have too many other expectations to meet. The scientific element of medicine does not necessarily lend itself to the intimacy of clinical interaction, and Lopez and Dyck (2009) illustrate that the severe time demands of medical school and residency make these arenas insufficient for developing the empathy that is necessary for medical practice. The time constraints that are such a familiar aspect of medical students' experiences have been observed to lead to a decreased willingness to be helpful, and though students are instructed to be compassionate and caring providers, the overall experience of their education strongly promotes desensitization and detachment.

Lopez and Dyck (2009) also note that after graduation, students frequently vocalized how instances of abuse and the traumatic nature of the medical education contributed to their cynicism about their upcoming years in practicing medicine. They report feeling as though they were forced to choose between being a patient advocate and assimilating into their clinical teams, a choice which left many feeling weak and personally defeated. As cynicism developed, ethical erosion occurred. This is not to say medical students are all destined to be cynical, emotionless, unscrupulous doctors, only that the environment they are educated in increases this likelihood.

Lopez and Dyck (2009) argue that it is crucial that attending physicians commit to modeling positive virtues for their medical students, who are extremely impressionable in the midst of taking on a new set of roles. Specifically, they encourage prioritizing personal reflection and creative narratives so that students do not lose sight of the empathy that is integral to successful patient interaction under the pressure of their immense workload. Additionally, they advocate overt humanism and empathy training throughout medical school and residency to

prompt students to incorporate these characteristics into their professional identities. Lopez and Dyck (2009) explain that students who are able to have healthy interactions with patients (as well as other members of the medical community) are more likely to have higher job satisfaction and a more positive personal image and self-concept, which will lead to a healthier overall medical experience for everyone (Lopez and Dyck 2009:663).

In examining other facets of the socialization process of medical students, Madhill (2005) focuses on how students progress through their identity development and transition from lay-person to medical student. According to Madhill, a key aspect of this identity shift is the student's acknowledgement of themselves as student doctors outside of their academic community. In other words, by the end of their first year of medical school, their doctor self had begun to replace other primary identities suggesting fundamental changes in their self-concept.

Notably, Madhill explains that cadaver dissection is the first step in bringing about this identity shift. The cadaver lab marks the first time the student is allowed, and expected, to merge their scientific knowledge with a *human* element. Adding this human element catalyzes the student's shift from researcher to doctor. Involvement, emotional coping, and ability were the three factors the medical students considered most relevant to cadaver dissection. While students generally described themselves as coping excellently with their stresses, closer reflection revealed that they still reported detachment and suppressing emotions, and many medical students are left without resources to aid them in coping with the overwhelming stress associated with their education.

Dealing with Uncertainty

To enter the medical profession and begin the process of developing this new self is to immerse oneself completely into a distinct subculture. For example, Beagan (2001) illustrates

this process in her research on third year medical students in Canada. She explains that medical students underwent a conscious, active struggle to assimilate into the affluent, white, male culture of medicine. In most cases, she acknowledges this transition came at the sacrifice of the student's personal life, and in some cases, dignity. Beagan acknowledges that due to the strong dominance hierarchy within the discipline, students virtually never challenged or corrected their superiors, even when there was risk of harm to the patient. This would be the ultimate violation of norms regarding social interaction in the medical world.

Pressure to conform was observed in the realm of appearance; there was a perception that dressing professionally equated to competency. Indeed, attire, terminology, and other elements of role play (Bollough 1966) were significant factors in socializing oneself into the medical professional identity. Students acknowledged they often felt like frauds but felt the need to maintain the outward image of a confident, knowledgeable doctor, both to patients and peers. These tokens of authority seemed to contribute to that image.

Uncertainty is an unavoidable reality of practicing medicine, yet it is predominately viewed as a sign of weakness and incompetency within the broader context of society, Western science, and, in particular, within medical education settings. Lingard, Garwood, Schryer, and Spafford (2003) conducted a two part-study of case presentations to analyze how student doctors are socialized into the language of case presentation and the subsequent effect on the development of professional identity. They assert that the language medical students utilize when presenting patient cases to attending doctors indicates how each student handles uncertainty. Further, they posit that a central element of the acquisition of the medical identity is learning to professionalize uncertainty and manage it in useful, ritualized ways.

Lingard et. al. (2003) identified two main attitudes toward uncertainty. The first was a student orientation, where uncertainty must be masked at all costs, and the second was a doctor orientation, where uncertainty was accepted as unavoidable and manageable. As students mature into their professional identity, they transition into the later orientation where uncertainty is accepted and managed. This transition occurred as students were socialized to overcome uncertainty by recognizing it and utilizing it in the overarching effort to project the certainty which is demanded of them; they assumed the image of the medical professional as they learned to "do uncertainty" in certain terms.

Timmermans (2001) argues that practicing medicine is inherently uncertain due to the ever expanding nature of medical knowledge. While uncertainty in the medical setting is unavoidable, it is reducible. Physicians, no matter which stage of practice they are in, will never be able to have all the answers, but Timmermans (2001) asserts it *is* possible to equip them with more reliable methods of acquiring these answers through the use of evidence-based medicine. When used properly, evidence-based techniques function as a tool for fighting uncertainty and keeping abreast with the perpetual surge of new medical knowledge. Conversely, residents have also reported evidence-based medicine as an additional source of uncertainty, seeing research as yet another source of variation to be managed and yet another skill set to acquire.

The Role of Professional Interaction

Professional relationships of any nature can serve to influence the development of the professional identity. We can observe this happening through interactions such as those between physicians and nursing staff. Barrow, McKimm, and Gasquoine (2010) observed novice doctors actively constructing their professional identity by attempting to garner the authority they consider to be inherit to their position; they did this by exerting control over the nursing staff.

The researchers interviewed a sample of residents and nurses to analyze the relationships and power dynamics within this team. They discovered that doctors and nurses still interact in accordance with a hierarchy which places doctors decidedly above nurses, though neither group was able to present a consistent, coherent description of either group's identity.

In the realm of patient interaction, Allsop (1998) references a trend toward patient-consumerism and identifies its role in shaping doctor-patient interaction, paying specific attention to written complaints over medical care. This marks a significant shift from the previous paternalistic model of medicine. As patients began to view their medical treatment as more of a commodity, they began to be more critical of their medical experience. Drawing from the findings of three studies, her team found that complaints were generally received as direct threats to the authority of the doctor and the autonomy of the medical profession. The complaint then forced the doctor to revaluate his or herself as a professional and often was perceived as a challenge to their technical, medical knowledge. This threatened the physician's professional identity because it directly challenges the cultural archetype of doctors as all-knowing, authoritative figures. Interestingly, Allsop (1998) notes that having a complaint filed against oneself served as a strong bonding experience to other doctors within the same practice; it functioned to unify colleagues and rally them to support their peer in his or her time of stress and uncertainty.

Consequences of Socialization

Martinez (2000) acknowledges that the assimilation into the medical professional role triggered a reprioritization which favored institutional and organizational outcomes. In his book on the widening gap between the priorities of healthcare professionals and healthcare institutions, he comments that historically medical providers used their roles as doctors to

distance themselves from their patients, creating an "artificial person" who acted only in the interest of the institution. One consequence of this is that students and professionals reduced delicate patient interactions to impersonal learning experiences and disregarded patient emotion. Furthermore, students revealed discomfort and guilt over this occurrence, but had no outlet for redress or reflection. Taylor (1991) attributes this moral decline to three factors: excessive individualism in contrast to social commitment and value, institutional and technological restriction of choice, and dominance of instrumental reason. Essentially, institutional values demanded a standard of care that disadvantaged patients by socializing doctors to be unreceptive to all their needs and concerns.

While researching methods for improving the socialization process of developing medical professionals, Clandinin and Cave (2008) prompted family medicine residents to create weekly parallel charts about their clinical interactions and discuss them biweekly in group setting. They assert that the creation of pedagogical space, in which developing doctors have the opportunity to share and analyze their experiences, enhances the contemporary development of a medical professional identity in the areas of caring and empathy. The researchers placed an emphasis on the significance of active inquiry into the elements of temporality and personal and social factors in each peer's experiences in order to cultivate a deeper personal value.

The residents came to acknowledge that engaging in personal dialogue with their patients contributed to better overall care. This mediated the effect of their own personal beliefs and refocused the doctor to the uniqueness of each patient's situation. It also kept the doctor engaged in their practice while prompting them to integrate the value of their own life experiences into patient care. An increased focus on a pedagogical approach would also mitigate the stresses of

medical school experiences such as anatomy lab and dissection. However, this approach sharply contrasts the traditional socialization occurring in medical schools.

Gender and Socialization

Still, not all medical students experience socialization identically. In particular, gender plays a significant role in this process (Campbell 1973). Her case study of women in medical school revealed that women face significant discrimination in their medical education. Like a number of other professions with social status, medicine has long been a "boys club", as demonstrated in Becker's *Boys in White* (1961), and only in recent decades have women begun integrating the community (Campbell 1973). Campbell notes that as women enter the medical community, they encounter four main categories of discrimination: *baiting*, where male students and faculty make comments intended to incite and annoy female students, *belittling*, where women are directly told their place is not in medicine but in the home, *hostility*, where comments and actions are direct expressions of anger (for example, an attending ordering a female medical student to sweep a room, stating he finally found a use for female medical students), and *backlashing*, where male students directly challenge any perceived expressions of feminism.

She observes that men appeared to use discrimination against their female peers as a bonding tool to strengthen their own group strength and identity. Female students used several strategies to cope with this discrimination. First, they seek out other women experiencing similar difficulties and band together to provide each other support. They also respond with direct displays of anger, or conversely, engage in protective denial, where they deemphasize the level and effect of the discriminatory behaviors. While the demographic of the medical professional education has changed rather dramatically since this book's publication, with women now

composing approximately half of the physician population, these behaviors have not disappeared.

Tying It All Together

The majority of existing literature argues that while the current traditions of medical socialization produce very competent doctors who present themselves in very authoritative, certain manners, they leave significant room for improvement in the development of empathy in caregiving. These traditions teach students to view patients as cases rather than humans and offer little support in dealing with stress and death and provide little guidance for managing uncertainty and negotiating the nuances of medicine as an interactive profession. In the current study I engage and expand the research reviewed here by interviewing newly practicing doctors to examine how they are socialized into their professional roles, which agents are doing the socializing, and how this may differ from the socialization that occurs throughout medical school. I am interested in examining how these lessons translate as new doctors begin to practice; specifically, I want to see how these individuals continue to construct their medical identity and "do doctoring" in a professional setting.

Newly licensed doctors in the process of establishing new practices or integrating themselves into existing ones are still readily pliable to the socialization process. They are in the process of learning how to practically apply their academic knowledge and as such are often open to guidance and suggestions from medical peers. As they interact with others in the field, these relationships directly mold what kind of doctor they will be.

IV. Methodology

As illustrated in the previous section, there is an abundance of literature on the socialization process of medical students, yet little research can be found on the socialization process of practicing doctors. In order to address this gap, I asked the following research questions:

- How does the socialization process for practicing doctors differ from that of medical students and residents?
- How do new doctors construct their professional identities?
- Which individuals and institutions influence how doctors construct their professional identities?

Broadly, there are two potential methodological approaches to answering these questions. The first is a quantitative analysis of doctors' attitudes and experiences using a survey instrument. The second is a qualitative approach involving observing or interviewing doctors. I chose to design a qualitative research study and interviewed local physicians using a semi-structured, open-ended interview guide. This study received IRB approval on May 5, 2011. Broadly, the interviews focused on who doctors were learning from, what they were learning, how prepared the doctors felt upon leaving medical school, how the doctors interact with other medical professionals, and what doctoring means to each individual (reference appendix A). Most interviews lasted approximately one hour, though they ranged from 45 minutes to an hour and a half. I chose this more ethnographic approach for several reasons.

First, I attempted to focus more on strength and depth of analysis rather than broad, generalized findings, and qualitative research was best suited for this sort of design. I also noted that I had to take into consideration the scope of a thesis research project and the limitations of resources- it was not feasible for me as an undergraduate to spend countless hours conducting and transcribing a large number of interviews.

Second, the nature of my research questions was descriptive rather than statistical. Warren (2010:5) states that "while quantitative research can capture important statistical relationships…it is not well adapted to interpretive or social constructionist understandings… many aspects of social life can only be illuminated using qualitative approaches". A well-constructed survey could have provided me with an overview of the socialization processes of doctors, but it would not have allowed for in-depth exploration. The inductive quality of qualitative research (Warren 2010:9) is well-suited to analyzing socialization processes because it allows the respondents to paint a realistic picture of their interactions rather than asking them to fit them into pre-established categories. Similarly, it was important to leave all interview questions open-ended so as to prevent myself from unintentionally shaping participants' answers to fit my initial expectations. By leaving questions open-ended, the doctors were able to tell me their stories, rather than confirm or dispel what I expected their experiences to be. This approach allowed me to explore unanticipated themes, such as doctors' roles as educators, but also drew me away from other topics I anticipated exploring such as sexuality in medicine.

Third, I wanted to cultivate a vivid picture of the professional identity of a defined group. The qualitative interview allowed me a unique opportunity to understand the process of how this professional identity is created. Young states:

> The personal interview is penetrating; it goes to the 'living source.' Through it the student…is able to go behind mere outward behavior and phenomena. He can secure accounts of events and processes as they are reflected in personal experiences, in social attitudes. (as quoted in Platt 2002, quoted in Warren 2010:128)

As I was interested in understanding how doctors create their own professional identities, it seemed logical to question them directly rather than observe it from an outside perspective, where I may misinterpret interactions. At the same time, I recognize the unavoidability of social

fictions when using an interview design (Warren 2010:8) and understood that I was only capable of reporting the stories communicated to me rather than seeing the actions behind these stories. This phenomenon came into play particularly as I observed doctors idealizing their patient interactions.

Sample recruitment

To participate in this study, participants needed to meet two specific criteria: they must be practicing in the primary care fields and they must be in their first five years of practice after residency. I chose to seek out primary care doctors because I anticipated the highest likely levels of participation; primary care physicians tend to have more regular, predictable schedules, versus the constantly on-demand nature of more specialized fields. I also expected to gain a more unified picture of socialization from this sample. I reasoned that specialists may have had more intense socialization experiences, but these experiences would likely vary from specialty to specialty and thus be less generally applicable. I chose newly practicing doctors because I was interested in analyzing how the professional socialization of practicing doctors differed from the socialization of medical students, and new doctors were more likely to both be able to recall their medical school experiences and still be actively engaged in the socialization process.

I began recruitment of this sample through my advising professor, who put me in contact with two physicians she knew personally. These physicians then put me in contact with some of their colleagues, and through this process I was able to gather a snowball sample. I also worked to create a recruitment letter and flyers, which I distributed to local clinics. Cold calling proved to be more difficult than I expected. I visited local clinics and approached receptionists to ask if they would pass my recruitment flyers onto the doctors. While receptionists were generally

amicable and agreed to help me make contact with the doctors, none of these cold-call doctors actually responded. I also spoke with a public relations coordinator in the Wheaton Franciscan organization with the hope that she would be able to pass out my recruitment tools to local doctors more efficiently, but this effort yielded no participants either. As such, all of my data is the product of the snowball sample technique. Generally, I would interview a doctor and, at the conclusion of the interview, ask if they felt comfortable speaking with their colleagues about also participating in my study. The doctor would then email my recruitment letter on to their colleagues. I found that I was most successful in securing participants if I asked to be copied in the initial email and then followed up approximately a week later to ask if each prospect was interested in scheduling an interview.

In all, I recruited five doctors, three male and two female. There were two family practice physicians, an emergency room physician, an internist, and an anesthesiologist. Though anesthesiology does not fall directly under my recruitment requirements, the nature of this particular field of medicine blended well with my intended research sample, and the specific participant was recruited via snowball sample. All five participants were married and four of the five had children. Interestingly, three of the doctors directly acknowledged having ties to small-town communities. Experience in practice ranged from minimal (Albert Hawk was still in the process of finalizing his employment) to four years. Pseudonyms were used to protect participants' confidentiality.

Because I was not offering any compensation for participation in my study, I made it a priority to make participation as simple and hassle-free for each doctor as possible. I quickly discovered that I was able to cover all relevant topics in the first hour-long interview, and doctors were more apt to participate in my study when they were only asked to make one hour-long

commitment. I also made a point of conducting the interviews wherever was easiest for them; this generally meant in homes, cafes, and parks. While this appeared to help entice doctors to consent to volunteer their time, it also became a challenge as I began transcription. Each interview was digitally audio recorded, and some of the locations doctors chose proved too noisy and made dialogue difficult to hear. I completed transcription manually on my personal computer and used ExpressScribe software to slow down the recorded dialogue to a rate at which I could comfortably type.

Coding and Analysis

After transcription, I began line-by-line coding each interview, following Charmaz's (2010) grounded theory approach. Grounded theory is an interpretive process by which qualitative data is collected and analyzed simultaneously. Codes are drawn directly from the data rather than preconceived hypotheses, and memo-writing elaborates upon these codes to develop theory. Uniquely, grounded theorists draw samples aimed toward theory construction (rather than population representedness) and advocate conducting literature review only after analysis has been completed in order to prevent researcher bias (Charmaz 2010:5-6).

Charmaz advocates line-by-line coding to "separate data into categories and to see processes…[and help] you to see actions and [identify] significant processes" (Charmaz 2010:51). I modified this process slightly, coding each action, rather than each line. While this generated slightly fewer codes, the codes that emerged were more directly useful. I followed Charmaz's suggestion to use gerunds as codes in order to keep my analysis action focused rather than descriptive. I then pooled the codes from each interview into a large list and grouped them by theme. This allowed me to pull out two major themes from my data: transmission of the

professional identity and transition through stages of uncertainty. Communication was a major factor in both of these themes. Rather than memo-ing each theme individually, I began one broad free-write that addressed each topic in turn. I used this free-write to generate an outline of my findings, which I referenced as I wrote my results and discussion sections.

V. Results

Acquiring the Professional Identity: What Doctors are Learning

Many of the physicians I interviewed acknowledged that when they recalled their lay-person view of a doctor, they specifically thought of a family practice doctor, whom they characterized as someone "intelligent, caring, [and] problem solving" and "very calming" yet still "someone with authority, a lot of information, professional." This doctor is someone everyone knows, someone "very involved in the community [who was a leader], someone you look to give advice." Although most doctors interviewed talked about how this view of what a doctor is evolved over their journey through medicine, these initial qualities reappeared as they discussed what they believed made a doctor effective.

Doctors tended to idealize their view of "doctoring"—the personalized style and strategies each doctor uses in clinical interactions—based on their childhood and pre-professional interactions with medical professionals. Robert Wilson explains:

> I had a friend I went to college with who became a physician ahead of me. And while I was thinking about becoming a physician I would go shadow him and spend a week with him…watching him in his clinic. I had the mindset that this is what I want to do and this is what a physician should be and that's who I became [and] that's still my ideal of an effective physician. I wanted to learn from someone I respected quite a bit in that setting.

He further idealizes the profession later in his interview, saying that "we are a combination of scientist and pastor…we know the science, we learn human behavior, especially in a primary practice setting."

However, this initial reverent view is challenged through medical school, as the developing doctor struggles to live up to an impossibly high standard of knowledge. As they gain experience and learn to utilize tools, a modified concept of knowledge becomes one of the predominant characteristics of what makes a doctor effective. Darla Meyers recalls "I remember thinking that doctors had all the answers…that's how I saw medicine back then." Though she described how her understanding of doctors as intellectual authorities shifted throughout the interview, she still described her mentors as people who were "so knowledgeable [who have been] doing it so long and [continued] to keep their knowledge sort of new and fresh and…educate themselves". Even though she understood that it was impossible to know everything, Meyers still reinforced her initial views of doctors as she chose her *most* knowledgeable peers as her mentors.

Acquiring the Professional Identity: How Doctors are Learning

General society emerges as a major socializing agent in the construction of the physician's professional identity as we realize that doctors model their practicing style on modified pre-professional concepts; in other words, doctors in this study wanted to embody the characteristics of doctoring that they grew up emulating. In this study, many of the doctors cited small town values as they discussed their concept of a doctor. Maggie Andrews considered her cousin, a rural family doctor, an example of the prototypical doctor:

> When I think of him, I think of him being very calming. He was always touching people and you'd see him in the grocery store and the doctor's office and just walking down the street and that's kinda my little idealized version.

Andrews, along with the other doctors, valued and emulated these benevolent, reassuring attributes, which function as a building block of the professional identity which each doctor's experiences in medical school, residency, and practice will refine. The physicians also spoke of rejecting characteristics that hindered doctor-patient communication. Robert Wilson illustrated this, describing an ineffective doctor as

> "someone who doesn't visit with the patient, doesn't take at least some time to talk to the patient…someone who's staring at the computer screen, doesn't look at the patient. [I think] the most ineffective doctor is a doctor who doesn't care, because if you don't care the patient knows that and they won't care either."

Here, a disconnect becomes apparent within the medical education, which Albert Hawk distinguished as a differentiation between "book learning and clinical training". He explains that he "met those people [in] residency that were amazing- they were an encyclopedia of knowledge. But when you let them interact with patients, they [couldn't]" (Albert Hawk). This disconnect (and ensuing inadequacy in patient interaction) is the product of a vocational education which heavily emphasizes the sciences yet places little importance on their practical application. Essentially, the doctors revealed that to be an effective physician, one must have *both* a vast knowledge base as well as the ability to meaningfully interact with their patients and community. While medical school generally equips students with this vast knowledge base, it does little to prepare them for clinical interactions, and the doctors indicated that having one of these characteristics without the other was insufficient to successfully practice medicine.

Doctors directly acknowledged that medical school was an incomplete socializing agent, saying:

> ...in terms of actual preparing you to be a physician and take care of people, [it wasn't] even close. All the biochem and anatomy you do, once you get into your field...I remember thinking what I spent all this money for in medical school is...what? The Krebs Cycle? I don't know that. I learned it enough to pass a test but I do think it's a building block of understanding. You have to start somewhere (Darla Meyers).

Albert Hawk concurs, explaining:

> Medical care is essentially people care, and if all you know is math, science, physics, biology, chemistry, pathology physiology you're going to lose out on the fact that you're in the position to teach, able to relate, able to dialogue.

As illustrated in these narratives, doctors explained that medical school was effective in giving them the basic medical knowledge they needed to be successful, but did little or nothing to guide them in applying that knowledge.

The overwhelming consensus that emerged from my interviews was that, although medical school provides the technical foundation for doctors, *doctoring* is something that is learned through observation during first, medical school and then, residency. As Darla explains, Generally, "[there wasn't] a course on how to do this or that." So although doctors are not being lectured on how to doctor, they learn by watching others do their own versions of doctoring, evaluate that doctoring, and attempt to implement the characteristics they value into their own professional identity and doctoring practices. At the center of this process is repeating things they have seen and consider good or effective practices and avoiding behaviors they consider bad or ineffective.

Perhaps the characteristic doctors in this study most often reported as valued was effective communication. For example, several doctors discussed the importance of touch in patient interaction. Robert Wilson speaks of a mentor's behavior he strove to emulate and weave into his own professional practices:

> he touches all of his patients. He walks in, puts his hand on their knee, puts his hand on their shoulder, and I have found that I do that all the time, whenever I'm talking to a patient, it's weird it's only with patients, I touch my wife my children, I don't touch other people, but I'm always touching my patients. Put a hand on their shoulder or leg when I'm talking to them, because it just makes a much stronger connection. A lot of doctors don't do that.

Wilson observed a behavior that resulted in effective doctoring and, as a result of this observation, incorporated it into his doctoring style. We can infer that this observational learning is particularly powerful, as it prompts him to do something he would not normally do. Conversely, behaviors which impede communication, such as pride and detachment, are considered bad and avoided.

Notably, doctors in this study typically emphasized internalizing these lessons and characteristics when they had opportunity to observe other professionals which primarily occurred during medical school and their residency. As practicing independent doctors, however, they often explained they doctored in isolation from other professionals. For example, Darla Meyers explains that once in practice "[physicians] spend so much time functioning as separate units from each other." Hence, this study suggests that perhaps the most formative years influencing the way that doctors *want* to practice occur before they set out on their own, at least in the case of general practitioners.

The Importance of Patient Interaction

The area that seems to most shape how doctors define and evaluate all medical professionals, including themselves, is patient interaction. In medical school, the student doctors are constantly being supervised by and interacting with the more experienced attending doctors and residents. As illustrated in the previous section, the doctors in this study carefully watched and listened to how those doctors practiced medicine. One lesson they reported learning through

this observation was that doctors seemed to have all of the answers and the endless wealth of knowledge that the students strove to achieve. For example, Maggie Andrews explains: "you learn a lot in just observing patient interactions…you are constantly observing different styles of patient interaction, ways of handling the patient, teaching and how the patient is reacting, you're going to see how the patient responds and you're going to pick up a lot from [the attendings]". It seems logical that medical students would want to replicate what these more accomplished doctors are doing, acknowledging "I had the mindset that this is what I want to do and this is what a physician should be and that's who I became" (Tim Biggums).

Doctors are also observing how to manage some of the more practical elements of patient interaction. Though medicine is a service, it is also a business, and Robert Wilson identified that time was an important factor in patient interaction. When asked what his model of an ideal patient interaction looked like, Robert Wilson responded:

> It would be one where you walk into the room, introduce yourself, and you ask what's going on and they get to the point and tell you what you need to know pretty quickly but they have a good time telling you and you can interact back and forth, kinda to the point but that gets to my efficient personality. I wanna get to the point, I wanna solve the problem, get pertinent information that makes sense so that I can come up with my diagnosis and confirm my diagnosis with my game plan and whatever I need to do so the patient knows what's going on and what we're going to do about it.

He adopted this model from a physician friend he shadowed prior to medical school who

> saw 45 patients a day, but his patients [loved] him, he [walked] in the room and he [remembered] things about [them], [joked] with them and they [got] down to business and [said] 'this is what we're going to do' and they [walked] out of the room happy and [he'd] maybe been in the room 7 minutes.

Here, we see that Wilson mimicked his friend's example of making a priority of balancing the quality of each patient interaction with his professional responsibility to see each patient in a timely manner. Patient interaction is a significant area of medicine because it is where the

doctoring act occurs. Each physician constructs his or her own style of patient interaction by piecing together observations of other doctors, paying attention to different emphases such as efficiency.

Communication in Doctoring

The goal of the doctoring act is to establish trust and rapport, as this allows the doctor to be effective in gathering information to make a diagnosis and educate the patients on their health. A more likeable doctor is a more effective doctor because patients are more likely to be forthcoming about potentially embarrassing yet pertinent habits and follow the doctor's instructions if they feel comfortable with the doctor. Recently, questions about physical abuse and home life have become part of the standard patient interview. It is particularly important here that the doctor has earned the trust of the patient, so that the patient may feel comfortable in discussing sensitive personal, if not medical, issues. If the patient reveals information about abuse or related issues, doctors may also assume more of counseling role, allowing themselves to be an emotional resource.

In this sense, the doctor becomes a resource in multiple ways beyond purely medical interaction. Many elements of medicine can be painful or personally invasive; it is the doctor's responsibility to ensure that the patient feels as comfortable and prepared as possible. This can be as simple as the doctor demonstrating that he or she understands and empathizes with what the patient is experiencing. The doctors I interviewed acknowledged the importance of being comfortable with close physical proximity and touch in bonding with a patient and providing comfort.

This returns to the trust and rapport discussed earlier; if patients do not feel comfortable or feel as though they are being listened to, it is unlikely that they will reveal sensitive information, such as drug use or sexual habits that may be pertinent to their health and treatment. It is the doctor's duty to read how the patient is responding to their approach and adjust accordingly. The doctors interviewed acknowledged that while younger patients respond positively to this new style of medicine, older patients are still more accustomed to, and thus generally respond better to, the more traditional, paternalistic style of medicine.

The modern style of medicine casts doctoring as a dynamic, balanced relationship between the patient and doctor. Robert Wilson acknowledged this, noting "[there have] been a lot of studies that have shown that there are certain populations that do better with their care if you bring them in as part of the solution." The balance facilitates communication, and treatment becomes a consensus between both parties rather than an edict handed down from superior to subordinate. This is particularly true of doctor-patient relationships in the primary care setting because these relationships are so often longitudinal. Albert Hawk recalled situations where his superiors "have been taking care of three or four generations. You take care of a child and now [they're] all grown up and starting a family of [their] own."

As an extension to establishing meaningful (yet efficient) communication, doctors also identified their unofficial roles as educators as a critical element of patient interaction. They reasoned that patients who are educated on the reasoning behind their treatment plan are more likely to understand why it is important to adhere to that treatment plan. However, doctors cannot act as educators without first acting as listeners, and my interviews demonstrated that the physicians are indeed aware of this (and, as previously discussed, idealize their experiences in this situation). When I asked the question, "What makes a doctor effective?", the answer was

almost invariably listening. This answer is very interesting, as it places emphasis on the interactive element of medicine rather than the scientific element. While the distinction is subtle, it is significant. Essentially, listening and interacting with the patient is the mechanism of "doing doctoring" that separates medicine from science; without this interaction with the general public, medicine would simply be research. Indeed, interaction is at the center of doctoring.

Listening became a factor in several different ways. First, and most obviously, a doctor must listen to the symptoms and personal information a patient presents in order to make an accurate diagnosis. More subtly, listening to what the patient is saying and how they are saying it reveals what the patient's learning style is. The doctors explained that when they were able to tune into how the patient best learns and what communication styles they respond well to, they were able to individually tailor the patient's medical experience, educate them, and thereby increase the likelihood of the patient making improvements and feeling well cared for. This standpoint, which allowed the doctors to create what they viewed as successful communication avenues, resulted from doctors incorporating 1) their layperson expectations of doctoring with 2) their observations of doctor-patient interactions.

In the medical setting, building educational relationships through healthy communication also serves a pragmatic goal. At the end of the day, medicine is still a business, and doctors need to maintain a patient clientele in order to make a living; "if you don't build that relationship, you have nothing. You could talk your head off, but if they don't trust you they're not going to believe you. They'll just go to another doctor" (Robert Wilson). Since patients now understand that they enjoy options in their medical care, they are unlikely to revisit a doctor who they feel treats them disrespectfully. A strong, repeat clientele may serve as a reflective measure of the quality and effectiveness of care each doctor offers and tell them if adjustments are necessary in

their standard of patient interactions. Additionally, doctors who maintained long-term relationships reported a stronger sense of job satisfaction, calling it a privilege to serve as a doctor for multiple generations of families and saying "I don't know that I can describe that" (Albert Hawk). Thus we see that effective communication served many roles; it promoted healthy, long-term doctor-patient relationships, facilitated trust and accurate medical care, and allowed for greater patient education.

Fine Tuning the Professional Identity

In *Boys in White*, Becker describes doctoring as a role which each doctor acts, much as an actor would act a role on stage. Doctors engage in both dramaturgy, which "suggests that a person's identity is not a stable and independent psychological entity; it is constantly remade as the person interacts with others" (Goffman 1974) and impression management, which Woolley (2001) defines as "maintaining a positive social image". I would illustrate these concepts, suggesting a "quilted white lab coat" as a metaphor for this role. The same way each medical student puts on their symbolic lab coat, they also adorn this amalgamation of observed behaviors discussed above before they enter any doctoring situation. In residency, the student doctors are offered more of an opportunity to practice the behaviors they are acquiring as they begin to practice medicine, with a bit more autonomy. They begin to realize which tactics are successful for their personal use and begin to fine tune them, while still being given the opportunity to observe attending doctors' styles and acquiring more medical knowledge.

However, in the primary care fields, once doctors leave residency and enter practice, they are largely an independently functioning entity. Most primary care doctors reported that the only times they interacted with their colleagues were to consult each other with questions; other than

that, they did not regularly see them throughout the day. This suggests that the building blocks of the professional identity are acquired during the medical school years, as this is the time period where the vast majority of observation of different styles and techniques occurs. However, the first five years of practicing medicine are important in *fine tuning* this identity. Robert Wilson shared that he considered the first five years out of residency to be another "personal residency." He goes on to say:

> You're around different physicians in different specialties and you're like this person does that. I don't want to do that. I don't like that. I would never want to do that to a patient. You pick and choose what you want to be and what tools you saw someone using that you want to use. So it's kind of an amalgamation of what you want to be and what you don't want to be (Wilson).

In this early time period, new doctors assume a more active role in their identity construction as they decide how they will respond to unexpected challenges and new situations on their own. These beginning years mark the doctors' opportunity to practice medicine and authority on their own terms–without the institution of the university as a safety net to counsel their medical decisions or supervision from other doctors to direct how they practice.

The absence of a safety net is significant, because practicing doctors are ultimately held responsible for the repercussions of their actions through litigation. In fact, I found that the risk of litigation influences how doctors communicate and how they handle uncertainty. They acknowledged "the only thing that protects you [from litigation] as a physician is being really real with your patients- spend as much time with them as you can, talk with them as much as you can, and if you don't know something. Be honest" (Albert Hawk). This appeared as one of the major shifts in how the doctors viewed doctoring before and after medical school and residency:

> Even when I finished med school I kind of had this idea of with residency I would kinda learn everything there is to know in that particular field and it was in residency that I kinda realized that I'll be fucked and my best way for being effective is to acknowledge

> risk when I'm taking risk for a patient, when a patient is sick we try to acknowledge all the outcomes, if something might not go well, and if it goes well, that's great..so I think my way of being an effective doctor has changed because I realized how real you have to be with patients, and if you're worried about something, you have to tell them that, and if you don't know something, you have to tell them that (Darla Meyer).

The honesty the doctors speak of is a safeguard against litigation because, as Darla goes onto state, "if there's a bad outcome, they remember that you talked about it earlier and told them that it was a possibility, so that's really important." Gebhardt (2011) writes:

> When procedures don't turn out the way patients think they should have, the patients are angry and hurt. Patients tend not to sue doctors they like and with whom they feel rapport; they sue doctors who never took the effort to get to know them and understand their beliefs and desires or who treated them without respect.

Interestingly, litigation is one factor that can induce behaviors that will go against efficiency in doctoring. Because doctors are always trying to avoid litigation, "You wanna do the right thing, but you have to end up doing the extravagant thing, You're worried about what people think about what you're going to do" (Albert Hawk). Essentially, doctors may knowingly order unnecessary tests and procedures in order to protect themselves against lawsuits.

Negotiating the Uncertain

Finally, as these new doctors venture out into practice and begin to fine tune their professional identities, they encounter many of the same feelings of inadequacy and uncertainty they faced in medical school. In medical school, these feelings are generally in response to the impossibly vast amount of medical knowledge the student is asked to learn and retain. In practice, uncertainty more commonly manifests itself in *applying* this medical knowledge. Throughout my interviews, I noted a general process of realizing uncertainty, feeling inadequate, masking uncertainty and inadequacy, and finally managing and accepting uncertainty.

Realizing uncertainty, which typically happens during medical school, occurs as doctors realize that it is impossible to know everything they need, and are expected, to know. Maggie Andrews explained this moment:

> I can actually remember my "moment" in med school, I had almost like a little crisis or breakdown moment, and uh, I was in my first year… I think what I had at that moment was that "oh my God, you really don't know anything" and we're not ever probably going to know everything. That kinda shook me to my foundation because I was like "what am I doing here?" I thought the point was so that I could learn everything there was to know in order to take care of people.

This realization results in feelings of inadequacy, because it directly challenges the initial picture these student doctors hold of physicians as all-knowing, authoritative figures. This feeling appeared to be universal in my sample, as doctors described "There was so much to learn, every piece of information uncovered there was a piece of information that nobody knew why…It was kinda scary" (Darla Meyers).

Feelings of inadequacy begin in medical school, as student doctors are expected to absorb and apply an inordinate amount of medical knowledge; these feelings continue as new doctors are thrust into independent practice and assume a great amount of responsibility for the health of their patients. Many report this to initially be a great source of anxiety. To deal with this anxiety, many new doctors attempt to mask their uncertainty (Beagan 2001). Meyers recounted observations of this phenomenon, describing peers "pretending to know the answers when they don't [and] not asking for help from other physicians. I've run into a lot of doctors that don't want to admit any weakness."

However, as the physicians accumulate experience as independently functioning medical practitioners, many learn to *manage uncertainty*. Managing uncertainty simply refers to the transition state between masking and accepting; in this stage, doctors are not comfortable with

uncertainty, but they no longer try to hide it. Maggie Andrews recalled one of her first night shifts working in the intensive care unit, saying:

> I was up all night doing two ICU patients um I wasn't used to that at all…so that was a terrible, terrible night. That one is burned into my mind. One of my partners saw me the next morning and asked "How did that night go?" and I just started *crying*. It was terrible. (picks up cheerful inflection) They both did fine. One of them I transferred to [another hospital] and the other one had a cardiac cath but survived her attack and everything else was all fine so it's just feeling like you have so much responsibility and [it's] overwhelming.

Though Andrews was thoroughly overwhelmed and unprepared, she realized she was solely responsible for the well being of her patients, and she did her best to recall what she had been taught about their conditions and was able to keep the patients stable and healthy. Andrews initiated the process of managing uncertainty in this case because she remained functional despite her anxieties in an uncertain, demanding situation. By not allowing her uncertainty to paralyze her, this doctor learned to function in spite of it.

Albert Hawk explains the process of learning to manage uncertainty as gradual saying:

> three years ago that I was talking about I wasn't comfortable. I was like, I'm not ready for this, I can't do this. And then you do it, and do it over and over and over again, and people ask you questions and you realize that you actually know the answers. Sometimes you don't know the question but you know how to figure it out and it just sorta happens gradually.

Indeed, this is the general pattern. As new doctors settle into practice, repetition and experience allow them to quickly become more comfortable with diagnosing patients and utilizing their knowledge base. Perhaps even more importantly, they learn that uncertainty is an unavoidable element of medicine that cannot nor should not be ignored. Gebhardt (2001:2) explains, "When an untoward event does happen in the operating room or the clinic, good communication skills are critical…but too often, physicians fear that an apology is an admission of guilt and are uncomfortable discussing these situations with patients."

Tim Biggums directly acknowledged that uncertainty was an acceptable part of how he practiced medicine and succinctly explained how he approached it. If he did not know how to diagnose or treat a particular patient, he realized that he had several avenues for proceeding: he could wait for an appropriate moment to consult a medical database or expert for guidance or affirmation, he could explain to the patient that he was experiencing uncertainty in their medical issues and offer a plan for how he would dispel that uncertainty (i.e., "I don't know what's wrong with you, but here are the tests I am going to run to find out"), or he could tell the patient he was uncertain of how to proceed with their case and refer them to someone more qualified with that particular issue (i.e., "I don't know what's wrong with you, but I know who does").

What is the source of this uncertainty? Virtually all of the doctors I interviewed spoke about the ever-expanding nature of medicine; new medical knowledge is constantly being generated and disseminated, and they acknowledge it is impossible to keep up with all of it. However, they also recognized that technology was a valuable resource that allowed them to interact with new information and stay updated. Most of the doctors held subscriptions to journals and databases in their respective fields.

Regardless of how each doctor broached the issue of uncertainty, the general pattern of realizing uncertainty, feeling inadequate, masking uncertainty and inadequacy, and finally managing and accepting uncertainty remained consistent. As doctors became more comfortable in their professional identities, they became more confident in navigating uncertainty.

VI. Discussion

The dramaturgical element of patient interactions contributes to the idealization of the professional identity. This idealization occurs as doctors focus on what they want to be (how

they want to play their role) and is generated from the expectations they hold of what doctoring should be (the all-knowing, caring, attentive model of doctoring they glean from society). Doctors consult this cultural archetype as they recall their idealized childhood and pre-professional medical experiences to decide exactly what form their style of doctoring should take. While it is likely that the doctors interviewed are often successful in this dramaturgy, it is interesting to note that doctors focused on their virtuous doctor-patient interactions but identified no examples of their own inadequate—or poorly performed—patient interactions.

The same way actors in a play do not want to reprise their role badly (or believe they have done so), doctors do not want to believe they are doctoring badly. If doctors were forced to admit that they were doctoring poorly, it would directly challenge their concept of themselves within their professional identity. Part of the professional identity is the characteristic of doctors as nearly omniscient authority figures, and if a doctor is aware that he or she is carrying out his or her role poorly, he or she is essentially admitting a personal incompatibility with the role of doctor. Here we must consider the pressures and expectations society places upon physicians. We entrust these individuals with an immense, direct responsibility for our health and well-being; over the course of a lifetime, we repeatedly place our lives in their hands. In order to deal with these expectations, physicians necessarily must be confident and positive. If they focus on their mistakes and negative experiences, it is likely that they will be less able to confidently develop the poise necessary to combat uncertainty, become medically competent, and effectively develop their professional identity. .

How Medicine is Evolving

Doctors are becoming increasingly aware of how they interact with society, and these interactions are changing. The themes the doctors identified of educating and listening to patients are strong evidence of physicians integrating their own personality and life experiences into their doctoring style, because they are a significant shift from the paternalistic model of medicine that has dominated medicine for decades, if not centuries.

It is possible that this shift results, in part, from a generation of doctors who, through the advancement of technology and the advent of the internet, have grown up with increased access to information. Basically, the doctors now leaving medical school have grown up with the same sense of "information consumerism" as the patients they are treating. They understand that patients are taking a more critical interest in the medical information that is relevant to their condition and realizing that there are options in treatment, so they are making more of an effort to both explain the information and offer options that are tailored to the patient's specific needs. Again, this is hugely different from the traditional, authoritarian style of medicine, where the doctor dictates every aspect of the patient's care. Interestingly, it also forces the physicians to be more self-reflective and self-critical in their profession, as patients expect more of a collaborative medical experience, rather than taking the doctor's word as absolute authority. As patients ask questions and inquire about different treatment options, they provide a sort of feedback which shows the doctors which areas they are medically competent in and in which areas they need to update their repertoire of knowledge. Hence, one thing the results from this study illustrate is that cultural factors, like shifting norms and changing technology, affect the way medical professionals understand their professional identity and simultaneously begin to alter the way doctoring is done.

The Significance of Accepting Uncertainty

However, an interesting consequence of increased patient-consumerism of medical knowledge historically available only to doctors is a new source of uncertainty. Now, not only may doctors be unfamiliar with the particular literature a patient may present, they must determine how to preserve their presentation of themselves as a knowledgeable professional as they discuss this new unknown. In each of the cases I referenced in the Results section on accepting uncertainty, the doctor recognizes uncertainty and is actively prepared to overcome it. Importantly, throughout the process, the doctors maintain their rapport with their patients by maintaining honesty and being confident in their own abilities, while still acknowledging their personal limitations. This confidence emerged as another necessary element of the professional identity. Though medicine has largely moved away from its paternalistic roots, the cultural story attached to the doctor identity indicates that doctors must still maintain some aurora of authority; patients will sense a doctor's self-confidence and allow it to bolster their trust in the doctor's decision making and competency. Doctors must establish themselves as competent authority figures because they make a profession out of saving lives. If they are not competent, they will not have the knowledge necessary to save lives, and they will fail to fulfill their professional role. Similarly, if a doctor does not communicate confidence, the patient will not view them as a competent authority and will not adhere to their treatment plan because they will not believe the doctor is sufficiently knowledgeable to be entrusted with their health and well-being.

It is important to note that the pattern through the stages of realizing uncertainty, feeling inadequate, masking uncertainty, and finally accepting and managing uncertainty can be cyclic. Doctors seemed to complete one cycle during medical school and residency and begin another as they entered practice on their own. I would propose that progression through these stages can, in the proper context, be used as a benchmark through the development of the professional identity.

The overarching theme that emerged from my data was that as doctors became more comfortable in their professional identities (particularly in their communication skills), they became less threatened by uncertainty and learned to manage it, rather than try to hide it. It appears that this transition occurs because as doctors become more comfortable with their professional roles, they do not feel as compelled to adhere to an idealized depiction of an omniscient authority.

VII. Conclusion

In organizing this research project, I sought to understand how new doctors constructed their professional identities, who influenced this process, and how it differed from the process that occurred throughout medical school and residency. The narratives from my project confirm the body of research that focuses on the role of medical school in the socialization of doctors; undeniably, to a significant extent, the building blocks of the medical professional identity, is transmitted primarily through observation during medical school and residency. Specifically, the participants emphasized the importance of observing doctors who communicated and interacted effectively with their patients. However, it is significant to note that while observation was the major mode of learning, the doctors did not accept all observed lessons at face value. Rather, they modified the lessons learned to suit their personal style and spent the beginning years of practice fine tuning this style.

Indeed, the professional identity appears to be highly personalized, as doctors chose to emulate behaviors they viewed to be effective and avoid those they considered ineffective. There were two main groups that influenced this process: predominant social ideas about doctors and attending physicians. Childhood observation and pre-professional experiences instilled the physicians with expectations of doctors as all-knowing, caring, authoritative figures, and while they eventually came to understand that these expectations were unachievable, the doctors still

strove to fulfill a modified form of these expectations. Attending physicians provided the basic skills and patient interactions that doctors observed to choose which behaviors were best suited for their own use. The major difference between the socialization process that occurred within medical school and the process that occurred within practice was the degree of active experience. Newly practicing doctors accumulated much more experience actively constructing their style of doctoring and did so without the safety net of medical school to protect them from litigation.

This research is significant in that it examines a currently underrepresented subpopulation in the literature. While there is a significant body of knowledge that examines medical students, there is relatively little available on doctors in practice. In this study, we come to understand that though the bulk of the observational learning associated with the professional identity occurs within medical school and residency, the doctors do not truly personalize and internalize these lessons until they are able to practice them on their own. Here, we realize that the first years of practice out of residency are critical in honing the professional identity, because it is the first opportunity physicians have to "do doctoring" on their own terms. This study highlights the importance of this time period as the first time doctors actively construct, and assimilate into, their professional identities.

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Appendix A

- How does the socialization process for practicing doctors differ from that of medical students and residents?
- Who influences the socialization process?
- How do new doctors construct their professional identities?

Interview Schedule

I'd like to start out by asking you a few questions about your time and thoughts in medical school and before it. For these questions, try to recall your layperson views, rather than your professional views.

- Before medical school, when you thought of a doctor, what image came to mind?
    - What were the duties and traits you associated with doctors?
    - How did you learn this "idea" of a doctor?
    - Did your idea of what a doctor is change as you went through medical school?
        - Can you give me an example of how this happened?
        - Who influenced these changes?
- Did you have a mentor in medical school? How did this person help you become a doctor?
- Do you think that medical school adequately prepared you to be a doctor?
    - Can you give me an example of one area where you didn't feel prepared?

Alright, let's talk about what it means to be a doctor for a bit.

- Why did you want to be a doctor?
- What does the title "Doctor" mean to you?
    - Do you remember the first time you were addressed as Dr. ____? What did that feel like?
    - Do you think you're supposed to act in particular ways with patients because you are a doctor?
        - Who teaches you what actions are appropriate for doctors?
        - What lessons are they teaching you?

- Do you feel like you fit into the title of Doctor?
    - Was there a particular transition moment where you felt like you really felt comfortable in that role?
    - Was this transition significant for you? In what ways?
    - If not, why don't you feel like a doctor?
- What makes a doctor effective?
    - Who do you think was most influential in shaping what your idea of an effective doctor was?
    - Do you think your idea of what an effective doctor is has changed since you've left medical school? In what ways?
- What makes a doctor ineffective?
    - Who do you think was most influential in shaping what your idea of an ineffective doctor was?
    - Do you think your idea of what an ineffective doctor is has changed since you've left medical school? In what ways?
- What role do emotions play in doctoring? Do they influence effectiveness?
    - Has your opinion on this changed since you've left medical school? In what ways?

We've constructed a pretty detailed picture of what it means to be a doctor. Now I'd like to talk about how that gets applied in your everyday work life.

- Can you tell me about a typical day in your work life?
    - Which colleagues do you spend the most time with?
        - Would you say you have someone that you would call a mentor?
        - Why would you call this particular person a mentor?
        - How does this person influence you as a doctor?

- How do you interact with other medical professionals?
    - Do you feel there is a social hierarchy within medicine?
        - What examples can you give me of this?
        - Where do you fit into this hierarchy?
        - How do you interact with people above you? Below you?

- Have you ever been a nurse (or CNA, etc)?
  - How does this affect the way you interact with nurses?
  - If not, how do you think this shapes the way you interact with nurses?

- Can you tell me a little bit about how you interact with your patients?
  - Do you think your idea of how patient interaction should look has changed since medical school? How?
  - What do you want your patient interactions to look like? Why do you want them to look this way? Do you think they do look like that?

As we're talking about your daily work interactions, I'm wondering what sort of factors might shape these interactions.

- Can you think of any specific ones?
  - Do you think gender shapes how you interact with colleagues and patients? In what ways?
- How would you characterize your work-life balance?
  - Would you say work has higher priority, or personal life?
  - Who helps you decide what is important?
- What do you find challenging about being a doctor?
  - How have you learned to handle these challenges?
  - Who teaches you how to navigate these situations?

We've talked a lot about how you do doctoring and the factors that affect it. I'm wondering if there might be other factors that we haven't discussed yet, that might influence the way you doctor, or how others doctor.

- Do you feel that sexual orientation affects a doctor's medical experience?
  - What do you think the general workplace attitude toward sexual orientation is here? Is it something that is discussed at all?
  - Do you think that being an openly homosexual doctor influences colleagues' perceptions of that doctor? How about patients' perceptions?
  - Can you think of an example where sexual orientation may have influenced how a situation unfolded?