Medical Education and Sociology of Medical Habitus: "It's not about the Stethoscope!"

Haida Luke

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by

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PAUL, AILISH & CIAN

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PREFACE

It is 7 a.m., second week in January, I walk into a room full of 50 noticeably nervous, and fresh faced first-day interns. Yesterday they were graduated medical students with their Bachelors of Medicine and Surgery - today they are 'doctors' and will be for the rest of their lives. In this hospital for the next year, as conditionally registered doctors by the State Medical Board, they will be under careful supervision and guidance by the senior doctors. They will be enrolled in a junior doctor training program. The next twelve to twenty-four months will be a time of significant professional and personal change for them.

It is now 1:00 p.m., and I walk into a room of several junior house officers (JHOs) who could get away from their ward duties for a non-compulsory medical seminar. The changes that many of the JHOs (which refers to the second year of medical training after the first year of internship) have gone through in the previous twelve months will parallel what the interns from the morning will go through as well. I have seen at least 150 interns start their first year in this hospital and now several years later they have progressed to registrars and are studying to be specialist consultants.

What is it, then, that doctors encounter in their graduate and postgraduate training that shapes them in particular ways as identifiable medical professionals? How is medical culture perpetuated and imbued in these human subjects? How do they shape themselves in relation to the many overt and unwritten (and indeed unspoken) demands and expectations of becoming a doctor? For my own purposes importantly, what set of analytic tools enable such an investigation of such a complex institutional phenomenon? A phenomenon that is not accessible as evidential research data, evidence or culture in any hospital policy guidelines, university calendar, or rulebook. These questions guide the research I report in this book.

Traditional research on early medical professional development has focussed on medical students, but usually it stops there. Working from a sociological framework with a focus on medical practice, this book examines the link between the first two years of medical practice and future professional life as a doctor. Early professional socialisation (or development) is seen as a fundamental process for the doctor, medical culture and health care of patients. What this volume describes and analyses are a range of cultural forces that impinge on the development for doctors learning about being a 'doctor' and how to survive in the medical system. Central to this analysis is Pierre Bourdieu's sociological framework and his concept of *habitus.* My aim here is to highlight and describe the complex and interwoven processes of internalising a particular medical habitus, to document structures and discourses that junior doctors (the first two postgraduate years are referred to as junior doctors) enter when they finish medical school. This is just the first step in their professional development.

Research has tended to generalise and universalise findings about medical students into claims about their professional lives as doctors. There are also studies

of doctors' attitudes, beliefs and practices as mature professionals. This book looks at the interface between initial training and career. This book is based on research that is an in-depth exploration of the experiences of Australian intern and Junior House Officers during their first two years of professional development. Here I want to challenge many of the myths of the medical cultural experiences and 'socialising' forces that are an integral part of early medical training. Bourdieu's theory of habitus is reconceptualised and applied to a domain of inquiry outside traditional sociological areas of interest such as family, social class or education. This volume is a theoretical and qualitative exploration of the concept of habitus as related to the professional development process of junior doctors.

The evidence here suggests that the weight of the medical culture and the unconscious and structuring habitus developed through institutional and medical/professional practices and 'codes of conduct', are mutually reinforcing in the 'construction' and shaping of a particular kind of medical professional: the junior doctor. The sociological research on interns' and junior house officers' (junior doctors') medical training primarily using sociological concepts to analyse the medical culture has indeed been lacking. Here I analyse the cultural developmental experiences of junior doctors to see how professional cultural change in junior doctors accounts for change across the first two years of their early hospital work. There are qualitative interviews at two distinct training points: the entry point, at the first weeks of internship and second year and at the exit point (after twelve months) of the medical training years. I also describe how through an analysis of videotaped medical and surgical ward rounds much of the video themes complement that of the interviews.

I suggest that as part of the professional development process, junior doctors are learning to become 'social doctors' as opposed to 'clinical doctors' through the training experiences within the medical culture. In these pages we read about and are drawn into the world of doctors we know as patients, colleagues, friends, admired professionals and relatives.

ACKNOWLEDGMENTS

Doctor: I feel comfortable answering these questions to anyone. Basically, once you are in surgery, no one can touch you.

Interviewer: Why would someone in surgery not want to answer this question?

Doctor: Well, because you imagine, if you ask someone from surgery these questions, the first person might be their consultant and that guy has the power to crush someone's career.

Beginning of second year, male JHO

Early medical graduates' commitment to medicine that early medical graduates have and the tumultuous path they are about to embark upon, defines what it means to being a junior doctor. This in part, motivated me to bring out their voices and the stories of the junior doctors here in this book. I thank the junior doctors in particular and their supervisors for allowing me unrestricted access through interviews and video of their daily medical practices.

This work was originally conducted under the facilitative supervision of Professor Robert Lingard and Associate Professor Charles Mitchell at The University of Queensland, Brisbane, Australia. A University of Queensland Graduate School Research Award in part supported the research reported here.

I appreciate the support and continuing friendship of Paul Martin who has listened to and shared with me the passion for research. You have provided your useful translation of the qualitative and interpretive habitus into the positivist discipline of medicine. We continue to share and foster an excitement for each other, life, family and work on a daily basis.

I also express my appreciation to you Ailish, for your laughter, sense of enthusiasm and sharing with me your love of life. Cian, I am grateful to see your smiles, share in your happiness and you are a pleasure to be with. Thanks to you three for sharing, appreciating and helping me with the demands of being a partner, working mother and reminding me how to balance the load of paid and unpaid work, parenthood and personhood. The times with my children and partner continue to be an honour and pleasure.

To Jennifer Celotto thank you for the last 17 years of friendship through so many varied challenges of life and womanhood. Thank you to Simone Bannan for much advice and stable friendship. Also to our Abyssinian cat who is appreciated for being a steady study Buddy. Thank you to Allan and Carmen whose analogy of the 'little train' has stood with me as I pursue academics in line with the history of our family tree.

My thanks also go to Kluwer for valuing this work and in particular Esther de Jong, I appreciate your availability, time and patience with the final stages of the manuscript preparation.

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INTRODUCTION

Medical culture teaches doctors ways of negotiating their identities within the medical hierarchy and structure. This is theorised throughout these chapters as the construction of what I here term the 'medical habitus'. The concept of medical habitus suggests that junior doctors are learning more about and how to navigate within medical culture through their professional development than previously thought. This book develops the concept of medical habitus, through observation and documentation of which is developed in the 'hothouse' effect in the first years of junior doctor practice in a hospital. The argument here is that this knowledge should be incorporated into an explicit professionally orientated program of teaching to ease the transitions of medical interns to their work as fully registered medical practitioners. At the same time, however, it is recognised that the experiences of junior doctors reflect the powerful hierarchies of the medical field, and as such, they will be difficult to challenge and change, as the following chapters will demonstrate.

Chapter Structures

I begin with a conceptual starting point in the first chapter "Examining medicine with new lenses" which discusses previous research that examines medicine in terms of professional socialisation. Much of this work leads us to examine medicine from a sociological perspective in terms of professions and professional development. Literature is reviewed on psychological and physical stress, workplace training, coping, medical educational issues such as improving training and understanding junior doctor development. In considering the role of doctors, it is necessary to look succinctly at how traditional sociology conceptualised the social. Chapter one also explains my methodological strategy and incorporates how knowledge of the medical culture was central to entering the field of inquiry which, in turn, developed strategies of access to data. I conclude by proposing a sociological case study, describing the process of a sociological case study with description of the hospital research site, wards and doctors. Through the description of study procedures I explain how my own standpoint and knowledge of the medical culture allowed me particular access.

In chapter two, "Theoretical dissection of medicine: Practice" I investigate traditional sociological perspectives, and more relevant work in sociology specifically focused on the fields of medicine and medical education. For instance, the work of Nicholas Fox (1994b) on surgical practice and ward rounds is used to focus on reproduction of values and behaviours within graduate medical training. This analysis enables the identification of structural hierarchies of the medical profession. Much of Fox's work suggests that modernist sociology places human beings in the centre stage as constructors of the social. It is with this grounding in traditional, modernist medical sociological literature, that we turn to explore potential explanations by pursuing a sociological theory of practice, drawing upon the work of Pierre Bourdieu. In this second chapter, we examine Pierre Bourdieu's

theory and three main concepts: capital, field and habitus. This chapter maps how the habitus constructs the social, which, in turn, provides us with the theoretical and conceptual framework for the fieldwork from which to begin my methodological endeavours. Bourdieu has given significant validity to sociological analysis of culture through habitus as a systematic and structuring phenomenon that organises and surrounds social actors. By this account, therefore, it is the suggestion following Bourdieu that the habitus is the means by which a particular way of 'being' is produced, enacted and negotiated in interactions between social structure, and action within practice.

In chapter three, "Putting it all together: Culture of junior doctors", much of the doctor's voices from the interviews are discussed following along the line of five principal fundamental themes derived from the data. The categories were themes and concepts generated by the data. Devising categories is largely an intuitive process, but it is also systematic, informed by the study's purpose, theoretical orientation and knowledge, and the particular meanings were made explicit by the participants themselves. The main themes I describe are: issues surrounding the training program, the doctor mould, medical hierarchy (consultants and registrars), medical culture (cynicism, ward rounds, paperwork, stress, critical incidents, patients and women in medicine); and finally reflections on the junior doctor years.

This leads us to chapter four, "Medical habitus", where we theorise and discuss medical habitus in the context of junior doctors. Also provided is an analytical discussion of the data and normative application of medical habitus in the medical field. As this volume is a description of a qualitative study of junior doctors' professional development, we find that the use of the Bourdieuian concept of habitus useful and the previous assumptions about junior doctors extended. Here I describe and analyse how doctors' personal characteristics and ways of behaving are influenced by the medical culture through the hospital as an institution of certain (medical) practices and cultural outcomes. In chapter five, "Future of medical habitus: Medical identity", I conclude with a more normative commentary provided for reflection, outlining future directions for research and for rebuilding medical cultures and the habitus itself.

CHAPTER 1

EXAMINING MEDICINE WITH NEW LENSES

> I want to say 'I've got a position in society, I can actually do something'. So you spend 6 years thinking 'I want to he there', and when you finally get out, you think, 'oh I'm a somebody, I'm a somebody'. And you come to a place like this and you're the bottom rung of the ladder again, and you're still a nobody.
>
> Beginning of second year, male JHO.

This chapter introduces the volume through a discussion of the significance of this study in relation to existing research in medical sociology. The impetus for this study, with the author's own location and personal testimony of entry and access to the field are discussed, as well as particular methodological issues in conducting sociological research in a medical field are detailed. In particular, I flag the significance of the research, in particular, utilisation of the theory of Bourdieu and the concept of 'medical habitus'. Junior doctors' own voices are used throughout to provide evidence to establish in support of the unique institutional culture as well as to foreground issues in gaining access to the field.

So we ask ourselves: why scrutinise medical culture? If the popularity of television medical portrayals of hospital culture, such as *ER,* is any indication – the public is fascinated by medical culture, its mythologies and stereotypes. The concept of medical culture is today no longer an exclusively academic term but is widely used to refer to the unwritten rules of conduct, personal dispositions and attitudes, and normative ways of doing things within the medical profession. In recent years, media scrutiny of the insider culture among medical professionals has brought the notion of medical culture out of the narrow purview of academic research and into the mainstream. Newspapers report on the closed ranks mentality of professional accreditation bodies, on the medical holidays financed by multinational pharmaceutical companies, on social class exclusivity and snobbery, and so on. The notion of culture applied to professions has a long history in educational studies where school culture, pupil cultures and teacher cultures have been the objects of study since the late 1950s, early 1960s. Similar work has been undertaken on the legal profession, also a focus of media and fictional portrayal. Academic investigation of medical culture also dates back to the 1950s located principally in field of the sociology of medicine.

My own professional and personal history has given me years of access and insights into medical culture. I therefore approach the task at hand with both have formal analytic lenses and more informal personal experience lenses, which together have shaped the conceptualisation and analysis of this research. I have engaged with experienced doctors, nurses, hospitals as a child, as an adult and as a parent. Like the universal experience of schooling, we all share these generic medical experiences since few of us in the urban societies of the North and West, like the universal experience of schooling, go through life without a formal medical encounter. I have also experienced medical culture as a hospital-based psychologist and medical educator, employee, friend and as a partner to a training and practicing doctor. My take on the profession is therefore is multifaceted and informed by. literally, in-sights from a range of formal and informal vantage points. What my professional and personal experience, alongside my intellectual position located with critical sociology of medicine, has taught me is that there are no simple questions to ask. Nor are there simple analytic templates with which to identify, theorise, and explain the dense complexity of how subjects develop in the medical culture, how it sustains and reproduces itself, and how those values and norms become embodied and enacted in subsequent generations of people on their way to becoming doctors.

Analytic scrutiny of junior doctors' (interns and JHOs) medical professional development is an essential problem for sociological inquiry. When I began working as a medical education officer (MEO), I began to examine and document the environment I was privy to. I was originally curious about the forces and dynamics that transforms interns into junior doctors, and what social and cultural elements shape their experiences of the medical profession. Much of my general understanding of professional development had been derived from observing my colleagues and personal friends in many different fields from accounting, finance, academe, social work and in psychology. I began to hear the difficulties faced by junior doctors and my location as an author is based on much of this field experience.

There is such a lack of focus in the research on the actual professional and cultural experiences of junior doctors. In particular, much of the work looks at the day-to-day practical and clinical coping aspects of their jobs or focuses on professional studentships at medical school. Further, examination of postgraduate medical training has been undertaken from a context of the positivist scientific perspective. No research has been conducted specifically on the first two years of post university or college medical training using sociological concepts of culture. My aim here then is to address and fill a knowledge gap in 'cultural' studies of medical professional development by using sociological theory to interpret and understand the professional and cultural change of junior doctors.

The first years of on the job medical training are filled with new workplace and medical activities. Many of the clinical components for junior doctors serve as ground work for learning how to deal with patients and illness, yet there are more social and cultural demands which are not met in the four to six years of medical school. Junior doctors undergo intense working weeks up of up to sixty hours and thus encounter a lot of stress and disillusionment towards the 'system'. The anxiety and cynicism that develop as a result of 'being thrown in the deep end' affect their

feelings about themselves as professionals, friends and partners. Professional burnout and the desire to leave medicine are common responses which can be attributed to a range of medical, social and cultural dimensions of junior doctor training. Through investigation of junior doctors' interpretations of their training, understandings of the problems and issues, we can begin to identify strategies for improvement in specific aspects of their formal and informal professional development, adaptation and workplace training. There is a problem with junior doctors being thrust into the hospital culture after four to six years of protected student life. The methods and data in this study that are provided here offer useful insights into these problems. It could conceivably, which serve as a template for developing strategies for change to assist in medical student transition from undergraduate to professional doctor.

The impetus for this research begins with a using a non-positivist (medical) sociological theory to focus on social and cultural dynamics characteristics. This way we can conceptualise how the demands of the job and the medical culture inculcate junior doctors into the medical culture. The professional and personal experiences and social dynamics of the medical workplace are underestimated as having particular influence on how junior doctors develop professionally and become doctors. Later in Chapter two, the cultural theory of practice developed by French theorist Pierre Bourdieu is used to examine medical habit as a disposition. In line with what Luckman (1989) suggests, the texture of everyday life experiences and the meanings people give to those experiences are best documented and understood through analysis of peoples' interpretations of their own lives. The process of professional development is critical to understanding how change occurs through the many-levelled and complex experiences of junior doctors.

POSTGRADUATE MEDICINE: JUNIOR DOCTORS

Existing research on junior doctors focuses and begins with the practical issues of defining the junior doctor, what junior doctors do and what are some of the key professional issues that they face. The following review of applied research is essential because the subculture of junior doctor medicine within the larger environment of medicine is unique when compared to other training levels of doctors. This is a fundamental transition time with unique markers, characteristics and experiences that contribute significantly to the professional development process and experiences of junior doctor work.

The first year of practicing medicine after medical school is generally called the internship. After the guided environment of undergraduate medical school for six years or postgraduate four years, the first two years of medical practice after university graduation are basic years for professional and personal development of the junior medical practitioner. The technology in medicine is changing at a very rapid rate, and what follows is the need to prepare doctors for the changes that will be required of them for the future. In Australian medical institutions, the job title 'intern' refers to the first year after medical school graduation. Here a conditionally registered doctor practices medicine under the supervision of other fully registered

doctors that are more senior. According to the Australian Medical Workforce Advisory Committee (1996, p. 7), this very important training period is:

> principally based on inservice training across a range of supervised hospital posts to provide a broad range of experience and training. It should provide continuing opportunities for the acquisition of further knowledge, skills and attitudes leading to registration for clinical practice.

Therefore, postgraduate training takes place in hospital-based settings, and formal temporal and curricular sequences formats and in hospital-based settings that all doctors must complete at their earliest stage of medical training. Historically in wartime, hospitals recruited medical students to complete the duties of junior residents (Fagan, Curry, & Gallagher, 1998). Pre-war residency training was seen as a natural extension of the medical internship initiation experience (Thomas, 1983). Today, the process of training to become a doctor still focuses on clinical training aspects, which encompass clinical and social aspects of development in becoming a lifelong doctor. These early training and clinical years lay the important foundation for medical experiences that guide and will provide the basis for further specialisation in medicine. As internship is the first point of professional entry into medicine as a doctor, it is also like many entry-level jobs, most likely to be a site for what is referred to today in North American terms 'scut work' or Australian terms 'being the dog's body'. That is, the tasks that define an entry-level job may entail: paper work, clean up, aspects that other seniors do not do or want to do and generally the least desirable or enjoyable aspects to the job.

In the second year of medical practice in public hospitals, doctors in Australia are referred to as JHOs (junior house officers). This is the first year of fully registered medical practice. Other states in Australia use terms such as residents, house officers or post-graduate year two (PGY2). JHOs practice with more independence, begin to study for specialty exams, have short-term practice experience in isolated rural communities (often without obstetric, gynaecology, anaesthetics or paediatric experience) and continue their metropolitan generalist hospital training. Senior house officers (SHOs) are defined as doctors in the third year of training in the hospital and work as generalist hospital doctors. This third year of medical practice is often characterised by doctors' preparation for specialty exams, continuation of country relieving practice or awaiting specialist training program vacancies. Junior doctors refers to interns and second year doctors, that is, those doctors who have just graduated medical school and are in the first two years of medical practice. So as we try to grasp at what is junior doctor development, let us look at residency.

Training for a medical or surgical specialty is an important part "of a general professional education and is a basis for responding to patients' needs" (Pritchard, 1998, p. 33). In previous research, personal experiences of interns in internal medicine at a major urban teaching hospital were examined in terms of the ideology of the medical service, unofficial language of interns and residents, and the hospital's rituals for marking status elevation (Groopman, 1987). The stability and perpetuation of internship is suggested as being an institutional form of training for medicine. The loss of identity where junior staff learn that they are a 'dogs body', a

clerk with medical knowledge is an important experience. For many junior doctors when they start, they do not understand that mundane activities will be the major proportion of their job. By mid year many interns feel animosity and look forward to potential changes in their second year. However, second year is often similar with the same paperwork requirements and similar responsibilities. Responsibility is a key developmental aspect of socialisation into the medical culture: how do doctors define and learn about responsibility?

Doctors in a hospital are often characterised as responsible to patients, their own profession and themselves as opposed to their administration, issues, larger healthcare organisations issues and the hospital. This differing responsibility relationship between doctors and the hospital executive are no doubt one of the cornerstones of a health care system (Groopman, 1987). However, because of conflicts that arise from different orientations of administrators and doctors, this partnership is affected by increasing working hours and conflicts of between patient care versus hospital finances. The medical group development in terms of feelings of persecution (sometimes towards administration) affects hospital medical culture and increases the distance between senior, junior doctors and medical administration.

The reinforcing and valuing of junior doctors' professional skills are requisite fundamental to the development of developing quality of care for patients and quality of learning for junior doctors (Rainey, 1997). There are not only organisational issues surrounding responsibility to patients, the health care system, but also the differences between senior and junior doctors. Many junior doctors see themselves as exploited labour working through poor working conditions such as on call rosters, shuffled from hospital to hospital or even not being able to get a hot meal when on call. It is inexcusable that many junior doctors are seen as less trained doctors, ideal for cheap and simple labour. They need to be trained in key decision making, clinical skills, patient care and valued as essential staff (DeQuardio, 1997a; 1997b).

Considering the varied experiences of that being a junior doctor provides, it is important that there are supervisors and junior doctors who are committed to enable and envelop a satisfactory career pathways and future in medicine. Medical training in Australia at both undergraduate and postgraduate levels has been of a high standard with postgraduate medical councils having been established to oversee graduate training in public hospitals (Brooks & Goulston, 1998). So what of the future of junior doctor medical practice? It seems that there are experiences within medicine that make doctors want to leave the profession at one time or another. Career focussed work such as Laster's (1996) "*Life after Medical School*" is an important contribution to the understanding of sociological and medical processes. Laster discusses the complexity surrounding the choices that doctors make within medicine and how this effects their careers beyond medial school.

There are a few studies on the reasons and factors (such as background or main influences) for people choosing medicine as a career. For instance, twenty-two percent of doctors after working an average of six years, said they would consider another profession if beginning their university studies now (Hyppola, Kumpusalo, Neittaanmaki, Mattila, Virjo, Kujala, Luhtala, Halila & Isokoski, 1998).

Disillusionment may also have gender differences. Some female doctors who begin to pursue a surgical career as early as when they are a medical student may be met with discouragement by senior male medical staff. They see the limited number of female consultant-level role models in surgical posts, and this may also contribute to wanting to leave medicine (Clarke, 1992). Despite the increase of female general practitioners, women doctors can still expect a strong sexual division of labour that is maintained and reproduced in practice (Brooks, 1998).

Many junior doctors have told me that they use strategies of detachment in their working lives. They say that at some point each almost everyday they feel useless. Although internship is a necessary part of medical registration, it is also "an important period of personal development … [where] the intern needs to develop skills and self monitoring, self care and stress management" (Australian Medical Workforce Advisory Committee, 1996, p. 9). Learning about and having new responsibilities as a junior doctor can be quite confronting especially in the transition from medical student to intern. Once finished university with a hefty medical school debt (Brooks, 1998b), junior doctors can look forward to what is most commonly referred to as the time of greatest stress, anxiety regarding competence and confrontation of the reality of medical practice (Kelly & Varghese, 1997).

As the first year is likely to be the most stressful in all the years of medical training, every year there are a number of suicide deaths ofjunior doctors around the world (Alexander, Monk, & Jonas, 1985; Houston & Allt, 1997; Williams, Dale, Glucksman, & Wellesley, 1997). This is significant concern for the medical community and those responsible for their supervision and training of them (Fitzgerald & Murray, 1998). Although much research on junior doctors focuses on practical skills attained during residency or particular educational components of a training program, stress during residency is also a fundamental psychological component to the professional development experience. Issues such as, intensity of workload, coping with diagnostic uncertainty, working alone, unsociable hours, and experiences of fatigue have emerged as significant factors for junior doctors that cause the most stress (Birch, Ashton, & Kamali, 1998; Brown & Gary, 1987; Firth-Cozens, 1987; Firth-Cozens, 1989; 1990; Godlee, 1990).

The changing context of medicine also adds to much of the psychological and physical stress that doctors encounter. The importance of performance of medical personnel (Vincent, Ennis, & Audley, 1993) and how working conditions and sleeping patterns (Reid, 1995) affect junior doctors in their early medical years are significant for health care service provision, the doctor, and the doctor's friends and family. In a study of JHOs, it was found that excessive hours contributed significantly to the junior doctors' anxiety and inability to sleep (Houston & Allt, 1997). Further, working excessive hours is related to the needs of the hospital and patients and is reportedly was a key factor for deterring doctors from further careers in medicine (Baldwin, Newton, Buckley, Roberts, & Dodd, 1997).

Many interns feel when they start their internship that they "are basically thrown in the deep end" (Cant, 1999, p. 6). There can be no doubt that early formal medical training and basic guided introductions to hospital medical protocols are essential to prevent patient care and intern suffering. A lack of clinical teaching time and

teaching on ward rounds leads to satisfaction or dissatisfaction working as a House Officer (Baldwin et al., 1997). In another study of junior doctors' coping, clinical measures were taken (eg, adrenaline/cortisol measures) in relation to on the job stress. The authors found that high medical demand and high personal resources were associated with enabling work skills and low fatigue, and high effort was associated with active coping (Hockey, Payne, & Rick, 1996). In a fairly clinical study, Hockey et al. (1996) demonstrate that people are beginning to research junior doctors on a number of levels such as, how low fatigue and high personal resources are important for making the junior doctor job less stressful. Therefore, it seems that teaching and learning may be important to mediations of the experience of the junior doctor job. Taking the time to teach in general and on ward rounds assisted junior doctors to cope with the stress of clinical duties more effectively.

There is no doubt that being a doctor places significant demand at a personal and professional level. At this point we can say that in medicine and the workplace training that occurs, experience is everything. Certainly in rural areas, the support of a partner or spouse plays a very important role mediating the stress of being a rural doctor (Wise, Nicols, Chater, & Craig, 1996). There are many inadequacies in hospital training and there is an increasing awareness that this needs to be addressed to improve the training of junior doctors (Calman, 1994). The combination of the increased likelihood of stress as a junior doctor and poor training will lead doctors to further feelings of a lack of preparation for a future in medicine or it may actually lead to abandonment of the medical profession (Kapur & House, 1998).

An analysis of understanding the nature of hospital training and other factors involved with workplace satisfaction is central to understanding the culture of junior doctor medical practice. It has been well documented that clerical tasks and excess of working hours (Leslie, Williams, McKenna, Smith, & Heading, 1990) impact negatively on the training and educational experience of junior doctors (Kapur & House, 1998). Hospital culture and environment are very complex due to the demands for hospital patient service versus doctor education (Rolfe, Pearson, Fardell, & Kay, 1998). The Australian Medical Association (1998) position statement on hospital medical officers' hours of work and workload suggests that extended periods of work with inadequate rest and recovery exerts a heavy cost to the patient and health care system, as well as the work performance of the medical officer. However, it seems that excessive hours are entrenched in complex interrelated ways in the traditional hospital culture. That is, if you are working long hours you must be committed to your work and doing a good job. This may not always be the case. Working long hours could mean there are not enough doctors in that unit or the doctor is disorganised and not efficient enough.

It has been demonstrated that long working hours and variable shifts have the potential and reality to have significant stress levels associated with them (Cole, Loving, & Kripke, 1990). Clinical depression is also experienced by samples of UK interns (Firth-Cozens, 1987), which may decrease over the training years (Reuben, 1985). The shift from protected medical student to responsible practicing doctor has a clear negative effect on the junior doctors' well being, clinically, physically, socially and psychologically. In the interests of patient and junior doctor care, looking at means of easing this transition should be well supported (Houston & Allt,

1997). Much reform in medicine has also occurred as a result of other fields examining medicine from a nonmedical perspective or as a result of legal cases (eg Libby Zion) (Reuter, 1994). The media frenzy and subsequent legal reforms after the Zion case began the critical examination of the "contradictions inherent in the residency system and their effects on the lives of residents and patients" (Rothman, 1996, p. 30).

Some work in comparing internship experiences of doctors and teachers has also been conducted, which has brought about interesting comparisons of the training, coping, acquisition of skills, and how these two early professional groups develop their knowledge (Booth, Hargreaves, Bradley, & Southworth, 1995). However, there is a difference between the service context of hospitals and schools in terms of students not necessarily wanting to be taught and patients wanting to be healed. It was also found that the 'osmosis' methods of learning for junior doctors was not satisfactory (Booth, Hargreaves, Bradley & Southworth, 1995).

Junior doctors are increasingly being questioned as to their commitment to health care by the managerial levels of health care services, who do not seem to understand some of the core values of the medical profession (Allen, 1997). As a junior doctor, the experiences of increased emergencies, patient deaths, looking for equipment or drugs from another part of the hospital is associated with making mistakes (Baldwin, Dodd, & Wrate, 1998). The concept of a doctor making mistakes is not pleasant, but the public does expect doctors to be free of error (Horton, 1999). Firth-Cozens (1989) found that in a sample of junior doctors who had just worked on average 91 hours in the previous week, four percent of them indicated that they use sedatives, antidepressants or hypnotics and that seven percent used drugs recreationally. This may suggest then that junior doctors are making mistakes (Baldwin et al., 1998) which can be attributed to long working hours, lack of sleep (Lingenfelser et al., 1994), and drug or alcohol effects (Daugherty, Baldwin, & Rowley, 1998).

There is still concern over junior doctor drug abuse. Some suggest that the hierarchy in medicine and the loss of balance in the mission of residency plays a key role in this and the aim should be to minimise mistreatment of residents (Baldwin & Daugherty, 1997; Rockwell, 1998; Whyte & Beall, 1998). Medical mistakes are commonly studied in terms of how doctors manage their medical errors or even if they are 'allowed' to make errors (Babu, Chang, Chodock, Klein, Kuo, Rene, Shin, Smith, & Schaberg, 1998). It has been found that the majority of doctors feel remorse and anger when disclosing their errors to another doctor, and do so under the guise of a learning experience (Allman, 1998). Residents are more likely to hide errors from their patients, not other doctors. The ability to even admit to an error for a surgical resident is seen as a step in the right direction (Allman, 1998).

This highlights that there are certain boundaries of the organisation and cultural rules that seem to be followed when under stress and perhaps after making medical mistakes. It is difficult to comprehend how junior doctors are continuing to work in these environments with conflicts between administration, excessive working hours and high substance abuse tendencies (Aach, Girard, Humphrey, McCue, Reuben, Smith, Wallenstein, & Ginsburg, 1992; Baldwin et al., 1998; Birch et al., 1998; A. Brooks, 1998a). What can explain the development of the profession and how are junior doctors getting through the demands of the job? The next section moves to a

consideration of coping and then other aspects of learning to be a junior doctor are examined further.

It has been suggested that junior doctors begin to acquire neutral emotions because of the demands of the job and the emphasis on medical skills. Ridder (1986) postulates that interns learn to develop emotional distance about what is accepted within the medical culture as a part of cultural development, in terms of what a junior doctor can legitimately display to be a part of this culture. What is becoming apparent here is that there is more to being a junior doctor than developing clinically in terms of the role and skills of the job. The working conditions develop abilities to cope and also social aspects of the medical profession in relation to clusters of values, beliefs, symbols, rituals, meanings, and survival aspects of everyday life in relation to the medical profession (Fox, Mazmainian, & Putnam, 1989).

There is often a lack of daily workplace autonomy in medical duties which affects junior doctors' stress levels and work satisfaction. It is essential then, to look at why junior doctors are rating their job satisfaction as low. It is apparent that the daily routines and workload of junior doctor medicine are often underestimated by other staff (Kapur, Borrill, & Stride, 1998a). In relation to these issues, it seems very clear that better models of junior doctor training need to surface. For instance, a review of residents' activities in psychiatry and job expectations of program directors was examined in terms of how the training and instructional approaches of the senior resident fulfilled junior residents' expectations (DeLisa, Jain, & Kirshblum, 1998b). The important duties of the chief resident included: to act as a liaison person, a role model, to schedule, build teamwork and give constructive feedback to residents. Thus, these aspects were seen as valuable because it showed that the important aspects of a mentor-chief resident assisted with some of the more stressful aspects of early medical training (DeLisa, Jain, & Kirshblum, 1998b).

The early postgraduate training years have, according to Calman (1994), three main objectives: acquisition of knowledge, skills, and development of attitudes. These are however, significantly mediated by other factors such as the amount of inappropriate medical tasks, paper work and heavy clinical workload that junior doctors encounter (Gillard, Dent, Aarons, Smyth-Pigott, & Nicolls, 1993). Although junior doctors are at the entry level of professional medicine, it is fundamental that their daily job is still valued enough to be nurtured in a professional and educationally focussed manner. It is well documented that early medical practice is dominated by paperwork. This is often of little educational value, does not always require medical knowledge (Kapur & House, 1998) and mediates the enjoyment and quality of work. The focus of most of the literature on postgraduate medical training centres on coping skills and practical aspects to learning skills in a training program. The daily grind of an intern's job is spent doing significantly large volumes of clerical work, filling in forms, organising, doing and reporting investigations, and organising senior doctors' consultation with patients. Research from Parkhouse (1991) indicates that daily activities appear to be dominated by routine practical tasks, which could be done by other hospital staff. This deprofessionalisation or rather practice as a 'clerk with medical knowledge' does affect residents' concept of identity in their position.

At the beginning of the junior doctor training years, newspapers pay attention to new interns and the first ‘dramatic’ weeks as doctors, which describe the daily medical activities, emphasising the newness and the more modern medical practice of today's interns (Butler, 1998; Hammond, 1998; Olsson, 1998; Parnell, 1999; Yallop, 1998). However, soon many interns will discover that the intense commitment of health care service provision for many hospitals overshadows educational quality and negatively affects their working and educational experience as house officers (Calman, 1994). Many teaching hospitals are “beset by a litany of now familiar complaints” (Kassirer, 1999, p. 309), such as short rotations of house staff and the effect on discontinuity of patient care.

However, it has also been found by Harvard researchers that care for patients in teaching hospitals is superior to that provided in other hospitals (Ayanian, Weissman, Chasan-Taber S, & Epstein, 1998). As suggested earlier, there is strong evidence that junior doctors work excessive hours and spend significant amounts of time on ‘inappropriate clerical activities’ (Leslie et al., 1990). Senior doctors suggest that this period of training is also useful for interns to learn from their experiences, recognise problems in themselves, and their patients and know when to seek senior advice before any harm is done (Johnston, 1992). Thus, there are no doubts about the quality or even existence of appropriate educational experiences beyond the daily grind for junior medical staff (Kapur & House, 1998).

This early postgraduate training period is a time of order and disorder. It is however, important for junior doctors to experience reinforcement of their undergraduate knowledge with postgraduate clinical experience which is reinforced through service commitments (Queensland Medical Education Centre, 1997a). However, meeting the educational needs of junior doctors, can often be at the expense of meeting community needs and straining hospital resources (Simmons, Richards, Roberge, & Kendrick, 1994). Medical education then, should also include the need for doctors to maintain qualities of care and a commitment to patients. As DelVecchio Good (1989) suggests, medical training still does produce cynical, biologically driven doctors, who have lost the ability to care and relate to patients. How does this happen even though there is such significant concern echoed through the medical and educational community about the quality of education and training for junior doctors (Dally, Ewan, & Pitney, 1984; Gillard, Dent, Aarons, Smyth-Pigott, & Nicolls, 1993; Roche, Sanson-Fisher, & Cockburn, 1997)?

This transition from medical student to junior doctor does seems to present a gap between the educational goals and the hospital demands of the first years of medical practice. Many JHOs practice with more independence in their second and subsequent years, however, structured postgraduate training is not always maintained, although continuing education designed with junior doctor needs in mind is still required (Luke, 1997b). It seems that specific guidelines such as a written and verbal orientation to wards, and appropriate assessment processes are essential for the quality training of junior doctors (Queensland Medical Education Centre, 1997b).

The ‘trial by fire’ (Fox, 1995) of the first postgraduate years and the early experiences of hospital working conditions after years of full-time study (and for some their first job since high school) continues to be a source of great concern for

doctors and hospital administrators (Daughterly et al., 1998). Although it is documented that many doctors are unhappy with the quality of their professional lives (eg. Editor, 1998), there is a focus more so on the positive effect that good teaching can play towards satisfaction in medicine (Dunnington & DaRosa, 1998). It also seems that through working long hours and learning clinical skills of the medical profession junior doctors are also learning "the implicit messages about professional attitudes and behaviours" (Daugherty et al., 1998, p. 1195) and perhaps how to define aspects to professional competence and identity (Fox, 1995).

Descriptive and personal accounts (Marion, 1991) describe harrowing experiences, stories, situations, critical incidents where growth during residency occurs. Flynn and Hekeman (1993) also describe the experiences of transition from medical school to residency. Using a family residency program as an example, the authors explored the transition in terms of 'reality shock'. Here reality shock may occur as a conflict resulting from moving from a familiar subculture of school to the unfamiliar culture of work. Further, role transition requires reconciling different values and behaviour that are required in the new culture.

Starting a new job can be stressful for anyone, regardless of whether one has just graduated from medical school or not, so what makes becoming a junior doctor any different? Firstly, junior doctors are in a powerless position on the account of their dependence on the hospital and their consultants in terms of their medical registration. Secondly, working conditions are mediated by the fact that an increase in numbers of junior doctor positions has often been made in light of the service needs of the hospital because junior doctors traditionally work more hours, and can be employed for less money (Urbina, Kaufman, & Derksen, 1997). Thirdly, the necessity of learning to communicate across racial, class or cultural lines (Henderson, King, Strauss, Estroff, & Churchill, 1997) coupled with long hours, lack of or variable supervision, daily stressful experiences of illness, suffering and patient death are among many of the clinical challenges for a beginning young intern. Through a lot of these training experiences doctors are also receiving lessons about different categories of expert doctor and patient roles and about medical dominance (Dundas Todd, 1989). Perhaps the loss of public trust of doctors can be remedied through medical training where schools can select and nurture future doctors who see the role of medicine in a broader context in society (Wallace, 1997).

Although traditionally medicine emphasises the importance of knowledge acquisition, understanding disease, interpretation and synthesis of medical information to guide clinical diagnosis and management (Sanders, Mitchell, & Byrne, 1997), sociologists have observed how through this process doctors are also able to gain positive membership aspects with this powerful group. It cannot be overstated that the process of entering the medical profession as an apprentice into a craft is unique. From the moment someone becomes a doctor, they are responsible for assessment of a patient, management of a medical condition and ongoing care as required. The way that doctors are taught and learn the skills, knowledge and attitudes necessary to become a doctor, need also to be special and unique (Grant, 1998). As suggested previously, the effects on the training process of night duty and constant sleep deprivation are profound (Neumayer et al., 1993). This period essentially is a time when a medical student is moulded into a clinician (Beckman,

1993) whereby one is expected to "realistically appraise professional abilities, manage a wide range of common conditions [while developing] a sound basis for continuing education and future medical practice" (Queensland Medical Education Centre, 1997a, p. 23).

Thus far, the focus has been on what defines a junior doctor, some of the practical issues in the transition period from medical student to junior doctor, the medical educational process and some of the more traumatic factors in entering the medical profession. However, there are many authorities concerned with not only the quality of training, but also what is actually going on in this early process. A great amount of practical information has been presented here about the experiences of becoming a junior doctor to illustrate the culture and what it means to be a junior doctor. Literature on junior doctors is most often focussed on the practical aspects to the job, experiences, clinical learning and trauma of the first years. A significant gap, which has not been addressed, is the role of the medical culture, the unspoken aspects to the job. Where and how are junior doctors learning about these aspects and characteristics unique to the job of becoming and surviving as junior doctor? I continue to look at what postgraduate education consists of to answer some of these questions.

The medical internship is an important time for stabilising learning, improving training and focus on clinical learning in a structured and in a paid medical service to the hospital. There are many factors that contribute positively and negatively to the learning experiences of junior doctors. Junior doctors perceive their internship year in terms of the contributions to their learning, overall satisfaction with internship, and what could have been done better (Daugherty et al., 1998). More satisfaction with their internship was mediated by further assistance in learning and less mistreatment. Other more basic aspects to improving training have been suggested to include more refreshments after grand rounds, computer maintenance, photos of nursing staff, training in particular procedures, a set house officer syllabus and coordination in xray film location (Weingart, 1998).

The indications that more emphasis towards on the job learning during internship is relevant here because it suggests that it is not only the transfer of clinical skills and medical knowledge that is important, but it is also the learning environment (Dunnington & DaRosa, 1998). Further, it has been demonstrated that interviews with junior doctors showed that not only was on the job training implicit, opportunistic and incidental, but that doctors were also not aware as to what the aims of ward rounds were or when the teaching for knowledge and understanding as opposed to service delivery was taking place (Booth, 1998a).

Much has been written about junior doctor problems with postgraduate training in hospitals, yet there is limited research on aspects that may improve the early training. The area where junior doctors are supervised by senior doctors such as registrars or consultants is important to training because of the role supervision plays in examination of patients, planning management, and presentation of patients' case to the supervising doctor. It could be suggested that supervision is an essential component to this early training period. Challis, Williams and Batstone (1998) conducted in-depth interviews with directors of postgraduate education, and aimed to identify how consultants conceptualised being an educational versus clinical

supervisor for junior doctors. Training programs for junior residents should consider the quality of supervision that residents receive to benefit the care of patients (Sox et al., 1998).

Further, in relation to the top ranked hospitals in the US, researchers have found a lower thirty day patient death rate from acute myocardial infarctions possibly due to medical aspects (such as the use of aspirin and beta blocker therapy), but also perhaps due to improved training of staff (Chen, Radford, Wang, Marciniak, & Krumholz, 1999). Therefore, training and appropriate supervision have implications for patient care. Challis, Williams, & Batstone (1998) found that educational supervisors rated themselves as currently non expert supervisors who required further training in terms of teaching, learning, assessment, and how to give appraisal and to perform in the role as a good supervisor. In a study of five Harvard teaching hospitals, the supervision of residents by attending physicians was examined in relation to the effect on patients' compliance with after care guidelines, patient satisfaction and reported problems with after care. Supervision was found to be significant in terms of patient compliance with after care guidelines when the attending physician directly supervised the resident (Sox et al., 1998).

Emphasis on the importance of formal training, induction experiences and other needs of junior doctors, such as the role of the consultants, feedback and needs of junior staff is becoming more important (Williams & Cheung, 1997). Looking at junior doctor orientation into hospitals with the aim of improving consultant supervision and feedback discussions with consultants is important for improving job satisfaction and training experiences (Paice, Moss, West, & Grant, 1997). It is still common that the financial costs of training for many hospital administrators is a fundamental issue that contributes to the conflict between health service provisions and education of junior doctors.

Although hospital training is costly, junior doctors provide health care that can be as cost-effective if provided by staff physicians working alone (Rosborough, 1998). Further, although postgraduate education is expensive in dollars and time, it seems that patient survival for common illness (such as hip fractures) is improved in major teaching hospitals (Taylor, Whellan, & Sloan, 1999). Therefore, appropriate training, supervision, safe hours, appropriate workload and a supportive training environment can only contribute to quality patient care and service efficiency. Specific suggestions in terms of improving junior doctor training may also include: empowerment of junior doctors, acknowledgment of the stressful nature of their work, commitment to residency training (Weingart, 1996) and even support groups for junior doctors (Butler, 1993). Useful tools that are also well received by junior doctors included resources that are specifically for junior doctors that focus on aspects that are of importance to them. This includes, general descriptions about the junior doctor job duties in that ward, working with the consultant and medical basics such as, how to admit patients, and generally roles and duties of junior doctors (eg Johnson & Iredale, 1996).

There is no doubt that the junior doctor years are difficult because of the nature of the transition between medical student to employed structured training. The years of clinical training are important to develop many of the educational standards and skills for the future (Rolfe, Pearson et al., 1998). However, as there has been little

research into the key problems facing junior doctors in Australia (Rolfe, Gordon et al., 1998), the early years remain a stressful, yet a necessary passage for future doctors (Mizrahi, 1984). The defining aspects to this 'passage' include experiences of hierarchy, constant job changing, long hours and sustainment of a conservative hierarchy (Roberts, 1991). It is no wonder that many junior doctors become unhappy, feel and experience the job as simply that of a clerk with medical knowledge.

Through the experiences of learning about clinical and knowledge needs in medicine, there are interplays of cultural development or learning about certain beliefs, values and behaviours that characterise so many of the specific studies of medical professional groups. Much of this literature is important and useful in understanding junior doctors and their training, yet, there still seems to be a gap in understanding what junior doctors are learning about medical culture, aside from the practicalities of the job. Junior doctors provide the bulk of medical care in teaching hospitals, therefore it has been suggested that excellent postgraduate training does not always prepare junior doctors with the practical survival skills needed during residency training (Weingart, 1996).

It seems that the medical hierarchy has been able to avoid "any but the most superficial of scrutiny by … feminists" (Conley, 1996, vii). The impact that the medical profession makes on junior doctors is essentially medical professional development that contributes to practice style, professional values, attitudes and beliefs. It has been suggested that physicians' gender may have an important influence on medical practice (Martin, Arnold, & Parker, 1988). Medical stress issues are generally similar for male and female junior doctors, where junior doctors score similarly on issues of satisfaction with career, perceived competence, fatigue, and overwork creates the most strain on personal life (Firth-Cozens, 1990).
Key issues and concerns for surgical residents included hours, finances, quantity and quality of formal education, and family plans (Gabram, Allen, & Deckers, 1995). Issues of more concern to women than men included: availability of role models, mentors (Firth-Cozens, 1990), comfort in expressing emotions at work, initiating and maintaining personal relationships, having children during residency and postponing family plans (Gabram et al., 1995). In a study which interviewed female doctors about their careers, mentors, models, training issues, and about private issues such as relationships and family, it was found that there was a strong need for female role models in medicine (Klass, 1996). This research is important because it documents some gender issues and distinguishes training and professional experiences in medicine at a sociological level.

In Australia, 15.6% of the specialist workforce are female (Australian Institute of Health and Welfare & Australian Medical Workforce Advisory Committee, 2000), and women compromise 47% of general practitioners under age 35 (AMWAC, 1996). Women are more likely to choose specialties such as general practice, psychiatry, anaesthesiology and paediatrics (AMWAC, 2000; Prideaux, Saunders, Schofield, Wing, Gordon, Hays, Worley, Martin, & Paget, 2001). It is sadly the case that from 1994 survey data indicated that women numbered 3.1% of general surgeons, and that surgery still remains 96% male dominated (Australian Bureau of Statistics, 1996), and female representation in obstetrics and gynaecology is only

eleven percent (Australian Medical Workforce Advisory Committee, 1996) compared to seventy percent in France (Kincaid-Smith, 1995). Recently, we find that 45% of trainees are female, ranging from 63.3% in paediatrics to only 13.4% of surgery trainees (AMWAC, 2001). Training programs with comparatively low levels of female participation, in addition to surgery, were intensive care (18.3%) and emergency medicine (38.4%). While the numbers are increasing, it is occurring at a very slow rate. In orthopaedic surgery, men also rate their training significantly better than women (Dailey, Brinker, & Elliott, 1998). This indicates that women may be choosing certain specialties because the career path and nature of the job caters to their particular needs such as childcare, partners' support and working hours (Commonwealth Department of Human Services and Health, 1995). Gender differences in professional socialisation have also been found to affect physician values, attitudes and behaviours (Martin et al., 1988). Furthermore, in terms of career paths, women tend to choose primary care, rarely enter surgery, are paid less and are more likely to be self-employed (Martin et al., 1988). The early professional development of female junior doctors may need to be looked at differently compared with senior doctors because the initial issues and experiences are likely to be different.

The junior doctor years challenge both men and women, where hospital based training can make it difficult to combine a personal life and career. It has been well documented that female doctors face conflicts between career and personal life (Pringle, 1998). There is also a strong misconception that for women who decide to become surgeons, they will have unsatisfactory personal lives and will be unable to afford the time to have a family (Falek & Brattebo, 1996). Therefore, important training issues such as lack of encouragement by senior doctors and fewer opportunities to assist or perform procedures (Falek & Brattebo, 1996) coupled with ideological misconceptions, have been found to contribute to gender imbalance in surgery. The gender compositions of orthopaedics residency programs have also been examined. Orthopaedic junior doctors are generally male, and orthopaedics has traditionally been considered a male dominated field. The modest increase in female medical students reflects an increase in women as junior doctors as opposed to an increase of women who are likely to train in orthopaedics (Biermann, 1998).

Medicine is a stressful experience for men and women, however, in some instances 'normal' behaviour from male doctors might be considered aggressive and obnoxious in a female doctor (Klass, 1996). Women doctors have unique experiences with female nurses, such as, difficulty getting help doing procedures, having to clean up themselves after procedures (which is not expected of the male surgeons by female nurses), or being seen as the nurse and not the doctor by patients. Conflicting loyalties, responsibilities and reactions of seniors to these concerns are issues experienced primarily by women in medicine (Swerdlow, McNeilly, & Rue, 1980). Further, attitudes (sometimes harassing, rude and hostile) towards women in surgery have been reported, which could account for reports of female junior doctors achieving fewer surgical skills than young male doctors (Falek & Brattebo, 1996). Due to low recruitment of women into surgery, those who teach surgery at both undergraduate and postgraduate levels are by and large, male, and thus need to address these problems (Falek & Brattebo, 1996).

PRODUCTION AND CONSTRUCTION: THE CULTURE OF MEDICINE

Medical education focuses on the continuing change in health-care management and workforce issues, especially in relation to residency training and effects on teaching hospitals (Moynihan, 1998). It is important to understand the medical culture in terms of these cultural 'thoughts' of leaving a profession once fully trained, having to choose a clear career path within medicine and the related workplace problems. Essentially these important sociological aspects and characteristics define medicine as a culture and one with unique aspects with a wealth of areas for investigation from many perspectives. Within the profession of medicine it is suggested that there is 'change' that is weakening the collective whole (Riska, 1998). Many aspects of clinical practice are emerging as complex sociological systems. There may be 'no truth out there' (Fox, 1992), sociologically speaking, in junior doctor training to be discovered. The future of medical science and practice may be uncertain (Frost, 1997). It is here that we begin to find many traditional medical training and professional attitudes and values being challenged by the healthcare systems, people within medicine, patients' expectations, technological advances and many doctors are becoming confused and demoralised in the process of change (Macara, 1994).

Within medicine, maintenance of professional values is very important. Traditional values of the medical profession have included learning and application of specialised knowledge, service to society and care for the suffering. Medical school and hospital training needs to model modern professional values for upcoming medical students (Swick, 1998) to meet the needs of future societies. In addition, the role and central goal of continuing medical education (CME) should be to improve patient care, but not at the expense of opportunities for junior doctors to further their education (Carter & Marr, 1998). Here learning medical knowledge has been of interest because of the way that medical students come to know about medicine and how medicine is constructed from students learning medicine (Good & DelVecchio Good, 1993). As previously explained through medical school, values and attitudes of doctors and students are shaped by time and through the professional development process (Swick, Simpson, & VanSusteren, 1995). Some of these experiences through medical school and postgraduate medical training may not be obvious to those within the culture (Fox, 1987; 1989), but an understanding of them might guide future direction to develop an ethos of caring and career directions among medical graduates (Good, 1995).

What is going on through the professional development of a junior doctor during the training years and the experiences of the medical culture? Medical culture no doubt has certain meanings and values enclosed within the medical hierarchy. How are junior doctors responding to the system of structure, training, professional development and, as Fiske (1994) suggests, the way of living that people devise within it? The literature on junior doctors presented so far indicates that there are these educational markers of learning, competence and stresses of the job, but what are junior doctors actually learning about beyond the clinical skills? They are learning about the medical culture. I hear the call from sociologists that suggest that there are not enough ethnographic studies of hospitals and this would provide

valuable information applicable to the micro-cosmic, cultural, perspectives on changes in medicine today (Fox, 1985).

The social meaning of medical practices are guided here by postmodernist theory; Fox (1992) originally conducted ethnographic research in surgical settings to deconstruct the practice of surgery. In Fox's primary work "*The social meaning of surgery*" (1992) he focussed on aspects such as: operating theatre personnel, surgical theatre layout, management of surgical tools, relationships between surgeons, general management of surgery and briefly ward rounds. Fox perhaps is known for his book "*Postmodernism, sociology and health*" (1994b) where he examined postmodern ideologies on health care, power, the body and the postmodern politics of health and technology. Of most interest here, is Fox's (1992) use of postmodern theory and application to the examination of ward rounds.

The concept or practice of a ward round is likely to be foreign, unless one has been a patient in a public hospital or one has worked in a hospital ward. Essentially a ward round is a medical practice based activity, whereby a group of doctors of varying levels move from bed to bed of patients (who were admitted under that consultant's care). The four main types of ward rounds include: ward round only (teaching or business), pre ward round meeting followed by the ward round, ward round followed by post ward round meeting and finally, a pre ward round meeting, ward round, followed by a post ward round meeting (Stanley, 1998). Parts of ward rounds can also take place in hallways, corridors, washing sinks, stairwells, doctor's station, and xray boxes, all of which form part of the ward round.

In ward rounds, doctors discuss the patient's current state of health (or ill health), treatment and discuss daily and long term management of the patient. Ward rounds are seen in many ways, but (primarily) as an important learning opportunity for junior doctors because the senior doctor is likely to discuss medical aspects about the patient (the consultant has more experience and a larger knowledge base to draw from). Ward rounds and the likelihood of bedside teaching focus on many things, but mainly the emphasis is on the process of history taking, diagnosis (Armstrong, 1992; Baldwin et al., 1997) and management. As a pedagogical practice, teaching medical students and junior doctors at the patient's bedside is central. In the process of travelling from bed to bed educating doctors and medical students, there is a transition in cultural and key pedagogical practice.

Much of Fox's (1994a) work in the surgical setting (and occasionally on ward rounds), is premised on the assumption that activities that are conducted by members within society should be open for interpretation by others. Fox (1993) has argued that through technical procedures surgeons adopted, not only did this constitute work practice, but also confirmed their authority which is achieved through the surgical work process. Fox's work describes how as an observer he gained access into a 'strange' field setting (surgery/hospital) to observe as a sociologist whereby specific practices can be discovered. Fox's (1992) approach to the surgical setting was uncommon in the examination of the social construction of surgery and how certain constructs in medicine mediate medical practice (eg. surgical masks). In this instance, surgery was found to have constituted, sustained and reproduced aspects of practice (Fox, 1994a). The inspiration for Fox's (1997) subsequent examinations of surgery have been conducted in a way that unravels the

medical/surgical practices of social theory which is particularly useful because of the capacity to analyse power as erratic, mediated by doctors' access, and what seemed to be accepted as knowledge (and behaviour) in the medical setting.

Bedside teaching is an important process to teaching professionalism to junior doctors in front of patients as opposed to in a seminar room (1997). Thus, the sociology of medical knowledge is grounded in medical work of medical practice. The ward round can be seen as an organised way in which elements of medical knowledge are produced and reproduced. The ward round is an important avenue to discuss with fellow doctors facts, opinions and patient management (Wilson, 1993). Ward rounds are complex social interaction occasions where instruction from the consultant and registrar engage social status and social control for the management of patient care and as a behavioural guide for medical training (Fox, 1993).

The ward round was seen by Fox as a collection of culturally prescribed devices, where medical work is accomplished in stable and predictable ways (Fox, 1992). The presentation of a patient during wards rounds conforms to a specific medical format where it is important junior doctors learn very quickly what is required for that situation (Booth, 1998b). Other research that has been done on ward rounds includes the role and contribution of nurses (Jones, 1998), learning experiences of junior doctors and other ethnographic work (Baldwin et al., 1997; Fox, 1993; Jones, 1998; Stanley, 1998). The focus on ward rounds (and surgical sessions) is where Fox (1992) examined how the discourse of surgery and medical 'truth' (or knowledge) produced, reproduced, and in some instances persuaded other doctors to those 'truths'. The analysis of surgical ward round interactions was also suggested to centre on perspectives of physiology, wound condition, recovery and discharge (Fox, 1992). The ward round is seen as a device where there are diverse types of knowledge and actions at play assembled under a single activity (Stanley, 1998). Therefore, this activity can be seen as a place for the reproduction of medical knowledge and may act as a socialiser for the medical profession.

Atkinson (1997) also conducted and documented informative work in medical settings, in relation to ward rounds indirectly, while engaging in participant observation and interviewing doctors. Atkinson (1996) suggests that a ward round could be seen as a highly formalised activity, where the senior doctors display their expertise for the junior staff and especially medical students. Atkinson (1996, p. 150) elaborates on the way that ward rounds "contribute to the spectacular enactment of medical culture", and that researchers disregard the context in which medical knowledge and action are produced. Thus, leading researchers to consider further the organisational context that medical work is being done in. The conduct of hospital based ethnographic fieldwork focussing on medical work by Fox and Atkinson is methodologically instructive because it illustrates how sociologists can get access to unique sites, interpreted activities from a sociological perspective and examines "the social construction of reality in the context of one phase of medical education" (Atkinson, 1997, p. 189). Therefore, in medical settings, it could be suggested that the concept of disease is produced through the social contexts of the doctors engaging in this social reality (Atkinson, 1996).

The vast nature of medical sociology and the areas it researches can be problematic for readers looking for their particular area of interest. Briefly I would

like to draw attention to how medical sociology has made significant contributions; in particular this includes study of the profession of medicine from a number of angles. The professions focus in medical sociology includes a focus on how the workplace norms and distribution of resources effect practice as well as research that has focussed on professionals in organisations and the competition between professions for authority and autonomy (Conrad, Bird, & Fremont, 2000). The medical profession is constantly changing and therefore the focus on much of the research does as well. This is reflected in, for instance, the change in the demographic composition of medical members, such as more women medical students entering college or the feminization of the workforce as more female GPs work part time while raising a family. Further other societal changes such as detailed clinical practice guidelines and the evidence-based practice have an effect on how doctors and medical sociologists practice and in particular, research that practice. The assessment of new technologies such as electronic script writing to minimise prescribing errors and electronic patient records also effect the way we interpret and analyse the medical profession. Finally as Hafferty (2000, p. 238) suggests:

> the sociological study of medical education, like many other academic endeavours, is a dynamic, contentious, and sometimes unruly beast. Ways of seeing and knowing are "discovered," disappear and are resurrected across windless waves of understanding.

Much of the sociological literature focuses on a class of professions as a whole such as nurses, doctors and generally the healthcare fields. The difficulty with this is the variation in a whole area of healthcare, and the lack of specific analysis on a level within medicine for example, junior doctors. It is important in a cultural analysis to have as a specific focus on how or what professions train its new members in. Beyond specific structural parts of junior doctors' work, such as stress or coping, are the social and cultural processes that are a part of their objective experiences. This theoretical gap is my main reason for pursuing a theory that has as its main principle a desire to understand how objects (such as junior doctors) are constructed in science through the modes of production (the profession) which are capable of or have power to constrain practices which underline the production of knowledge.

The suggestion here is not that the medical sociological literature is not useful. It does identify how through the social structure of medicine, it has particular functions and describes generally, many aspects of what is going on within medicine, as well as the effect on the health-care systems. As a general introduction to medical practice much of the previous literature describes how medicine is focussed on an interpretation of biological systems and it is essentially a practice shaped by particular values. Attainment of this medical authority base is through a specific form of training where there is a set construction of medical knowledge and a process of application of knowledge.

As reviewed earlier, medicine in sociological terms has been researched as organisational practice and looked at in terms of the language of medicine and how it is quite powerful in its constructs relating to medical knowledge. Further, many of the ideologies of the profession are organised and sustained by the occupation

through particular attitudes and behaviours associated with being a doctor. These specific knowledges and skills are enforced by training institutions and thus, certain ideologies that are present in the professions. It is key to use innovative ways to see how junior doctors are not simply products of the organised nature of medical school or a part of a professional subculture. This is a key problem with professional socialisation theory because it emphasises reproduction, locus of control, role strain, work satisfaction, values and role identity. It is too much of a traditional focus using psychological literature looking at the social through old theories of attachment or learning. This literature also often constructs an 'over socialised' view of the doctor.

As I will show in the following chapter, Bourdieu's theorising is clearly different because his theoretical work allows us to clarify how professions at a more detailed level succeed in reproducing themselves in the form of durable dispositions in people. This is where the previous research moves from a psychological level to a more detailed sociological level. The first two years of medical practice in a hospital are very important here in the development from medical students to graduate medical practitioners. This is also why Bourdieu's work is so useful for this area of investigation, because his sociological theorising is really a theory about practice, including its embodied, cognitive and cultural aspects.

In so much of the literature reviewed thus far, the focus was on situations that induce certain behaviours, and professional development was seen in terms of learning of roles or a collection of values. For many researchers then, professional training becomes a collective solution to shared problems with a focus on how the institutions affect the student. Bourdieu's work is different because it uses sociology to examine how people are products of similar social conditions, supports of similar relationships and become products common to similar structures.

We move now to inside medicine, and beyond previous medical sociological research. The question I pose is that: as a sociologist, how does being reflective about positions within a system of relationships influence interpretations about a specific way of being (eg, the habitus)? It is the assumption here that the way of being is learnt from certain positions and generates certain sociological practices and endeavours. As I will demonstrate, beyond just a socialisation process of attitude change, I maintain that a person's habitus changes as the social structures change. In turn, social structures change as a result of the transformation of certain practices produced at certain times through the changes and enactment of what Bourdieu (1991) calls the habitus. Here there is movement beyond currently existing literature through the application of a social scientific sociological theory of practice to a field traditionally examined by pure science and psychological models of inquiry.

Previous research on junior doctors has focused on professional socialisation as simply an internalisation of values, beliefs and behaviours that stem from medical school. Further research specifically on junior doctors, focuses on singular components of the early experiences such as hours worked, stress levels, women in medicine and so forth (cf, Australian Medical Association, 1998; Birchard, 1999; Hannon, 2000). By contrast, here we are looking at the holistic perspective of cultural development and experiences of junior doctors, and how other components

(e.g., relationships with seniors, coping with stress) make up a professional development experience beyond socialisation and internalisation of values. These factors interact and co-constitute the process of 'becoming a doctor'. Integral to this process is how doctors organise themselves as key players within the social system of the hospital, how they use specific characteristics (eg. various capitals according to Bourdieu) to learn how a situation works, how it can work for them, and how they work within that context to attain further social standing.

In documenting medical culture and doctors as cases in the culture, we often aim to provide a snapshot of the medical culture. In doing so, we do not suggest that there is a separation between the researcher as an abstract, being hidden or as an impartial researcher seeking 'truth' (Scheurich, 1995). Here unique characteristics as well as common themes across the local site, individuals and the group experiences were sought. It was anticipated that identification and theorisation of particular patterns of events that have transferability across similar, although distinct situated contexts were identified. This is relevant for understanding attitudes and experiences in medical culture. Often with analysing and interpreting qualitative data, there are no formulas for determining significance (Patton, 1996). Moreover, there are no methodological techniques with which to ensure a perfect replication of the analytical thought processes of the researcher at that time. Nonetheless, many qualitative studies are in themselves unique and each analytical approach will always be unique.

WHY USE THE CONCEPT OF HABITUS IN MEDICINE?

It is through the concept of the habitus that this book is driven. At its most basic, definition habitus is the way people have a specific style or manner to their being in the world. The development, modification and enactment of the habitus is a significant means to describe a process of professional development. We describe in detail the habitus in Chapter 2, here I briefly outline why we are using the concept and flag the importance. Many aspects of early medical experiences on the job are mediated by the habitus, which shapes individual doctor's activity and which, in turn, reproduces specific structures of opportunity or impediments. It is through learning about and internalising specific dispositional requirements of becoming doctor this can be analysed through the concept of the habitus. This suggests that in any given 'social field' or context, there are particular social conditions that enable doctors to enact and reproduce required or 'dominant' dispositions. The role of the embodied medical habitus is a key in the reproduction of the social-medical hierarchy encountered in the first two years of junior doctor medical practice. The habitus is situated in social interaction, which is contextualised in particular social fields, and within which positions form a system of relations. Additionally, as a core of a person's subjectivity, habitus incorporates into the physical body ways in which individuals act in and negotiate their way throughout their training.

The concept of habitus is used here to suggest ways of relating and linking social structure and subjective agency/action approaches in sociology. Bourdieu's concepts of habitus and social field have been applied to analyses of numerous

professional and workplace cultures. Krais (1996) studied university culture and academic life, and found that academic and intellectual practices are inculcated in the habitus of the community members. Using Bourdieu's conceptualisation of the habitus and the incorporation of junior doctor medical culture, this opens for analysis those conditions that shape the motivation, learning and enactment of particular rules of social life and junior doctor medical culture.

Moreover, the concept of the habitus is also a method in terms of a new way of conceptualising the social world. Through reading and hearing the junior doctors voices this will demonstrate how through participation in the practices of the medical culture, junior doctors take on a habitus that consists of particular behaviours. Yet the habitus is also a part of a social trajectory through medical culture: a sense of collective and individual social identity, habits of thoughts, tastes and dispositions that are formed in and by those particular medical practices. It is through the theory of the habitus that many of our conventional ideas about medical professional development are challenged, rejected and/or redefined. The habitus offers a theoretical framework within which living within a social space can be interpreted as structuring and being structured by particular institutions and culture rather than merely by its inhabitants.

Bourdieu's overall sociological theory is analytically useful and instructive to show how the habitus as a sociological theory can be translated into the medical field. The medical system prescribes rule-based actions, procedures and behavioural repertoires to which junior doctors must adhere to in order to function within the system, and to achieve status, authority and mobility within that system. The habitus regulates individuals' particular choices in response to the contexts, situations and learnt dispositions.

The key theoretical and methodological issues then, are how to describe the change in cultural knowledge or 'feel for the game' (Bourdieu & Coleman, 1991) that junior doctors experience throughout their first two years of postgraduate hospital experience. Using a Bourdieuian analysis is an innovative way of looking at how medical culture works, and what it reveals about the making and construction of a professional culture. In developing a particular perspective on junior doctors' professional development this volume begins with a theory that allows readers to follow the data which then builds a relationship between data and theory. As the doctors here were a part of a case study, it was important to document the activities of the social situation to be studied.

ENTERING MEDICAL CULTURE: QUALITATIVE INQUIRY IN THE MEDICAL FIELD

Qualitative inquiry depends on a variety of skills, previous insights and variations on capabilities as a fieldworker. Consequently, the role of values in the process of inquiry is influenced by particular principles expressed through the choice and framing of issues. In this field, however, as a researcher not 'formally' part of the medical establishment, it was crucial that some sort of social acceptance with the group is established. This formed a large part of access to the data and field of

research. In the attempt to understand the complex social culture of junior doctors in medical institutions it is important to not impose *a priori* categorisation that might limit the field of inquiry.

Qualitative analysis ultimately depends on the analytical intellect and style of the analyst (Seale, 1998). In developing an understanding of the doctors, most literature does not represent a realistic or holistic picture or understanding of the experiences of junior doctor medical training. For that reason, the aim in this book is to examine aspects of professional development of junior doctors. While it is impossible to extract one aspect of a total working year, we can still examine how the (re)production of professional norms and values through the year of workplace training contributes to the process of professional change and development in junior doctors. Through understanding the process and fundamental aspects of doctors' professional development, the effectiveness of workplace training in this process can be optimised.

The experiences entering the medical field develop and contribute significantly to the way researchers choose their methods. These experiences greatly facilitate entry, development and understanding of the medical field later on. Next the focus is on the wards, research hospital and participants. The process of selecting participants and the initial lessons in introductory meetings were fundamental to researching in a medical context in terms of finalising the study methods and encountering barriers in the field. It became clear that the researcher becomes a research instrument.

What is provided here is an intertwined examination of how knowledge of the medical culture affects methods in the research process and the way that research is conducted - a method in motion, as it were. It is difficult to separate empirically the methods and the cultural influences on the process of investigation. For instance, my personal knowledge of how this hospital and the medical culture worked, the best ways to navigate within it, were in fact the best way to make use of the issues that were known in respect of this site prior to and during data collection. This also affected the validity of the data and the tools used to examine junior doctors' cultural development.

Medicine has long been examined using the primary assumption that as a science, it can only be studied from within a positivist scientific framework. The approach to the examination of medicine is essentially in opposition to that assumption. It is conceptualised that social and cultural research from the textured descriptions of local participants, that is, particular social meanings in medical setting are best represented from the perspective that values social interactions. Views regarding social meaning, certain discourses, and even new positions are important because these positions provide a method to comment on these representations and beliefs. Kellner (1997) also makes this point, namely, that when contemporary assumptions of social unity are discarded the stress is on multiple, plural, and unspecific social actions.

The intent here is to value and research the context of medical social interactions in a more detailed way. As readers of other qualitative work, we should welcome richer descriptions of culture and the related social environments. Through the interviews and voices of junior doctors here, readers will be brought into the world

h
understand medical culture, accounts of lives and experiences that junior doctors describe and the social environment that they live in and give meaning to. Once armed with pre-study experiences and assumptions about the social construction of the social world, the development of my theoretical position and the investigation of medical culture began.

So when we consider constructing the case and doing case study research in a hospital, it is key to consider that the medical cultural and professional fields need more research attention than has been given so far (ten Have, 1995). Many authors recommend (Denzin & Lincoln, 1994; Hamel, Dufour, & Fortin, 1993; Yin, 1989) case studies as the most appropriate to examine specific research questions; for instance, what is happening in certain situations, what are the important themes, patterns, categories in participants' meaning structures and how are these patterns linked with one another. Researchers also need to examine and understand social and human behaviour from within a framework of participants' thoughts, feelings, and actions (Patton, 1996). It is important to understand the variations to the phenomenon of junior doctors' early postgraduate experiences, identify important variables and potentially generate hypotheses for further research. It is also important in applied methodology to be able to address the consequences of relationships between social positions and changing practices (cf Schmidt, 1997).

The experiences entering and working in the research hospital, and previous research experience seeded my conceptual understandings of medical culture. Here in this site of research, aspects were beginning to be detected within the medical culture that was based around significant social constructions and common experiences. In much social research (cf Best & Kellner, 1991; Fox, 1998; Willems, 1997) the emphasis is on local phenomenon. In the research hospital, it was therefore initial knowledge on a personal basis of the experiences of junior doctors that stimulated my interest to examine the medical culture from a sociological perspective. Their cultural experiences and the variety of discourses in the medical culture were of interest, which also correlated with some of my initial assumptions about this field. The notion which provides social scientists a means to comment on social realities and denaturalises culture representations was relevant in this hospital (Best & Kellner, 1991; Kellner, 1997). It became apparent that, over time, aspects of the medical cultural were being transferred, learned and enforced. It has been suggested that social context can be interpreted in terms of power relations which influence the growth and development of work (Lather, 1991). Within this junior doctor medical culture, there were unique phenomena whereby the culture was clothed in traditional representations. Here, the medical cultural and clinical experiences were developing or contributing to the professional development of recent medical graduates to become 'junior doctors'.

Junior doctors were a part of the unique experiences for I already had significant access and existing entry, a fascination for, and desire to research further. Many researchers utilise their involvement in employment, vacations, or early career employment to experience and utilise the roles of a full participant for academic investigation (Punch, 1994). Important aspects to researching in a medical context, initially identifying important social positions, insights, and limitations of social

practices in a hospital are key to observation of medical practices which contribute or constitute discourses.

Building upon the assumption that ideology is the story that culture tells about itself (Lather, 1991), this investigation was also driven by a focus on a cohort of junior doctors to seek information about their experiences. Marshall and Rossman (1995) suggest that when entering settings without predetermined categories or strict observational checklists, researchers are able to discover the recurring patterns of behaviour in relationships more clearly. Here researchers can gain access to social (or read medical) practice and particular aspects of work roles and practice. The investigations of such practices taken up in the routine organisation of work practices are worthy of consideration. In other words, the descriptions participants provide to the researcher and often each other, do not occur in the background but "in and through practices and the reasoning that support those practices" (ten Have, 1995, p. 250). Therefore, medical ideology is what these doctors experience in daily life, define and which promotes development and propagation of a medical culture.

The representations of medicine allow us a way to develop perspectives in terms of context and the way truth is constructed from the local which informs the methods. As a qualitative researcher we accept that much research is ideologically driven, where there is no value or bias free design (Janesick, 1994). One of the objectives is to emphasise the strength of this approach for research that is exploratory or descriptive. Not being constrained by labels and strict protocols of structuralist discovery - context and setting are valued for the ability to engage and search for clearer and detailed understanding of the junior doctors' lived experiences. Janesick (1994, p. 213) adds that "while in the field the researcher is constantly immersed in a combination of deliberate decisions about hypotheses generated and tested on the one hand and intuitive reactions on the other".

Part of researching in a medical culture is also valuing the research curiosities, intuitive thoughts and interesting phenomenon. For instance, my initial impressions of hierarchical structures included noticing the division of ward labour duties that junior doctors performed, such as making notes in the medical record on ward rounds (as opposed to the consultant doing so). Other aspects that are of interest included the styles of dress (and how it changes over the year), and the different ways stethoscopes and pagers are worn. Other institutional markers of dress and symbols such as junior doctors carrying intravenous (IV) materials (straps, gauze), colour coded identity (ID) badges, patient labels stuck on clothes, use of drug company pens, post-it notes, and even company socks. These seem to be a part of the culture, mark the culture, and are accessible for doctors.

Utilising the theoretical framework for this work which is based on recent medical sociological applied research (Fox, 1992; 1993; 1994a; 1994b; 1997), critical social theory, including particularly the works and concepts of Bourdieu (cf, 1977; 1989a, 1989b, 1990, 1991, 1998; Bourdieu & Passeron, 1990), which are discussed in some detail in chapter four. This researched designed here is based on the assumption that everyday life experiences and meanings are best documented and understood through people's own actions and interpretations of their own lives (Berger & Luckmann, 1966). The methods involved look closely within the field of medical culture as a whole, yet specifically focuses on a small group of people

within the wider hospital culture. The type of case study research requires researchers to stay in the organisation for an extended period of time to document the research aspects and become a part of the daily activities.

As others have argued (Marshall & Rossman, 1995), such a story is actually an important part of the research itself, where it is believed that a researcher is not separated from the research itself. Hence, the story here presented as an integral part of details of the field. The professional development processes into medical professional life are, therefore, most appropriately investigated by beginning with people's subjective experiences (Atkinson, 1996). Further, Atkinson and Hammersley (1994) emphasise the ethnographic approach as one with emphasis on exploring research aspects rather than testing hypothesis about particular situations. This approach also includes working with unstructured data and a small number of cases; this approach:

> involves explicit interpretation of the meanings and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations, with quantification and statistical analysis playing a subordinate role at most (Atkinson & Hammersley, 1994, p.248).

The benefit of using this approach is doctors can be seen embedded within a social culture and the multiplicity of sanction systems including the hospital, the general public and patients' family (ten Have, 1995). The methods employed here are not in the 'traditional' ethnographic style, but is in an ethnographic fashion. The data gathering in line with ethnographic research precedes much of the hypothesis formation, where revision focuses on descriptive investigative analysis (Fox, 1993; Lyon, 1997). The use of qualitative methods in both the collection and analysis allows documentation of the medical context and the social conditions of what was being studied at the time. In an attempt to give priority to ethnographic observation and quality interviews, awareness of the consequences of abstracted analysis through non-directed interviews was formed (Bourdieu, Chamboredon, & Passeron, 1991).

As opposed to positivist researchers, it is important that qualitative researchers acknowledge that their values permeate inquiry and allowed themselves to approach culture for examination in a self-reflexive way. As Lather (1991) suggests, the ways of knowing are culture bound and dependant on the perspective of the observer. Through self-reflection as a researcher into my own practice, I recognise that research conducted can be a particular perspective and yet one based on substantial data collection. However, much of this is an interpretation and not the primary experience: here it is documented, researched, but not ever experienced in the primary way. I am not a medical doctor, cannot wear the 'uniform' and do not have the responsibility - nor do I take the risk (Manning, 1972).

I was always researching and working in this hospital before the research began, was in fact a pre-study. In a completely separate position, to develop and set standards for junior doctor medical training needs within the hospital, allowed me beneficial pre-study entry and independence for future technical considerations of fieldwork. A degree of 'participativeness' in terms of roles or a role constructed in the daily life of the research setting is important (Marshall & Rossman, 1995). It

was necessary to incorporate oneself into the work that was essential to the junior doctors' professional lives in medicine. Thus, attending medical (educational) activities, such as medical and surgical grand rounds was very informative and useful. Integration into the network of the professional social hospital and most importantly, into the medical culture was fundamental. The negotiation of entry was a complex process that guided development of questions to ask and aspects to look for, or even begin to answer research questions (Marshall & Rossman, 1995).

Development of the research and workplace role was fundamental in developing confidence and the ability to work within a culture which was friendly, but had not 'let me in' entirely. It could be suggested that this early entry process was socialisation through disclosure and development of the role (Marshall & Rossman, 1995). Here, a research relationship was developed and negotiated with the employees of the hospital. Using activities that were familiar to the doctors which was important to show that the researcher was not too 'alien', and that the researcher could integrate into their familiar world.

The initial experiences of entering the hospital culture and negotiation in light of medical cultural encounters began with the challenge of presenting project information to doctors' about the development of the research in a medical-like succinct manner. As part of initial 'humanities' socialisation, I spoke in a 'humanities' format and have since learned to speak, present and take consideration of a particular medical format of talk. After a period of months, seasoned in respect to presenting clearly, it was also apparent that I had in fact learned to speak introductions in a medical manner. This became useful to establish rapport, present clearly the topic to the doctors. Rapport here is emphasised because of the ability to recognise the influence of character on the integration of the researcher and this informed the kinds of relationships that needed to be established and maintained.

Entry and rapport establishing processes are important to give insights and understandings with which to perceive junior doctors on a different level to how patients see them as clinicians. It is useful to track specific issues that are important in respect of junior doctors' experiences. Therefore, significant effort was put into the development of trusting relationships. As a result of a variety of efforts and commonalities with the residents, local knowledge of certain issues began to develop. These included career, personal, workplace and professional matters of concern for residents. Subsequently, I developed a closer knowledge of medicine, training, stresses and needs of junior doctors in the public hospital system. Being a supportive research link in the training and workplace development was key.

In retrospect, it probably helped that I was of the same age as the residents and had a similar level of education. I could relate to junior doctors as a peer professional, but also was seen as someone "who took care of them" (I was also a member of the 'medical field'). When I decided to conduct a study, I took up the task of examining the practices and experiences of my colleagues on a more formalised level. I realised that I had already been doing much informal research on what I perceived at that point as young doctors' professional socialisation out of personal and professional interest, but now it became a more formal methodological and theoretical issue. Through my involvement in this hospital for two years of paid employment and subsequent years of research, I was given insights into the early

hospital based and private social experiences of first and second year doctors. This led me to investigate the multiple layered social and professional issues that impinge on the professional development of young doctors. Therefore, because I was responsible for the development and implementation of a professional training program and to act as an adviser, this gave me an acute awareness into how young doctors negotiate multiple demands on the job, develop professionally and construe responsibility.

Access was already significant in gaining access to the hospital culture, doctors and therefore the culture of medicine. It is well documented in many qualitative methodological texts (Crabtree & Miller, 1992; Denzin & Lincoln, 1994; Hammersley & Atkinson, 1992; Stake, 1994; Willms & Johnson, 1993) that key characteristics of an ideal site for research include: entry is possible, there is a sufficient mix of participants, aspects to study interest present, ability to build trust and rapport relations with the participants and where data quality and credibility of the study are reasonably assured. This infiltration is an important means of access and technique for fieldwork, which is crucial to the access and acceptance in the research relationship (Punch, 1986). The unique access to the hospital site, coupled with my interest in junior doctor medical professional development and culture, were fundamental characteristics which formed and confirmed my early and highly significant decision to continue with a detailed research study.

This hospital and medical training facility at State University Hospital (SUH) is characterised by it being a tertiary referral hospital where primary or initial patient management takes place, for instance, a coordinated group assessment and management of a patient by different levels of doctors, nurses and allied staff. As a tertiary care facility there are large proportions of specialists who staff the hospital where definitive treatment is the norm; that is, where no further referral would be perceived as useful for the patient. In addition, as a teaching hospital SUH is accredited to train medical students, conditionally registered doctors (eg. interns) and specialists (registrars) for various medical specialty colleges. This hospital also serves a metropolitan city of two million and conducts air retrievals as part of its role.

Table 1. Hospital Summary.

- 900 Beds
- 150 Visiting Medical Officers (VMO)
- 100 Senior Doctors
- 100 Registrars
- 25 Senior House Officers (SHOs)
- 50 Junior House Officers (JHOs)
- 50 Interns

Many hospitals have a variety of reputations from being centres of excellence in medical research, paediatrics, or even being hospitals nearest beaches! SUH which

has a reputation for being the hospital to work and train in for the best hospital training in surgery. After passing final year medical school exams, new doctors state preferences for which hospital they would like to train in and are subsequently allocated to a hospital. Potential doctors also assign preferences for training terms beyond the three state medical board required terms: emergency medicine, general medicine and general surgery. Every medical training year begins from January, where interns, JHOs, SHOs and PHOs (all called residents or house officers) are rotated through five terms a year, between ten to twelve weeks with a variation of two to five weeks holiday (depending on the hospital). Terms refer to the medical or surgical units and the medical specialties within that, for instance a term in General Surgery may be in the urological unit.

House officers (JHO, SHO, and PHO) are also asked to assign choices for elective term preferences and are rotated through five terms a year between ten to twelve weeks long. In this hospital, second year residents also complete a term in emergency medicine and a term in the country, as the relieving doctor or acting medical superintendent. Residents choose terms that they are interested or intend to specialise in. The elective term choices for second and third year doctors are specialty and subspecialty units, which require more medical experience and knowledge.

Often more junior doctors want to do the same training term than there are places available. The intense competition for terms, which has a variety of non structured factors towards allocation, causes significant stress and animosity from junior doctors towards medical administration. It is part of the medical culture that sometimes doctors are not given the ‘prestigious’ surgical terms because they have not indicated that they want to be surgeons, but have indicated they would like to do the term before they go country relieving. This importance of getting ‘good terms’ has implications for doctors to be considered for training places with the Colleges of Surgeons, Physicians and General Practitioners.

It is extremely difficult to describe a hospital medical ward, as so many are different. However, as a public hospital generally, compared to the subsequent hospitals I have been to around the world, this hospital is ‘typical’. The overriding aspect to any hospital ward is the human suffering that occurs. This is not to say that healing and great things do not occur as a result of seeking medical advice and subsequent hospitalisation; nevertheless, for the patients and the working conditions of doctors and nurses it is not always a pleasant experience. During the study there was no air conditioning in the wards (the hospital has since been demolished and rebuilt), and temperatures ranged from 30-35 Celsius in summer. Most medical wards were painted in beige colours with cement walls and with linoleum floors with hallways down the centre of the wards with approximately 30-40 patients in the ward. At the beginning of one of the more typical wards one enters through the hallway, through the double doors there are sinks to wash hands upon entering and exiting of the ward. In the middle of the ward are the nurses and doctors station and the ward receptionist seating and desk area. Other rooms off to one side of the main hallway include: cleaners, toilets /shower, drug cupboard, and linen room. Most wards are busy, with a couple sets of registrars, junior doctors and nurses to take care of many patients in the wards.

The purpose in selecting these doctors for this book, was to provide further detailed insight into what was happening in this cultural site. Most importantly, I do not attempt nor mean to generalise about junior doctors beyond this hospital. However the 'findings' may be transferable (Silverman, 1997) to other junior doctor sites with similar hospital settings. Because participants were initially selected to represent a variety according to age, gender and ethnicity, there is no assertion as to a representative sample of the junior doctor population being studied, but rather the cases selected are of intrinsic interest in respect of the phenomenon being studied. Case study research is predicated on the idea that the case is looked at in depth, its context examined and ordinary activities detailed (Flynn & Hekelman, 1993; Hamel et al., 1993; Yin, 1989). In line with a deep and textured description of particular individuals' cases, here transferability of this research may be applied. This enables theory building and the generation of possible hypotheses and implications (Eisenhardt, 1989). It is first necessary to describe the participants, and the considerations made for selection of the people studied. The next two sections address these tasks. In total, thirteen doctors, five of whom were women and eight were men, participated. All doctors' names here are pseudonyms; there are no relations to any part of their first or their last names.

As the researcher my presence in the daily working lives of these participants is likely to have been in some ways as an instrument myself, which is fundamental to a qualitative, case study, ethnographic paradigm (Campbell, 1998; Fetterman, 1998; Morrill & Fine, 1997). In retrospect many brief encounters either at work, being seen at the cafeteria, grand rounds or liaising with the switchboard to page doctors, my presence was sustained and intensive. Even in the relatively brief, but personal conversations in the ward and hospital hallways over the years and especially in the interviews, I entered the working lives of participants. This was fundamental to the selection process.

Table 2. Doctor Selection Process.

- Began early, up to 6 months before the study started.
- Interns pre-selected during hospital orientation interviews
- JHOs selected on basis of: who were known previously, had established rapport with, who was going to be at the hospital at the interview time, who was studying for exams
- Senior doctors also approached about their perspectives on junior doctors

Working within the culture for data collection such as paging doctors was a key learning experience. Part of the second phase exit interviews and re-entry challenges included how to contact the doctors after several months of absence. For instance, in the effort to page and book doctors for interviews, some of the knowledge that I had developed over the years had become useful. That is, I knew when doctors were doing a ward round, they do not answer their pages. This is because they are taking the details of the management of a patient from the registrar

or the consultant. I had observed and had been told that a junior doctor would not generally leave a ward round to answer a page (in the presence of their consultant).

Further, it is with other previous fieldwork knowledge that I had learnt that if the junior doctor is in a surgical term, they are likely to be scrubbed for theatre during the day. Usually a RN (registered nurse), who is at the surgical reception (where most pagers are held for all doctors in theatre) near the theatres, will answer the page. This is because the resident is sterile (has scrubbed and is wearing the gowns) and is obviously not in a position to answer pages. The best times to get surgical doctors are around 7am, at lunchtime and after 6pm. I was also knowledgeable of the fact that junior doctors memorise certain numbers (e.g., their ward, medical administration and surgical theatres). If they recognise a number sometimes, they will not make significant immediate efforts to answer the page. If the number is an outside call, residents are more likely to answer their pages.

I mention all this detail because, working within the paging system and the discourse of being paged and returning calls is very important because one is working with the tools that are familiar to this medical culture. It had been my experience that not only did this take months of my pre-study experiences to learn and understand, but once I had understood, it made my efficiency in the field much better. Naturally, being aware of and having a good relationship with the variety of workers within the hospital system from the switchboard, RNs and even the doctors themselves facilitates the initial contact, communication, and most importantly the data collection and establishment of good relationships.

Concurrent with the process of selecting junior doctor participants it was important to consider the role as researcher and the variety it may take in terms of the level of ‘revealedness’ to the participants studying. As Taylor and Bogdan suggest (1984), researchers should attempt to be truthful, but vague in the portrayal of the research purpose to participants. Full disclosure was not required, nor was it ever actually asked for. In medicine, initial impressions are most essential as an entry point to gain access to collect data. Therefore it is essential that information is presented according to more familiar medical language framework in terms of what doctors would be most interested in, as well as displaying the researcher’s integrity as a colleague and researcher. This is where having had experience in this hospital and retaining that knowledge of the medical culture was a definite advantage. This was the first step, learning to present the relevant study information and contacting the junior doctors.

The intellectual approach or ability in the field helps to determine the selection of research topic (Clarke, 1975), but it seems in medical culture that the personality of the researcher is also very important. It was understood that in this hospital it was very important as a non medical person in this environment to not be a gregarious personality. Assuming a low-key demeanour may prevent doctors from feeling threatened especially from a strange researcher. Anderson (1976, p. 22-23) suggests that it is this kind of role researchers as outsiders must play so not to disrupt the “the consensual definition of social order in this type of setting”. After being told by more than one person, that researching in a hospital environment, people ‘could make things difficult for you’. It was important then in certain instances to display

that my understanding of the medical and hospital hierarchies. One of these ways was to ensure that I followed the hospital hierarchal cultural norm.

The medical choreography of learning lessons in introductory meetings began as part of working within the medical culture to research and understand where the power bases are. Any doctor will tell you that the consultant is the most powerful and decision making person in the medical team. I found that as a courtesy and an essential research step I contacted all the junior doctors' consultants for their consent for 'their' intern or JHO to participate in the study. No junior doctor is likely to participant in research unless their consultant knows and approves of their participants. They are not trying to impress me. After waiting weeks to see a consultant between patients and consenting in 45 seconds, often a kind of 'institutional acceptance' occurred. That is, once one is accepted or seen as a capable professional in their own right, you are let into other aspects of the medical culture and practice. I have been asked into operating theatres, invited to stand on a chair in theatre (and done it), looked up a sigmoidoscope, stood next to a kidney dish with a bowel being resected while the consultant is explaining the cancer to me (as opposed to the Intern) the cancer. In these situations, I have learned how to put on the theatre scrub gear, what a sterile field is and what the junior doctor's role and duties are. These experiences were very central to be a part of and learn from because they were essential aspects of the medical culture and fundamental aspects to this type of medical life. These experiences have contributed in many ways to the understanding the importance of acceptance and ability to mesh into a culture (Westrum, 1994). Fundamental to qualitative research, then is observation, building trust, maintaining good relations, respecting norms, establishing reciprocity and having sensitivity considering ethical issues.

Doctors, as with many professionals, are extremely busy. It is not just that they have a lot to do, charts, investigations and so on, but they are treating sick patients. There is often a different meaning of time for many of them. There are of course rumours that doctors have poor time management, but many are just flat out trying to get things done and treat the sick patients they are responsible for. Observational methods to record the interactions and activities on ward rounds in the 'natural setting' were used and doctors were interviewed to provide insight into the medical culture. Observation is an essential element of all qualitative studies. Here, participants are observed which demands firsthand involvement in the social phenomena chosen for study. This type of immersion in the hospital setting allows researchers to hear, see and begin to experience the ward round reality that the doctors participate in. It also allows the ability to establish rapport with doctors. Conversations with the doctors in their natural situations did reveal many nuances of meaning in their work from which their perspectives and definitions are continually forged.

Video of ward rounds and examination through subsequent interviewing was important because it allowed reality itself to be "studied, captured and understood" (Denzin & Lincoln, 1994, p. 4). The future of qualitative data collection is in multimedia data collection methods. Searching, reporting and coding themes in relation to moving visual images may expand the field of visual sociology by giving researchers access to both verbal and nonverbal behaviours of participants (Hesse-

Biber, Dupuis, & Kinder, 1997). The power of video to illustrate medical practice is unparalleled. Further, I decided that video methods are excellent to record people and activities as the basis to generate ideas, construct data, test hypotheses and develop theoretical perspectives on an issue (Albrecht, 1985). In addition, it can be suggested that fieldwork with the video camera captures social structure and processes that arises from the human interaction, such as habitus in a medical setting. As Albrecht (1985) suggests, video methods may also arm the investigator with the ability to more closely examine certain behaviours being studied. Another aspect to conducting videoed participant observation is the different stance that the researcher can take. By virtue of actually being there bedside and being in the situation I was being drawn into the round of activities.

Atkinson (1992) in his work on how instructional talk and medical work are interwoven suggests how educationally relevant the tasks and materials at hand to the clinician are. I decided to video ward rounds because they are a key workplace interaction where consultants and registrars decide on management of patients which acts as an important learning opportunity for residents. Ward rounds develop and are often dependant on the senior doctor in terms of learning and perhaps an important site for the reproduction of professional norms and values (Booth, 1998b; Fox, 1993). Ten Have (1991; 1995) found that rhetorical skills that are illustrated are intrinsically linked to physical movement through the clinical space of the wards. Heath's (1986) work on doctor-patient interaction also focused on the coordination of body movement and speech in medical interaction. As she suggests, some medical based TV programs also provide insight into medical social activities, which are of particular interest for sociologists. I found that being a part of and witnessing events that were important to the research participants, or indicated symbolic importance to them, allowed me to get a more holistic view to gather data that informed the structuring of the interview process (Merriam, 1998). The videoing and participation in the ward round allowed me to share and have a perspective of those studied by sharing in their day today experiences (Denzin, 1997).

January was the best period for ward round observation because it was the first week of the first year of internship and first week of the JHO year. The transfer of cultural knowledge and skills is likely to be paramount here because of the newness of the doctor. Focus was on the workplace situation where a team of doctors were followed around on their wards. The on-the-job observations were useful to observe the activities and job behaviours that occur during a ward round. Further, it was through the observational trailing that rapport was formed with residents, as opposed to initially doing an interview, which was conducted later. The interviews were fundamental because it allowed the junior doctors to elaborate on their experiences initially, and at the end, and over the year. The researcher developed semi structured interviews (see Appendices) included questions on training, education, and current work related activities. The developments of the semi structured interview instruments were linked to previous observations in the field.

One dynamic change learnt with a video in field was the difference between medical and surgical rounds. After a surgical round going for 20 minutes and a medical round going for three hours, researcher resources and time were

reconsidered. Video of the wards was important because it was a very powerful means to show primarily the aspects of a ward round, illuminate space, contextual environment, the use of space on a ward round, medical practice and the lay out location of conversations and ward rounds (Booth, 1998b). As well, expressions and the non-verbals are illustrated which is often difficult in field notes. The main element here is that practice is reflected as unmediated on the video. One of the notable aspects to qualitative methodologies, namely here the ethnographic case study, is the developmental in-situ aspects to determining practical, efficient, feasible, and ethical methods of data collection as the researcher progresses (Fetterman, 1998; Seale, 1998). Research questions may change as the researcher progresses, the methods may change and researcher must ensure this flexibility (Atkinson, 1994; Denzin & Lincoln. 1994; Wolcott, 1990).

The decision to use video was important because of the way it conveys medical practice and the use of language; indeed, the way it provides some documentary insight into a (medical) habitus. In addition, the interviews provided meaning and reflections on that practice to illustrate the professional developmental process. Here then, the design is the result of methodological decisions based on knowledge gained from field and the methodological literature (Pelto & Pelto, 1997; Seale. 1998). Tapes were reviewed several months after collection looking at patterns of interaction, and interesting snippets of activity. This was not a primary data collection method, but as a supplement to the interviews and the themes arising from them. Therefore, once themes and key issues were extracted from the interviews and applied with the theoretical framework, further viewing began to illustrate key themes and physical activities that were illustrated by the video differently from the interviews.

Much information about potential research barriers (ie the consultant) came from the participants. One unit I was moderately concerned about regarding an observational practice effect (Morgan, 1997; Nielsen, 1995), was a surgical ward. Dr P the intern for that unit told me that the consultants were talking about "how this (me coming to videotape) would be a good reason for them to improve their ward rounds". He also kept calling me on behalf of the consultant arranging 'certain' rounds to come to. It was becoming an unnecessary hassle for Dr P to call me when, I specifically tried to be unobtrusive and definitely tried not to create *any* extra work for the junior doctors.

One of the luxuries of actually being on site was I ran into one of the consultants in the foyer of the hospital and he informed me that the surgical unit director had actually decided to decline, his words "canned" involvement. He suggested that the reason was that they "did not want bad performance of the unit and resident recorded on video, in my eyes and on tape". This was especially the case for video because it would reflect badly on the unit. As well, they "did not want to show an intern who was going to be bad in the first few weeks". As one of the consultants said about the other consultant that declined involvement: "things are black and white and this is indicative of surgeons". He said he was happy to be interviewed later, even on camera if required.

Table 3. Interviews and Analysis.

INTERVIEWS
- Took place in meeting rooms, wards, offices, hospital grounds
- Discretion important (taking doctor away from ward attracts attention to them/us

ANALYSIS
- Identification of recurrent themes, statements and practices in the transcripts and from behaviours on tape
- Close analysis required viewing and reviewing of transcript data to look for patterns and clusters
- Transcripts analysed in terms of potential alternative explanations and theories

The first interview schedule was constructed and informed by the literature, personal ideas and assumptions and adapted around the main issues that emerged from the pilot interview responses. This developed my questions for the first and second phase of interviews. These were written specifically as open questions and not closed questions because it was important for doctors to elaborate on their answers. Doctors interviewed fully understood questions, answered in detail, were to the point with their answers and only occasionally required gentle elaboration about a topic they raised. In examining how honest one needs to be about the research purpose, Krathwohl (1993) suggests that it is not necessary, nor methodologically sound for researchers to make known the specific hypotheses, background assumptions, or particular areas of interest. The aim here was to have a semi structured almost conversational discussion about their experiences - a conversation with a purpose as Burgess (1984) has put it. Of course, it was important to maintain ethical standards in terms of issues of harm, consent, deception, privacy and confidentiality of the data.

The important aspect to facilitating entry into hospital wards and conducting research in a clinical environment is having close knowledge and awareness of the culture where one is conducting research. It is very important to have this awareness, to be sensitive and to observe the hospital/ward that the researcher is collecting data and working in. The ability to establish rapport and trust with the participants was an essential aspect in dealing with earlier problems, later barriers and quality interviews. This research would have been significantly more difficult to videotape, audio record and participate in interactions without the help and guidance of the doctors involved.

When the junior doctors began to talk on tape during the interview great access was gained into their interpretations. In this study, interviewing techniques were supplemented by other qualitative data collection methods: observation and video taping of ward rounds. Regarding assumptions and issues present in the timing of interviews, it must be acknowledged that there is significance in appropriately sequencing ethnographic observation and interviewing (Campbell, 1998;

Hammersley & Atkinson, 1992). Accordingly, the objective was to look at issues within the culture of junior doctor medicine, document and attempt to understand professional development of junior doctors by interviewing at two distinct times (beginning and end of the training year), and to observe a series of ward rounds.

An important aspect in writing and conducting the interviews was to not have any predetermined response categories as with much research on interns (eg. Valerio, 1992). The doctors' perspectives on the phenomenon of interest was a focus during the interviews and came primarily from the participants and not as a researcher driven question and answer process. In these interviews it was essential to emphasise confidentiality and also my attitude that what the doctors were saying was acceptable and that it was also valuable without letting them know what my exact research interests were (Crabtree & Miller, 1992). A lot of the ability to exercise good listening skills and be skilled in interaction with doctors facilitated re-entry to the field (Harrington, 1998).

Table 4. Interview Components.

PHASE 1 INTERVIEWS –	PHASE 2 INTERVIEWS –
• Beginning of year • Researcher developed • Semi structured • Interviews developed from ideas that had been in consideration over previous years	• End of year • Researcher developed • Semi structured • Themes developed from interview transcripts, literature and in field observations

This was a period of a changing discourse, the self became a research instrument. Field research is essentially dependent on one person's perception of the field situation at a given point in time. This perception is often mediated by the nature of the interaction with research, which can make researchers their own research instrument (Bender, 1975). Fieldwork case study research then is predicated on the need to spend a lot of time onsite and in regular contact with participants. The related activities of and emphasis on the researcher is important for reflection and revision of research based ideas in terms of 'what is going on here'. Carr and Kemmis (1986) suggest that this reflection process is useful for the researcher to reflect constructively and not necessarily follow the conceptualisation of other theorists, actors or audiences. As ten Have (1995) suggests, case researchers tend to reflect on local, foreshadowed and readers' consequential meanings of the social phenomenon where the work is inherently reflective.

This was translated in my role mainly in the data collection process. For instance, after the first series of interviews I used opportunities between interviews (if there were more than one that day), to think about strategies to maintain myself as the research instrument. That is, the instrument of myself asking the questions and actively listening. I realised shortly after I started conducting consecutive interviews and ward round videos that strategies were needed to protect physical

endurance and mental space. It was necessary to have a time out facility through the provision of quiet private places or a time out period between interviews. This provided excellent opportunities to write notes, organise tapes, reassess aspects retrieved from the setting and facilitate some of my thoughts about the directions of the research.

As Marshall and Rossman (1995) suggest, it is appropriate and recommended for a researcher to modify aspects when exciting and significant focuses emerge from early data collection. Further, the flexibility that encourages exploration for many researchers is seen as one of the significant benefits of using a qualitative approach. Accordingly, as tension does arise when researchers are involved over the long-term, researchers must plan strategies for easing these on-site tensions (Taylor & Bogdan, 1998). Incorporating this perspective, I ensured that during the semi-structured interviews I was able to not only understand what the participants were trying to convey, but that I was also able to establish rapport during the interview process. One of the goals of semi-structured interviewing is to appreciate the participant's perspective. It was therefore, paramount to be able to put myself in the role or at least attempt to see certain situations from their perspective. Here, I aimed not to impose an academic frame of reference or pre-conceptions about what the doctors were saying to me. Being aware of the importance of rapport with the doctors was likely to open more doors and allow for more informed research, which was carried into the video method.

On one occasion I experienced barriers. I had organised for a ward round to be videoed with a JHO and her registrar in a medical unit. It was in this unit that I had already received approval from two consultants and just had to gain consent from another medical consultant (the director) to video the following week. I was due to go to a round on a Wednesday, but on the telephone, he said, "I want to know what's this is all about, I'll need to see you before I make a decision!" Rossman, Corbett and Firestone (1988) also found in their fieldwork that they were being questioned about their credibility as researchers. I finally had an appointment with this consultant on a Thursday, and thus missed the Wednesday round I had booked for that week. I put this down to the consultant exercising his control and positioning his authority towards me. I have found then, that it is instances like this that reinforced my knowledge of the consultant as a powerful agent of the wards. As a dutiful researcher, I attended his appointment, smiled and explained the project. The consultant doctor asked how I was going to analyse the data, what my qualifications were, why I was interested in this research, how long I needed to be there for and so forth. By the end of the conversation, it seemed as if he just wanted to know if I knew enough about junior doctors and to prove to him that I did have academic credibility and the right to be in his ward. By the end of the conversation he asked me where he should sign on the consent form and invited me to the next ward round – his! Consultant positioning, researcher learning to play the game and initial barrier battle won!

Before returning to this field site after several months, efforts were made to re-integrate into the culture. One of the first activities I engaged before arrival was to let all the junior doctors who were involved in the study know that I was returning to the hospital. This was done three months before my arrival by telephone to assess

whether the junior doctors were still happy to be a part of the study and whether they were going to be at the hospital at that time. Before my actual arrival, I sent a reminder letter detailing my contact telephone number and a note that I would be arriving in two weeks.

There were a few concerns and issues involved in re-entry into this medical field. As I re-entered this hospital, to some degree personality, and previously established rapport played a key role in dealing with some of the unexpected obstacles in the field. Some accounts of field research discuss issues of deep personal involvement, role conflict, the physical and mental effort, and even the danger for the researcher (Cantwell & Ramirez, 1997; Lear, 1997; Novack et al., 1997). For this research at this particular point in the year, it was important that I made significant efforts to re-establish the research relationship with the doctors. I was not in the same city as the junior doctors, and I had invested a significant amount of 'rapport establishment time' in earlier years. I also had not been a part of their daily lives in the previous six months; thus it was essential that returning to the hospital was right to facilitate the final aspects.

It was important to almost start where I had started two years previously; thus the first port of call was to attend medical grand rounds. This was important for a main reason: I needed 'to be seen'. Grand rounds being a unique activity for the medical profession at this hospital, anyone who is not there every week gets noticed. I was not acknowledged at that particular point, but as it turns out people did see me. I felt it important to go through the 'local' daily motion of the medical lecture. The second activity that I engaged in on the first day of re-entry into my fieldwork was to get a pager. It was with the previous knowledge of having carried a pager for two years, I knew and understood the benefits (and inconvenience) of having a pager. In retrospect, these two activities were significant markers and facilitative aspects to two weeks of fieldwork that I was about to engage in. Having a pager allowed junior doctors to contact me as they do many other people during their day through the switchboard. Most importantly, I had to be very flexible according to their schedules and I could be paged around the city.

I aimed to tread lightly and to let the medical administration staff know that I was visiting on official academic business. Instances such as having lost my rights to parking, having no hospital identification badge to allow me official access to certain wards or behind the emergency department highlighted my new status as an 'outsider'. Although as a small component of the whole phase two data collection process, being back in the framework of using the old familiar parking lot, crossing the old road, almost put me back into the psychological framework that I once was in earlier in the year. However, crossing the road was only the beginning of the re-entry feelings because later that week, I had to contend with hostile feelings dealing with gatekeepers.

I had not previously thought about or realised that a significant issue such as gatekeepers would potentially encroach on the returning process. It was only upon my return to the field that I truly understood the determination of some 'watchdogs' who were suddenly interested in protecting the institution or at least playing power games with me as I was no longer a part of the hospital. It must be said however, that the doctors never displayed, or I was not aware of any subversive gate keeping

activities on their part. It became apparent that my presence was only an issue for those who were involved in medical administration or general administrative issues.

For example, when I was booking interview rooms, I was dealing with people who knew me previously, what they actually wanted to now was why did I want to use the room – "was it university or hospital business?". This particular situation, was actually a critical incident for re-entry into the field. From the first day that I arrived back on the hospital grounds, I was cognisant of the fact that I was no longer employed within the hospital. Therefore, I ensured that I went through all the standard formal avenues that were required, for instance, to book a room. It was after the third time that I was asked what my business was and small barriers such as a certain rooms not being available for me to book to use, that I had to declare my position. By that I mean, I had to indicate that I was indeed a legitimate person to be there as I was a conducting research and my being there was known and supported by my senior on site Medical supervisor. Punch (1994) suggests that the support of key figureheads is vital to access in some settings or harmful in others. I was quite reticent to mention this connection, and it was done as a last resort as I only had a short time to conduct the fieldwork. My main aim was to finalise interviews with all the junior doctors who had been interviewed earlier in the year. I felt no gain or desire to have any ex-workplace battles. In retrospect, this experience provided me with theoretical understanding about re-entry into the field. Having actual or pretended full commitment to a role may be essential to gaining legitimacy and acceptance from within the research setting (Punch, 1994).

One aspect that I never considered, and in hindsight I should have, was leaving the field. I only became aware of participant feelings of potential abandonment when, after several interviews some participants actually expressed sadness at my departure. It was as if it was an end of an era for them as well. Although I could be wrong, I found that markers such as exchanging email addresses, business cards, conversations about what was I going to be doing next, as indications that there was some sort of desire to continue this research relationship. Like many other field researchers, I had not conceptualised my transient nature of being in this field or my relationship to this field. I felt touched by the sentiments of care, for I had conceptualised that they would be glad to not have to answer more questions about their professional development. The final interviews were lengthy conversations with a purpose. These were enjoyed by both myself and the doctors because of the impending conclusion to the study.

Ethics in qualitative research

The politics and the ethics of qualitative research are important because without a certain level of training and even supervision, turbulence can be brought into the field that may create ethical dilemmas or even causing damage to the research project. In my instance, I was not a medical doctor and often others can question aspects of medical credibility in those circles. I ensured that I had onsite and off site academic university and medical supervision. The usefulness of the onsite medical supervision was important because I am not a doctor and have not gone through the

hospital training process. I thus wanted to ensure that what I was doing was not completely inappropriate in the field. Methodologically and theoretically then, the university academic supervision was very important because I was able to ensure an ethical data collection process.

In terms of the specific ethical standards and procedure for participants and patients, all participants whose interactions and statements were videotaped were provided with a written and verbal explanation of the aims, procedures of the study. They were also asked to read and sign the written consent form indicating their willingness to participate in the study and to be videotaped. All were given the right to withdraw from the study at any time without repercussions. I was prepared for at anytime a patient or patient's family declining involvement to videotape or record that interaction. This never occurred. To ensure minimal intrusion in the field I used a hand-held camera that also used small tapes. To ensure quality recording, junior doctors wore microphones attached to a micro cassette recorder, which they wore on their belt or in their pockets. I also took field notes when the camera did not work or was not appropriate to use the video. It is important to remember that in this type of innovative research that patient care came first and foremost. This study aimed not to be intrusive and did not collect data at the inconvenience of any participants (including patients) or the functioning of the ward. I attempted to be as unobtrusive and independent (not requiring assistance from nursing/ allied health staff) as possible at all times. In emergencies, patient care always came first in medical management, ward protocols and related procedures.

Researchers must anticipate more routine ethical issues and be prepared to make on the spot decisions that follow general ethical principles. One particularly relevant example occurred during a medical ward round when the doctors were seeing a patient who had delusions of being watched. The consultant never actually told me this directly; I was paying attention to what the doctors were saying on the pre-ward round discussion while I was preparing the video. By paying close attention and listening to what was actually happening during ward rounds, as well as collecting data, in this case provided very useful. As with many other ward rounds, I was always introduced to the patient. Before I even entered the room, I decided that I was not going to video this interaction. In many instances, the doctors never paid any detailed attention to me. I always attempted to be very discreet and not distract the doctors from doing their job or lose any credibility with their patients by having a video camera following them around.

However, in this situation, I decided to turn the camera off and sling the camera over my shoulder, after the bedside visit, the patient noticed me in the hallway with my video camera. He asked the consultant in the hallway, 'did I video him?' The consultant re-explained to the patient about the research. At this point, I stepped in and told the consultant that I did not video that bed visit. The consultant told me later how sometimes these patients can be difficult in those instances. It was apparent that the consultant had not been aware at that time that I had made the decision not to video. In retrospect, I realised that the consultant was grateful that I had not videoed. In some way, it was apparent that I showed the consultant that I was not just there to collect data, but was also aware of the workplace needs and was paying close attention to what was going on. Finally, in the observation of ward

rounds, and the audio recording of interviews I ensured that the participants were fully aware of their right to withdraw from the study at any point.

When attempting to be reflective on the research process, quality and the validity of the data to be collected I looked at my role as the researcher. I examined the doctors' perceptions of them and their interpretations. However, it was fundamental that I also looked at the effect I may have had on research collection, how participants interpreted themselves (and my role) and how I gained access to this data. I held two roles in sampling this population. Firstly, at one point, I was a co-worker within the hospital; I had a job and a clearly defined role there as a participant in the medical field. I had been there for three years and saw three classes of interns (approximately 150 doctors) going through the intern training program. I gained the interns' confidence, trust and performed duties for their benefit. Therefore, in that sense at one point I was an insider. However, it should be noted that they all knew that I was not a medical doctor. This is very important, although I know some medical language, and issues in residency training program, I can never really understand or experience the life role of practitioner, clinician and medical doctor. However, I could understand, help and work within the constraints of the hospital. I was involved with the intimate aspects of their working lives, but I did not actually work and perform medical duties with them. Therefore, in that perspective, that definitely made me an outsider. These complementary perspectives were not always equal.

It is important for ethics and validity of qualitative research that the researcher has awareness, appreciation of, and a commitment to ethical principles for the hospital research. Some of the more common and important issues are for example, being able to demonstrate use of data recording strategies in the setting that will be sensitive to the participants and are only used with participants' consent. Other ethical considerations are informed consent and protecting participants' anonymity. Le Compte and Preissle Goetz (1982) have examined the issue of reliability and validity in ethnographic research. They discussed that in the formulation of a research problem, ethnography emphasises the interplay among variables situated in a natural context. The naturalistic setting that research is conducted in facilitates immediate analysis of causes and processes. Further, the nature of the goals in ethnographic research means an attempt to describe systematically characteristics, variables, and to avoid *a priori* constructs or relationships. I aimed to document relationships, both interactive and structural, activities that occurred and the distribution of these events over time. Thus, my work was informed through ethnographic methods of observation in a setting over time where I proposed to look for professional development aspects that were being played out over a period of time, which affected the development of junior doctors and the emergence of a medical habitus.

Traditional ethical concerns have been about informed consent received from the subject after she or he has been carefully and truthfully informed about the research, participants' rights to protection of privacy, and protection from physical, emotional or any other harm. As a qualitative fieldworker, in this hospital I exercised general common sense and responsibility to the participants in the study primarily and this study secondarily. In terms of situational ethics, if there was a situation that was

going to benefit the study, but it was not appropriate for the participant at that point, I took the perspective towards the direction of participant and not necessarily as a benefit to the study.

Nothing is bias free and as an analytic interpretive researcher I bring what I know and my experience to this research. A fundamental issue is bias - I cannot separate this research from other aspects to my life. Strauss (1989) suggests that researchers should understand that previous personal experiences are a part of the inquiry process and should understand that this is a potential ethical issue. The essential point here is that any view is that of a participant observer, so it always incorporates the stance of that participant observer. This is important because I had a lot of professional working relationships previously established at the research site, including even friendships made outside of the study. These professional relationships were the initial starting point for me to create and define the role for myself within this job in the hospital. It is also my growth in the position and learning about my colleagues that precipitated my desire to research further. These are part of the reasons for conducting this study in this organisation, which I have mentioned previously. I had access to this research site, its culture, while some participants in many of my pre-study experiences were also professional colleagues. I ensured confidentiality, ensured that the doctors knew that they did not have to participate and could most certainly withdraw at anytime without having to give me any reason whatsoever. Confidentiality and the procedures for involvement in a study are essential research protocols and an advantage for both the researcher and the participant to know about for active participation without duress.

This chapter described how based on immersion in the situation, gathering and storing information about people and the culture being studied. The methods described reflect the role of the researcher entering the field, development of the perspective and the methods chosen. Understanding the medical culture was essential in participant selection, conduct of the observational and bi-phasic interviews and especially significant in relation to entry of the field. The question of entry is not one which is answered once and for all in the process of conducting research, rather, as shown in this chapter, entry and re-entry have to be negotiated and renegotiated throughout the research period. Infield changes were also made based on insider cultural knowledge and contributed to the selection and implementation of the methods. This chapter has also provided a description of the methods chosen, the specific process and barriers encountered while conducting the research and the previous literature that guided the method implementation.

CHAPTER 2

THEORETICAL DISSECTION OF MEDICINE: PRACTICE

> I was just a puppy trying to please everyone and you realised you couldn't do that all the time. And I then started getting things which really knocked me off, like people paging you and not really answering the phone. And you just smack the phone off the table and you say 'bug you, you can rot for all I care'. 1 remember this guy [another doctor] who was there at that time and he just laughed and he says: "well you're learning, you're learning real fast". Yeah, I'm at that stage now...
>
> Beginning of second year, male JHO

This chapter argues that traditional medical sociology, socialisation theory and conceptualisations of professions do not meet the theoretical and practical needs of looking at early medical cultural experiences. Instead, a new model, based on Bourdieu's theory of practice is introduced that provides greater theoretical and analytic scope for investigating the complexity of social and cultural factors in early medical professionalisation. Utilising interview data, this chapter argues that through the sociological theory of Pierre Bourdieu here is an innovative approach that is useful to examine and interpret medical culture and the professional developmental process of junior doctors.

Medicine has long been 'dissected' into many different areas for theoretical examination by disciplines such as medical sociology (Frost, 1997), medical anthropology (Becker, et al., 1961), medical ethnomethodology (ten Have, 1995), and post modern sociology (Fox, 1992; Fox, 1994b). There are large bodies of literature relating to medicine, doctors, medical knowledge, culture of health and illness and other models of scientific knowledge which provide interesting social perspectives on traditional 'clinical' medicine. In the search for perspectives specifically relating to junior doctors, it is easy to come across many tangents of medical sociological description. We often look for explanations, conceptual understandings and description of medical culture, where we try to extend previous sociological understandings and descriptions of medical culture. In this context, early postgraduate experiences of junior doctors and the related medical culture are of primary interest, which often leads us to examine initially the literature on medical student professional socialisation.

Medicine is a distinctive profession in terms of the relationship it has with life, health, human suffering and death. The working experiences that doctors respond to. reflect on and develop strategies to cope within medicine are central to medical practice. Development of doctors' professional behaviour changes in different stages of the professional life cycle, which has been addressed in various ways. Such accounts from: fiction *"House of God"* (Shem, 1978), classic longitudinal work *"Boys in White"* (Becker et al., 1961), to more recent novel-like publications: *"The Intern Blues"* (Marion, 1989), "*The Coming of Age of a Young Doctor:*

Learning to Play God" (Marion, 1991) all of which discuss medical education, the development from an insider's viewpoint or *"Harvard Med"* are accounts that chronicle the 'stories' behind the medical school and making of doctors. These provide informative accounts of stories of medicine from those who have experienced medicine. It is however, the early medical experiences as a doctor in traditional and more modern hospitals that set the stage for rapid development of the physician's professional persona (Barondess, 1998). However it is difficult to be persuaded by this previous research on professional socialisation. This chapter tells us how medicine has been interpreted sociologically and touches on the enormity and variations of perspectives on socialisation, junior doctors, medical practice and critical sociological theory, which set the stage for a more critical social theory.

SOCIALISING MEDICAL SOCIOLOGY

Medicine, medical practice, doctors, medical students, hospitals, medical structures, medical knowledge are all a part of the culture of medicine which is a complex, varied area and long standing domain for study for social scientists. The focus for medical sociology for the last two decades (Elston, 1997) has been primarily on interactions between medical work, dealing with patients, scientific practice, or the construction of scientific medical knowledge (Casper & Berg, 1995). Medical sociology uses many different theories both classical and contemporary, to analyse social aspects of medical interaction, such as medical power and health care structures in contemporary societies. Here it is apparent that sociological theory evolves and responds to variations and transformations in society, social relations and social experiences. Generally, it could be said that the strong emphasis in many sociological approaches is on the role of social structure. For instance, the founding work of Durkheim was concerned with the way society 'produces' individuals (Lemert, 1981).

As further investigation into understanding the social basis to medicine, other aspects of the sociological perspective emerged and needed to be examined. The construction of medical knowledge was developed as a theoretical shift from sociology *for* medicine to sociology *of* medicine (Glaser & Strauss, 1967). Here it was seen as important to examine relationships between medicine and science as complex and multifaceted, and thus necessary to further examine the "particular contexts and the discourses that construct these relationships [which] might be recorded as topics for sociological inquiry" (Elston, 1997, p. 5). Emphasis has also been placed on usefulness of other perspectives, such as postmodernism and the role that it plays to examine the self and body within medicine in new ways (Bauman, 1991). It is through theoretical shifts in health sociology that sociologists have created new tools to view medicine as a part of society, and its social functions and not a distant 'untouchable' institution (Gabe et al., 1994). Thus, what is going on within the medical profession is just as important and interesting as the effect it has on health care systems (Hoff, 1998).

Alternatives to traditional medicine are popular in health treatment and thus a whole new way of conceptualising medicine is uncovered. Medicine has been

traditionally interpreted within a scientific arena and viewed as an objective practice or bias/value free science that contains a small social component as a product or mirror of societal arrangements. The debate in sociology to understand modern society in terms of class-based community or institutional structures it seems is long-standing. Perspectives such as Marxism suggest that the science's self-interest is where the underclass should query the content of the medical knowledge being given (Best & Kellner, 1991; Eisenstadt & Helle, 1986). Marxist perspectives analyse medical knowledge in terms of disease as a product of social class and practice. What people do in their life practice contributes to the perception that certain forms of knowledge inform the life practice or lifestyle (Figlio, 1977).

Medical practice then, is not just an interpretation of medical/ biological systems, but practice is shaped by norms, values and the interest of class (Lupton, 1997). These works suggest medicine based in certain judgement is related to certain discourses and dependant on models and social constructions. Validity in medicine is relevant for those who have passed thorough a specific form of training and socialisation (Nicolson & McLaughlin, 1987). Social theory of medical science, such as a history of medicine and the sociology of scientific knowledge, indicates that social construction of the 'valued' knowledge can also be explored within medical contexts. This approach views medical reality as determining, not necessarily modifying, operational practices and understands socialisation processes (Casper & Berg, 1995). The key then, is how the social construction of medical knowledge is relevant and not just the process in the application of medical knowledge.

Modern medicine is a social organisational practice (Foucault, 1971), that creates discourses of its own in terms of objects of and for analysis. Emphasis on medical ideas and how these practices are shaped in social context allows researchers to explain and interpret how context may shape certain ideas and medical practices. Knowledge in itself is a certain discourse, which is produced in and through the social (Jordanova, 1995). The term 'discourse', is used to refer to "written, spoken or enacted practice organised so as to supply a coherent claim to a position or perspective" (Fox, 1994, p. 161). Yet, discourse for others, relates to words used, and most importantly, the carrier of those words in terms of institutions, authorities and experts (Foucault, 1971).

Without getting caught up in such a deep debate over discourse, the concept relates to the medical culture here where I have seen and others have reported (Loewe, Schwartzman, Freeman, Quinn, & Zuckerman, 1998) that there is almost a special language in the use of terms. For instance, management 'tactics', 'invasive methods', 'operating team', 'team spirit', 'marathon surgery' and 'daily form', which indicate particular medical practices and relations within the hospital. These discourses contribute to a particular understanding which in turn organises how these practices define behaviour within the medical culture. Anspach (1988) suggests when presenting patient cases, account markers, such as 'states', 'reports', and 'denies', doctors who are presenting in this format, use these words to socialise those who are present. Certain discourses used in medicine and in themselves may be contributing to a socialising situation where doctors put themselves into

discoursed positions (Anspach, 1988). This suggests that certain words, actions and teaching define the context of medicine.

Clearly, perceptions on social aspects to medicine are affected by 'discourses' on knowledge where medical ideas carry and mediate values. Pinell (1996) suggests that medical knowledge cannot be neatly separated into understanding social meaning or the judgements of doctors. For doctors then, the way of knowing as a medical discourse has implications for the shape and development of ideas (Foucault, 1978). Behind this knowledge must be particular social processes, where variations on interpretation and meaning can be created and given intellectual priority and standing. The societal influence on development of medical knowledge frames medicine as a natural science, but excludes the input of societal actors (Fox, 1985; Lowy, 1988). However, it is through the social processes, which are constructed by social actors, that the social construction of medical knowledge emerges. What is important for understanding the 'social processes' and aspects to construction of medical knowledge and practice is the process that the practitioner develops within similar social contexts. Relations between medicine and social action are useful because these can form a social theory of medical practice. Medical knowledge is worthy of investigation in the interactions within medicine, because the social activity is related to the single body within a defined social network.

The argument has been for so long, that medicine is not viewed from within a social context and is not necessarily open for analysis within a community of variable discourses. In relation to the legitimacy that is placed on medical interactions, it is suggested that through social actions in society we have been 'disciplined' (Foucault, 1977). Disciplined by those who are the 'experts' (medical community /practitioners) and as 'bodies' of discourses. There are fundamental discourses and social constructions of those disciplines, compliance and constructions (Foucault, 1977b; 1978) related to the medical aspect of the medical phenomenon (Fox, 1993; 1994). Essentially, medicine does not want to act in ways which are likely to threaten its authority base or the power of construction relating to medical knowledge and the experts surrounding that (Arskey, 1994). Here sociology of medical knowledge has contributed to a theoretical framework whereby, scientific knowledge can be conceptualised as constructed through 'discourses', the medical community or social actors who participate in verification of specialised medical knowledge (Arskey, 1994). This knowledge needs to be open for analysis.

The institutionalisation and conceptualisation of 'professions' begins back to Ancient Egypt and during medieval Cathedral based medical schools the cultural transformation of the professional role and contribution to society that doctors made has been explored (Mellor & Shilling, 1997). Professions are generally viewed in terms of the role and contribution of a profession in society. The conceptualisation of what a profession is has been primarily driven by the earlier and most noted work of Elliot Freidson. This early work (Freidson, 1963; 1970; 1975) focussed on the medical profession, implications of the ideological character of the profession and the way medicine sustained authority over patients. The defining aspect to professionalism was also conceptualised in terms of skill dominance, control of a

specific body of complex knowledge and for some professions the role of service to society. The term profession is used to refer to specific aspects of a profession whereby there is focus on control over work and utilisation of a special set of esoteric knowledges, which are maintained in a specific set of ideologies by a specialised body of people (Freidson, 1986).

It seems that medicine is a target of most of the criticisms of a profession in terms of how occupations seek to improve their economic position, social standing and prestige. It is through some criticisms that professionals are viewed in terms of an ideology which is organised and sustained by the occupation (Freidson, 1984). Foucault (1977) suggests that the concept of power in medicine is important because it demonstrates how through institutional practices, forms of professional discipline are exercised. This is to suggest, that medical interactions with doctors are perhaps mediated by previous role models, reference groups or landmark events (Fox, 1989; Fox, Mazmainian, & Putnam, 1989). The concept of medical professionalism is important in terms of the attitudes and behaviours associated with being a doctor. Currently, medical professionalism is being brought into a standardised scale to measure for medical education (Arnold, 1998). Medical culture is based on normative action where the influences of the organisation have been seen as social control of professionals (Freidson & Rhea, 1963). The ideology whereby a profession disciplines its members can be seen as almost organisational punishment. This suggests that within medicine, there are particular norms, values and rules to abide by which are reinforced and can be enforced through the practice of medicine.

Professions within healthcare play their own unique role and have certain implied relationships and rules within society. This is often covered through means such as legislation, licensing and practice privileges. The specific knowledges, skills and attitudes that are taught for professions generally relate to commonly held attitudes of that profession (Engel, 1997) which are enforced by training institutions. It is the educational institutions which mediate appropriate assessment of training and the related professional behaviour (Cruess & Cruess, 1997). Sociologists need to constantly evaluate the change in the understanding of a profession, the role of professionalism, and also how rules about medical work reach the doctor and govern the way medical work is conducted (Hafferty & Light, 1995).

Many professions are also defined in terms of specific beliefs, values, shared languages and practices, which develop and reproduce a certain professional culture (Itzin & Newman, 1995). Within that culture there develops a need to value certain skills and contributions to the profession. For instance, in medicine it is more common now to not solely train as a general physician or general surgeon, but to fragment and direct attention towards training for a specialty or subspecialty early. This early subspecialty choice that many doctors make has implications for the quality of research and variety of medical training doctors experience while trying to maintain a balance with departments for quality training (Herndon, 1998). This early division of the general profession is a result of the profession as a collective defining boundaries and controlling entry to members once they have conformed to the model of professionalism (Baszanger, 1985).

It is easy to suggest then, that in a theory of professions, some knowledges and skills are more prestigious and valued for the profession or the sub-professions

within the overall profession. Yet, the distinguishing feature of an occupation remains the variety of skills and specialised knowledges linked to the complex division of labour. The Bourdieuian concept of cultural capital explains many precursors to entering a profession, in terms of how people bring with them to the professional situation pre-existing valued characteristics and goods, even deportment which may be more valuable in certain professions or social situations (Bourdieu, 1986). Therefore, it is not just once in a profession that people begin to experience the features of professional selection, rites of passage and develop professional commitment and identification. Perhaps it is the ideology of the group that in some way in addition to what that person brings with them to the professional table that is also important.

Discussions on culture and the effect on medical practice are important. Moreover, the power of a normative culture on a larger scale of the hospital may be underestimated. Those who mediate professional norms, exercise control through practice also maintain interest in certain professional values. The certain 'ideologies' that have been highlighted so far are present in the development of understanding a profession, professionalism and the role that characteristics play in the medical profession. Here medicine is seen as having a unique role within society through control of its own members, and establishing itself as a profession with unique specialised knowledges. It could be suggested that through this training process which is mediated by voicing dissent there is a perpetuation of medical internship as an institutional form of rite of passage and control mechanism for training within an official medical ideology (Groopman, 1987).

There are many other areas in terms of professions, professionalism, and the societal influences on professions across the board. However, the interest here is directed not towards the general category of the medical profession, but some of the internal mechanisms within the (junior) medical profession. How through the process of entering the first two years of postgraduate medical training junior doctors experience and learn about the desired values, characteristics and knowledges associated with the profession of medicine? Essentially, how do doctors learn to practice medicine?

The sociological study of professions, and of concern in this work medical education, has been developing at a rapid pace. Readers unfamiliar with the vast amount of theories from the professions literature may find studying such classics as Mumford's (1970) examination of interns to professional physicians evolution of medicine (Starr, 1982) history of medical education (Ludmerer, 1997) and the classic medical socialisation work of Renee Fox (1989), Donald Light (1979; 1980), amongst other key work in medical education and the examination of the medical profession (Good & DelVecchio Good, 1993; Good, 1995). Naturally there are always many ways to examine medicine and other theorists such as David Silverman (2001) and his work using interaction theory or Strauss (1978, 1993) and negotiated order may also be of use to some readers while not a focus of this work. Here, Hafferty (2000) suggests that the hidden curricula allows us researchers to understand the various structure, process, and impact of medical education where we can also examine what medical students are taught in college or university and what they learn formally in the workplace.

Often junior doctors are seen as part of the training in a professional apprenticeship. The seniors doctors ask: what is wrong with socialisation? The interest in junior doctors' education, development, and workplace issues are important for examination how professionals are socialised through the medical training process. Any investigation into workplace professions whether it is teaching, nursing, police or medicine, leads one to read the professional socialisation literature. Change in modern health care delivery and development of alternative theories for academic sociological investigation leads me to read the professional socialisation literature critically. I strongly reject the term professional 'socialisation', because I see that this term actually minimises variations in cultural and social experiences, and attempts to fit medical students and current doctors into a certain trajectory of a single path towards the goal of being 'socialised'. Another negative aspect to using the perspective of professional socialisation is that it implies a passive role of the individuals supposedly being socialised. Therefore, my preference is to use the terms 'professional development'. This alternative conceptual frame of development versus socialisation does not suggest that medical practice through school or hospital training is merely socialisation, or that all doctors are professionally socialised. Rather, it is my position that I do not see the need to label the medical professional process as socialisation, with particular steps and characteristics (eg. Blishen, 1969) or concur with the classic socialisation research positions from the '50s and '60s (eg, Becker et al., 1961; Merton et al., 1957) on medical student socialisation.

At this point we can conceptualise that junior doctors develop and are affected by a range of influences, but they are not simply products of the structured and organised nature of medical school, which produces an 'arrival' as a pre-registered junior doctor. As we investigate how the experiences in a public hospital mediate the medical and social training of junior doctors, we draw upon work of sociologists, medical anthropologists and medical educators. From this work, we set out to investigate process aspects to development and change for junior doctors. Medical culture is central to this because we can see characteristics and aspects in hospital medical rituals, markers and events appear to have influence (and a long history) in the development and reproduction of medical culture. The medical profession has a large corpus subculture from which to examine the role and function of a profession in society.

Professional socialisation emphasises professional behaviour that is taught and then reproduced by practitioners. Medical professional socialisation mainly focuses on medical students relating concepts of locus of control, role strain, ambiguity, work satisfaction, values, attitudes, role identity and learning styles. Essentially professional socialisation looks at where and how values, behaviour and attitudes are reinforced and replicated within a profession (eg, Merton et al., 1957). To identify essential socialisation processes and specifically, learning behaviours through reproduction, these characteristics have been used primarily to explain the medical student socialisation process. Furthermore, professional socialisation theory incorporates two aspects of traditional social psychological and sociological cultural models. The social psychological perspective views professional socialisation from an attachment theory of learning and development of values and behaviours, where

professionals are dependent on the organisation to learn certain ideologies from the organisation (Nelson, Quick, & Joplin, 1991). On the other hand, sociology tends to look at cultural markers in terms of reproduction and internalisation of behaviours within the culture (Delamont, Parry, & Atkinson, 1997).

It has long been assumed that medical school socialised students for their future roles as doctors. Merton et al. (1957) considered this process as an induction approach as opposed to Becker et al. (1961) who saw medical student socialisation as more a reaction approach to the medical school (Harper Simpson, Back, Ingles, Kerckhoff, & McKinney, 1979). In the past 'anticipatory socialisation'was seen as the process medical students used to internalise values of the student group to which they aspired to (doctors) but are not apart of yet (Merton et al., 1957; Shuval, 1975). Medical students are initiated into a profession that not only controls the profession overall, but also has implications for the initiation into the medical culture. Further,

> the profession of medicine...has its own normative subculture, a body of shared and transmitted ideas, values and standards toward which members of the profession are expected to orient their behaviour. The subculture, then refers to more than habitual behaviour; its norms codify the values of the profession (Merton et al., 1957, p. 71).

These authors suggest that the attitudes that are likely to be held by junior medical residents in the future are formed and developed before entering the postgraduate training programs in medical school. The focus of other medical student professional socialisation studies is on the development of specific values and attitudes, often expressed as socialisation into an early medical ideology (eg, Becker et al., 1961). Further, the socialisation of medical students, the way in which a doctor learns to 'be'a doctor involves learning, adapting and blending the doctor role with patterns of professionally defined normative behaviours, values and norms. The role and extent that values play in medical student socialisation (for instance, learning medical skills and acquisition of knowledge and skills for medical practice) has however, been strongly critiqued (Wilkes, Coulter, & Hurwitz, 1998). Today, medical student socialisation is being questioned - are medical students ready for the new corporate age of health care? The professional values, it seems are being challenged, remodelled and there is concern as to whether the new class that goes through medical school will be prepared (Relman, 1998).

Light (1980) contributed an original and innovative understanding of professional socialisation. Most importantly, he discussed how medical practice and the structure of power were related. Light asked, how do residents negotiate their own professional socialisation? His main argument was that socialisation is a structural process which has it own characteristics. However, the process as a larger structure is built into that structure of role learning. In contrast, Becker et al., (1961) and Merton et al., (1957) viewed professional socialisation as a process where residents enter a medical culture that involves acquisition of attitudes, values, (certain medical) skills and behaviour patterns. This then in turn, was seen as constituting key social roles, which are established in the existing medical social structure.

The concepts that dominate and represent the perspective of Becker et al. (Becker et al., 1961) included: group perspectives, student culture, the organisation.

and development of attitudes and values. In many ways, they can be defined as symbolic interactionists who deny a general theory of the professions and focus on the institution's effect on the student (May, 1996). Becker et al., (1961) in "*Boys in White*" show how the influence of perceived autonomy limits the extent and nature of professional control. This previous work on professional socialisation has been used to reflect on how socialisation and the processes students undergo affect their need to attain status within the profession (Becker et al., 1961). This work informs the way we can look at the displays of culture and the adaptation and learning of professional norms. This then can also be related to, as I have discussed previously, socialisation and the way a profession controls and sets the agenda for a new body of professionals.

Many of these early studies on professional socialisation see students as solely students, physicians-in-training (Bloom, 1979), or examine the medical school as part of the medical profession and not as a training institution or part of society. The sociology of the early medical professional socialisation does escalate the medical school role and accounts of what medical students might bring to medical school. I suggest that there needs to be some consideration of the characteristics that medical students bring to university compared with the rest of society. Clearly these students have had some sort of socialisation prior to medical school. There is concern that medical school negates and suppresses many positive qualities and not only fails to produce doctors that have the qualities that are of most value to the health care system, but also that some of these qualities are actually suppressed through the medical school process (DelVecchio Good & Good, 1989).

This classical work on medical students laid the foundation for much of the subsequent work on medical student professional socialisation. Acceptance for medical students was perceived as allowing easier adjustment into the student group. However, this adjustment was also mediated by potential role conflict when the definition of the role by the students did not match the senior definitions of the role. The perspective of 'primary socialisation' was also originally put forward to suggest that early socialisation that takes place in the early years of life, may contribute to future deviant behaviour towards the role norms once known (Colombotos & Kirchner, 1986; Coombs, 1978; Lesserman, 1981). However, this concept does not explain for some groups a unity to the values of a certain profession. Credential monopoly (Freidson, 1984) has used as a potential explanation for recruitment, licensing and thus control of professions which was also seen as avoiding deviant behaviour in society. Here it is suggested that through credential monopoly this is the means to conceptualise socialisation because there is little room for role innovation, and there will be a stronger commitment to an ideological basis of the socialising group or profession, which is controlled by professions (Freidson, 1984). To some degree, this may be relevant in terms of the need for a regulating body for the profession, but it is narrow in terms of an examination of the way the social structures (family), or even the co-training group of junior doctors may affect the individual.

Medicine in relation to health and illness is essentially surrounded by controversy, conflict and emotion (Lupton, 1994). In terms of the practice of medicine, a significant limitation of medical knowledge is that diagnosis is the result

of described symptoms. Using previous clinical experiences throughout history, a doctor will manage a patient according to current and previous known evidence and medical knowledge. Perhaps then, for junior doctors their experiences in terms of mastering the medical knowledge, role and diagnosis is the uncertainty and the limitations of that medical knowledge. Fox (1987) and Light (1980) suggest mastering uncertainty is a part of socialisation, because it allows for development of a good professional doctor. Furthermore, for many doctors training in a specialty or subspecialty is another way in which they may limit the degree of uncertainty for which they may be confronted throughout their career (Light, 1979).

It is at this point that we really need to think critically about redefining the institution. That is, what are the weaknesses in traditional socialisation theory? Much of the sociological literature focuses on a class of professions as a whole such as nurses, doctors and generally the healthcare fields. The difficulty with this is the variation in a whole area of healthcare, and the lack of specific analysis on a level within medicine for example, junior doctors. It is important in a cultural analysis to have as a specific focus on how or what professions train its new members in. Beyond specific structural parts of junior doctors' work, such as stress or coping, are the social and cultural processes that are a part of their objective experiences. This theoretical gap is the main reason for pursuing a theory that has as its main principle a desire to understand how objects (such as junior doctors) are constructed in science through the modes of production (the profession) which are capable of or have power to constrain practices which underline the production of knowledge.

Medicine in sociological terms has been researched as organisational practice and looked at in terms of the language of medicine and how it is quite powerful in its constructs relating to medical knowledge. Further, many of the ideologies of the profession are organised and sustained by the occupation through particular attitudes and behaviours associated with being a doctor. These specific knowledges and skills are enforced by training institutions and thus, certain ideologies that are present in the professions. The key problem with professional socialisation theory is it emphasises reproduction, locus of control, role strain, work satisfaction, values and role identity. This literature also often constructs an 'over socialised' view of the doctor.

As we see now, Bourdieu's theorising is different because his theoretical work allows us to clarify how professions at a more detailed level succeed in reproducing themselves in the form of durable dispositions in people. This is where we can take the previous research from a psychological level to a more detailed sociological level where people, here junior doctors, who are subjected to the similar conditions and placed in the same material conditions of practice which are changing their particular ways of being junior doctors. The first two years of medical practice in a hospital are very important here in the development from medical students to graduate medical practitioners. This is also why Bourdieu's work is so useful, because his sociological theorising is really a theory about practice, including its embodied, cognitive and cultural aspects.

Professional training becomes a collective solution to shared problems with a focus on how the institutions affect the student. Bourdieu's work is different because it uses sociology to examine how people are products of similar social

conditions, support similar relationships and become products common to similar structures. The habitus can be considered as specific schemes of bodily inscription, perception and actions common to members of the same group, constructing the preconditions and reproduction of practices. As an entry point, medical sociology and the professional socialisation literature can be useful, but we need to consider in more detail what constitutes a medical profession and some of the early professional development features for junior doctors. Building on some historical classical work on medical students, we have seen how there is a need for some socio-cultural critical theory work. As I will show, provides theoretical tools for insightful descriptions of junior doctor medical culture, the medical field and emergent medical habitus. We now move to examine further junior doctor development through the culture of medicine. We approach the theoretical gap in understanding medical culture within a sociological framework of Pierre Bourdieu‘s theory of practice.

BOURDIEU'S THEORY OF PRACTICE: CAPITAL, FIELD AND HABITUS

Three of Bourdieu's defining concepts from his theory of practice are discussed here: capital, field and the habitus. I begin by describing briefly the shortcomings of the previous work detailed, how Bourdieu's theorising helps to overcome these inadequacies and detail why these concepts are useful for medical culture and how the use of the habitus averts problems with previous research with junior doctors and extends the thinking on medical professional development and cultural research.

One of the primary shortcomings of previous research in medical sociology is the focus in medicine on the perspective that medical practice cannot be modified. Much of the research conducted takes the position that there are particular discourses in medicine that work on a basis of reproduction every year. The assumption that medicine is bias free is at odds with theory here, that simply sees medicine as another construction that has particular authority base or power, but is equally able to be deconstructed as a representation of a particular set of values. Further, the previous research on medical development looks at training nurses, medical students, general practitioners or patients and often excludes doctors in internship or career hospital doctors. Within this previous research there is limited insight into the medical culture which is evidenced by research that focuses on gaining skill dominance, attitudes and behaviours which are sustained by the occupation and even professional control of doctors through licensing.

Much of the learning in medical school socialises student doctors unofficially. Merton et al., (1957) for instance as one of the classic studies, focuses on how in medical school behaviour is taught and then reproduced. Further, other studies look at how there are situational controls that induce certain behaviours (Becker et al., 1961) or there is a psychological focus on an attachment theory of learning. Other authors looked at how becoming a doctor is about mastering uncertainty (Fox, 1989) or how socialisation is a structural process (Light, 1980). Other research on young doctors looks at practical aspects to the junior doctor job such as: skill checklists/knowledge acquisition, psychological and physical stress, long hours and

medical mistakes. While these are all valid contributions to looking at medicine and doctors, none of these discuss the role of culture or attempt any theoretical strategy of action, behaviour or cultural reproduction. Examination of the culture of medicine is best done with a theory that examines the concept of culture generally. Bourdieu's theorising helps to overcome the previous research shortcomings and extend our understanding of the culture of medicine.

Based on the idea that a socio-cultural theory of practice can be applied to understanding the experiences of junior doctors, three main components of Bourdieu's theory are examined. First, the term capital and its various forms, social, economic and cultural, are used to illustrate and understand how Bourdieu sees society functioning around these various capitals. Although one could start with any of these three main concepts, cultural capital is explained first in order to understand how agents' (people's) positions, are the key to understanding interactions in society which are driven by capital based relations. Secondly, field is described to understand the relations of forces surrounding agent struggles. Lastly and most importantly, the habitus is explored as a principle of action, affected by capital and relevant to negotiating one's way through the field of social interaction. Let us begin with a brief introduction to the work of Bourdieu.

Born in France in 1930 and recently deceased (January 25, 2002) at 71 years of age, Pierre Bourdieu contributed decades of original theorising about social activity and relations within societal structures. Bourdieu's theoretical writing approach, however, has been a "permanent struggle against ordinary language" (1988, p. 149). This can be daunting when reading his work. Bourdieu (1989b) suggests that social reality is complex and thus his language usage reflects this reality, rather than any decadent desire to say complicated things or discuss theory in a complicated manner. Frank (1980, p. 256) has argued that the "European idiom of Bourdieu's writing should not distract …sociologists from its extraordinary importance as a theory of method". Much of his work has focussed on the critical concepts of structure, capital, the habitus and practice (Faubion, 1995) which have been utilised in many empirical studies. The application of the concept of the habitus is durable and transferable, and has been utilised in many empirical studies ranging from: art theory (Zolberg, 1989), astronomy (Gauthier, 1992), film (Clark, 1997), music (Lindberg, 1997), sexology (George, 1996), theology (Carpenter, 1997), nutrition (Suederberg, 1997), and farming (Fandino, 1997). Through his theorisation of culture we can see that there are certain medical practices and institutions that maintain unequal relationships which can make a key contribution to sociology of medical culture. Bourdieu's theory is most useful for addressing how culture shapes interactions and he tries to promote cultural analysis similarly to what Marx attempted to do for the economic realm (Swartz, 1997).

Bourdieu's work has been primarily influential in sociology, but also has the theoretical diversity to contribute to linguistics and educational concepts. Although his approach is fairly structuralist, it seeks to go beyond structural determinism (Bourdieu, 1999), being one specific response to the central sociological dilemma of structure/agency relationships. That is, economic, political or social structures frame human agency and experience in recursive ways. For instance, structural determinism focuses on how the structures of mind determine social interaction. In

contrast, for instance, Foucault as a post-structuralist rejected predetermined structures and structural theories as determining action, thought and social interaction. In respect of the structure/agency dilemma, Bourdieu classifies his work as constructivist structuralism or structuralist constructivism. He refers to how structures in the social world (and in people) exist and, in terms of constructivism, these are developed through schemes, such as, the habitus (Bourdieu, 1989b). As such, Bourdieu through the conceptual use of the habitus introduces the notion of an agent. An agent refers to the active process of being a person within a structure, such as a doctor in a hospital. Bourdieu's work thus, tries to walk a line between structural determinism and voluntarism through constructing a theory of practice via the concept of the habitus. Agents (doctors) thus act in a relationship between "history objectified in the form of structures and history incarnated in bodies in the form of habitus" (Bourdieu, 2000, p. 152).

Bourdieu's original work was an anthropological ethnographic study of the Algerian Kabyle (Bourdieu, 1961). He examined the cultural organisation of time, space, social relations and identities which indicated their relations, structuring in a symbolic and cultural order. For Bourdieu (1977), objectivist knowledge works to construct relations, practices and representations in the social world. Yet it also works against a person having explicit knowledge of the truth in structures or just through experience. The progress of Bourdieu's thinking was related to his understanding of the construction of scientific knowledge. He emphasises the sociologist's need to be aware of her/his assumptions entering into scientific discovery in terms of the relationship to practice and knowledge (Bourdieu & Wacquant, 1992). Bourdieu (1990) is also interested in examining the relationship between the researcher and the object of research. In much of Bourdieu's work he describes social reality as existing in the body of individuals, outside of individuals and in things. Within these processes then, there is power to develop specific dispositions (Bourdieu, 1977). Bourdieu's theorisation of social practice is informative because of the perspective that social activity is organised through societal rules, symbols and language, which signify specific practices.

The concept of the habitus is a dynamic set of principles useful for examining culture, particularly medical culture as it is manifest in medical practice. Throughout much of Bourdieu's work, he suggests that learned (social and physical) dispositions, practices and knowledges are embodied by people (he uses agent) through their social practices. Bourdieu's theory of the habitus is critical because it is my assumption that through junior doctor medical practice, the habitus develops specifically within particular medical structures or within the medical field, to use Bourdieu's language. More particularly, I argue that a medical habitus emerges.

The relationship between structure and agency is fundamental in Bourdieu's work. Habitus can be used as a research tool to form a part of an empirical analysis about the culture and formation of dispositions. Habitus interacts with the medical field and ultimately shapes the dispositions and preferences of junior doctors. Habitus, then, as a set of dispositions, creates and transforms through a personal history (Bourdieu, 1977; Bourdieu & Passeron, 1990). As I will discuss in more detail later, the notion of 'social doctor' describes how daily activities of junior doctors are influenced by individual dispositions, which then affect how doctors

interact within their social network and under particular workplace constructions and vice versa. I present the concept of capital next because it is key in understanding the market economy of a person's worth and how an agent enters the market with existing capital. Then, I discuss the concept of field which describes the struggle based on certain positions surrounding capital. Finally, I move to describing the habitus. These are central concepts and tie together the sociological understanding of medicine.

WHAT YOU ARE WORTH: CAPITAL

Capital refers to objects of value, such as money, goods, attributes or wealth. Bourdieu (1997) describes three main types of capital: cultural, economic and social. These objects of value, as defined by capital refer to the construction of economic goods of value. Cultural capital defines the social gain through mixing with people or networking to attain higher social standing. Symbolic and social capital are very similar and refer to how people are a part of and able to access these networks. Doctors for instance, are able to access Drug Company perks, such as 'educational' dinners, this is symbolic capital; and how these are used to gain funding for research, for example, is cultural capital. They are part of the medical culture, at a senior level, of value to the Drug Company, and thus doctors are given access to these occasions, networks and benefits based on particular capitals in the medical field.

As with common usage, economic capital for Bourdieu refers to material like goods, such as one's job, education and one's material wealth. As suggested above, social capital relates to aspects such as social contacts and networks. Cultural capital, which is the focus here, refers to the types of capital that are deemed to be of value, such as a 'prestigious' job or the value of a 'private' school education (Carrington & Luke, 1997). Capital is however, not just subjective aspects to social life, but can also be knowledge, language or relationships to aspects of culture. However, to understand these, it is imperative to clarify capital. According to Bourdieu, the concept of capital provides a good grounding to understand how society works. That is, through the exchange of capital, people attempt to achieve prestige and distinction.

All the types of capital are of relevance here because all people struggle for their position in the social world through the primary use of one or all of the interchangeable aspects of capital. Hence, people try to gain a position in the social world through the market of exchange and achievement. Primarily, the use of capital is to improve one's social standing and position which is negotiated by capital in a social field and mediated by the habitus. A (social) field is discussed later, but at its most basic, it relates to a system of relationships with concomitant related structures, rules and forces acting upon it with a certain degree of autonomy from other social fields. Figure 1 below shows a one-dimensional perspective of capital linking into the field, such as the hospital.

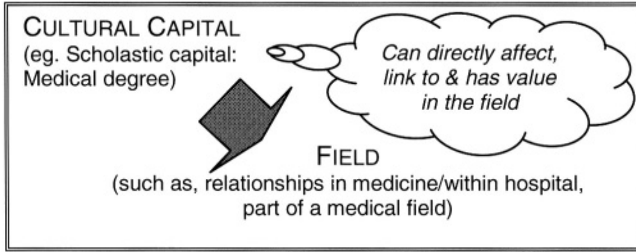

Figure 1. Cultural capital - field model.

As people negotiate in a field, they bring with them capital, a resource or aspect to that person that has value in the field's market. Above figure 1 shows how cultural capital (eg. the medical degree, but it could also be economic or social capital) directs a person's social position in that field. In a study of cultural capital (for instance knowledge of financial systems) and habitus in the field of personal finance (Aldridge, 1998), it was found that investors who had access to cultural capital were better informed, which enabled them to invest appropriately. The appropriate habitus also prevented them from being financially exploited by their financial advisers.

The perspective on the habitus thus far enables us to see that it is something within agents that mediates what happens to us as well as how we respond to activities. The concept of capital has key links to habitus. All people bring with them certain social standing or goods, which interact in social contexts to signify valued factors for social reproduction. People are categorised then according to the types and volume of capital they have. For example, the way that people save money (or even the fact that they are saving money), invest to enhance their social position, or the goods they use as part of their lifestyle are seen as cultural capital and will advance or hinder their social positions in different fields.

Cultural capital refers to types of legitimate, valued and applicable knowledge, skills and attributes that an individual brings to a social field (Carrington & Luke, 1997). For instance, primary school students who know their multiplication tables when called upon by the teacher, are more likely to be seen in a valued way by the teacher and be successful in the mathematical field/context of the class. An agent's perspectives in the field then, are based on capital, position and dispositions, which helps them negotiate their 'place'. Cultural capital also refers to the ease or lack of ease with which individuals approach and relate to certain cultural objects and practices of high status and regard. With cultural capital, society values or devalues aspects that people bring with them to certain situations. For junior doctors, the time working in a field to embody valued goods (capital) is also time invested in the development towards gaining cultural capital. Junior doctors may bring with them their university medical degree (scholastic capital) which indicates that they are a 'doctor'(social standing) in the social context of a hospital within a medical field. Therefore, cultural capital can be conceptualised in terms of educational credentials

and the collection of certain internalised dispositions through the socialisation process. Internalisation of specific capital is significant as the person adapts the desired cultural capital and proceeds through the field, while being set up for another set of rules or subjective possibilities. Activity surrounding capital can be seen as acting as a negotiator in instances of material, cultural or social form (Swartz, 1997). It is evident how Bourdieu's work can be seen in a neo-Marxist way, but the theory takes on a different tangent through the application of those ideas in terms of transferring skills, it does not offer a passive account of individual action.

Regarding movement within a market, field or social space, Bourdieu (1993) takes the position that the dispositions and social properties of people (or as Bourdieu suggests agents), relate to the position that they occupy within society and within various fields. These positions are fundamental to understanding culture and society. Within the social world, there is a struggle to achieve recognition, legitimation, capital and access to capital (Harker, Mahar, & Wilkes, 1990). Further, capital is involved in the development or is a result of the workings of an individual's habitus (Meisenhelder, 1997). Junior doctors, for example, are learning to acquire medical cultural practices, to inherit, and to develop the cultural capital from the profession through their workplace practices. Bourdieu's sociological inquiry then combines aspects of objective social structures (such as the education of children) with subjective dispositions (as in feelings or behaviours around those situations). The focus here is how cultural capital in the cultural analysis framework interplays with a person's behaviour.

When people are buying a house (which is accessible to or even desired by some people), for instance, they are gaining material capital using certain ideas (dispositions) and the financial capital to act on this. Capital also lends itself to people learning how to manage and make best use of cultural, social and economic goods that they have access to, achieve and carry. Cultural capital then, is important and valued in relation to the legitimate knowledge that a person has (Luke, 1997). Figure 2 next extends a simplistic link between capital and field by showing how structure can mediate capital, the field, and how the field is affected through practices as a continuous process.

The figure 2 illustrates how structure identifies parts of a complex social situation while acting as a metaphor (Sewell, 1992). Further, structure could refer to rules, organisations, resources or even schemas. However, it is my understanding, that using the concept while discussing the habitus, elaborates the way that structures can mutually reinforce rules, which enable people to act and understand their social world in a particular way. Practice in this figure 2, as well, can be characterised as what people do in their life that makes up their social relations. In this context, this refers to struggles within the field, about distribution of types of capital (May, 1996).

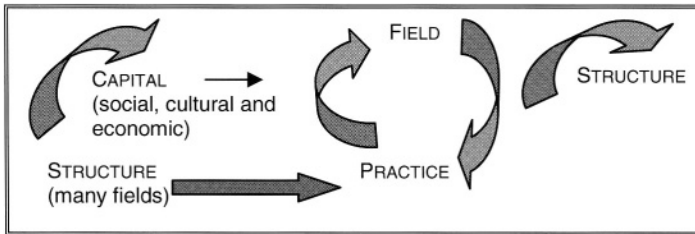

Figure 2. Capital - structure - field - practice illustration.

As I have discussed, people negotiate the social field and bring with them a resource or aspect about their personhood that has value in the social and economic market. Capital, whether it is financial, social or cultural mediates positional standing in a social field. For instance, within a hospital structure creates a field with a self-perpetuating hierarchy of social prestige and social standing. According to Bourdieu (1993, p. 64), the likelihood of something happening in a particular field relates to the agent's career, desires and expectations. Yet, these are all constructed, perceived and appreciated through the habitus, which is linked through the field by capital. Further, cultural capital may be sought through certain structuring processes of training during the junior doctor years. This can be seen in the way that cultural capital is acquired.

Bourdieu (1989b) describes how an objective world combined with a framework that emphasises a more subjective reality (of social structure and institutions) can result in specific patterns, representations and practices. As figure 2 above demonstrated, exchange of various kinds of valued capital (cultural, social and economic) are crucial to the social structuring process by either directly affecting the field and the practices in that field, or are mediated by structure and then linked into the field. For Bourdieu, his point of theoretical departure is practical action (Schmidt, 1997). A defining characteristic of Bourdieu's work is the way that he ties in abstracted relationships, actor's knowledge and social action as a defining characteristic of sociological knowledge or potential explanation (Hamel, 1998). This can be related to the environment within which junior doctors work. The hospital, for instance, has specific provision for a significant amount of knowledge, understanding and practice which are not always formally learned. It may be unconsciously acquired, acquired through enculturation or through incidental learning. Beyond that, it is the struggles for capital by agents in the field, that change what is valued in a field.

STRUGGLE FOR POWER: FIELD

The concept of field refers to social space, whereby interaction occurs in a distinct social domain. Here individuals and the collective operate with varying degrees of

autonomy based on capitals. The field operationalises interaction based on structural relations, power and hierarchies. Field also refers to sources of conflict (such as over cultural capital) in a given domain; that is, the process whereby relationships within society or an organisational culture come to a disagreement to forge a way for certain ideas or activities to be enacted. The concept of field is based on the assumption that social interaction and practices are mediated by certain embodied dispositions to enhance social distinction. Bourdieu uses the concept of field to examine how cultural socialisation engages individuals and groups in a competitive manner (Swartz, 1997). Fields collectively are seen to constitute social structure.

Activities within a field are based on social position and capital. Here we can see how field in relation to capital is linked because agents may have valued capital, with position(s) in a field being determined by capital. The effect of position in each social field (eg, a home for family, going to work on weekdays) for the actors within it has unique form and characteristics associated with it (During, 1993). The structured space that field refers to, revolves around the struggle for position via capitals. Capital and habitus are parts of the field, and are defined by the relationship between the field and the habitus (Bourdieu, 1993, p. 65). Patterned activities in a field, such as a medical ward round are shaped by positions of hierarchy and structured relations. Although there are relationships and struggles in a field, the concept shows how a person can be 'multiply situated' where change occurs in relation to specific practices (Scott & Stam, 1996).

It is difficult to separate these three concepts of capital, habitus and field because they comprise a relational theoretical system. Bourdieu suggests that the way people pursue their interests within the social field also produces and reproduces social stratification through capitals. The emphasis here is on capital and field prior to discussion of the habitus, because of the need to use an approach which looks at how the social and cultural components of the hospital linked with specific cultural, historical and institutional factors (Wertsch, 1991). Bourdieu's approach utilises the structures in fields and how they reproduce the individual's action to achieve their own personal ends by struggling for position in the social field (which is in fact the structure reproducing itself). It is here that Bourdieu calls into question how personal power is negotiated within a social field (Caston Boyer, 1996).

Relationships within a field acquire specific meaning because of the field struggles. Struggle, power and control over objective structures in fact may disguise the possibilities that the field provides the agent. For instance, in academic culture the enculturation of doctoral students is seen as the structure structuring the process of reproduction and production of knowledge (Delamont et al., 1997). More specifically then, a field:

> consists of a set of objective, historical relations between positions anchored in certain forms of power (or capital), while habitus consists of a set of historical relations 'deposited' within individual bodies in the form of mental and corporeal schemata of perception, appreciation and action (Wacquant, 1992, p. 16).

This definition describes how field is a relationship based on power from capital, while the habitus is more of an internal relationship of appreciating types of capital. Further, the role that the habitus plays, connects the field through the agent's own

understanding and knowledge of the field. The habitus reinforces and regulates social relationships within a social field which assist to describe a complex, yet practical nature of the social environment (Luke, 1997). The concept of field gives a perspective on sociocultural activity in terms of conflictual situations that people experience. The field allows us to see where struggle for reproduction of culture takes place. It does not suggest that this is where cultural change occurs, but is a place to shape behaviour based on the struggle or conflict over cultural capital.

Bourdieu defines much of his work in terms of how (social and cultural) knowledge is gained, utilised and reproduced. Within a field, how knowledge is constructed through objective relations and struggles for social distinction is a fundamental aspect to social life (Swartz, 1997). As suggested earlier, society is seen as consisting of independent fields where struggles for power through this process and the change in the structure of the field occurs (Chan, 1996). Therefore, the potential struggle, chance and access to different positions (cultural capital) in a field may bring together the preferred dispositions in a field (habitus).

The individual is a social product of their (cultural) capital which through the field generates certain practices. The world around agents helps to construct and organise through acquired schemes action and classifications (Marker et al., 1990). The systematic relationships between capital and field allow us to look at how habitus is the graduate of the forces within the field and a product of cultural capital. The important aspect of the field and its description here is how the relations between positions interact in a specific culture. As Scott and Stam (1996) suggest, those people who can define particular fields (such as an educational structure) are also able to define possibly a truth, which will allow them to perpetuate their interests (ie. become a principal). The next section looks at the habitus and the nature of regulation in the field (with capital) to describe how cultural practices (playing the game) work. Each field produces and reproduces a particular logic of practice which is manifested in a particular habitus.

HABITUS

Habitus as this section will demonstrate, is a tool to help understand how junior doctors internalise particular dispositions and preferences from the medical field. Bourdieu's concept of habitus examines how the body expresses certain dispositions, and how requirements of the field are 'tattooed' onto the body. This includes walking, accents, handshake and even kissing (Hardy, 1990) and manifests in people's attachment to types of food, exercise, sport and art (Bourdieu, 1984). This means that the way we know that a picture is painted by a certain artist indicates 'taste' or knowledge of specific experience (even presence in an art gallery indicates something of our habitus). The habitus connects a person within structured fields, to contribute to and develop culture and capital laden ways of seeing, being and participating in the social world. In Bourdieu's work, he prevents a lot of the problems with 'oversocialised' traditional socialisation theory because he demonstrates that culture is capital. Culture is a part of social reproduction allowing for a more recursive relationship between structure and agency.

Bourdieu's theoretical position as an empirical method incorporates interaction between individuals and social structures. This allows for understanding how doctors make choices based on the organisation structures (that in turn, shape their actions). Bourdieu's concept of habitus refers to a set of dispositions which primarily are the product of collective history (Scott & Stam, 1996); in effect an interplay between social and individual histories/biographies. The term habitus, in Latin literally refers to a habitual or typical condition, state or appearance particularly in reference to the body (Jenkins, 1992). It has also been used in other work such as that of Weber, Hegel and Durkheim, and has been used to refer to acquired schemes adjusted to certain conditions. Bourdieu (1977) is interested in the practices produced or reproduced by the habitus as ways to deal with unforeseen and changing situations.

The dispositions that habitus reflects are the social conditions in which it was formed and maintained. It focuses on the individual's past and present experiences for transfer to the possibilities of the future requirements of action (the habitus). The habitus then, is able to incorporate past dispositions with present situations as valued cultural knowledge in the social field (Wacquant, 1992). Direct interaction of people with each other dominates the development of specific habitus as opposed to impersonal institutions (Calhoun, Lipuma, & Postone, 1993). That is, a person is unlikely to gain knowledge of relevant behaviours by being in a carefully scripted situation, but rather where the rules of behaviour are not explicit. Habitus appears to be acquired through incidental learning, although Bourdieu does not provide an account of 'habitus learning'. The habitus is also an internalisation of external rules or behaviours. Bourdieu informs us that he sees habitus as being internalised from early primary family experiences which set the groundwork for future practice, as well as the co-ordination of practices (Bourdieu, 1977). This relates to understanding the habitus as a way of organising and relating to the world and responding to past practices and directs future ways of being (Schaffer, 1995).

On one level Bourdieu sees the way culture works is actually a specific theory of practice. The field and capitals within it mediate actions that occur in a social context such as going to the doctor. This is a relationship or interaction that is connected to cultural structure and power. Health-related behaviour for instance, is based on a choice from options (Cockerham, Rutten, & Abel, 1997). By this, I mean that the choices that people make about health, such as eating or going to see a doctor are actually mediated by certain structures within social fields. However, as some suggest (Harker & May, 1993), structure, choice and agency are actually enclosed and enfolded within each other. As a social group or group concept of health, the construction of the habitus or dispositions relating to that concept of health, represents a unifying principle of those particular practices and ideologies (Bourdieu, 1975). Health for one person may be seen differently for another and the practices surrounding ill health are likely to be different based on one's habitus. Living in remote Australia and seeing a specialist doctor for heart disease may not be possible until the Royal Flying Doctor Service (RFDS) comes to town. The city person has more access to specialist doctors due to the structure of the field (more specialists in the city) and capital (general practitioners refer more commonly to

specialists in metropolitan areas). Therefore, previous knowledge or experience, the habitus, mediates the action surrounding one's health needs.

Despite the extensive use of the concept of habitus throughout various literatures, Swartz (1997) suggests that the concept of the habitus is far from well understood. Bourdieu writes about the habitus in various ways in his work. Although discussion of the habitus has begun to take place, I have not brought Bourdieu's 'original' definition of the habitus forward. Bourdieu can be complicated and even convoluted in explaining his theoretical position and 1 have tried to provide a small lead into clarifying the concept prior to the most often quoted definition of habitus. Several paragraphs into this section, his original definition can be examined and clarified. The most common definition of the habitus provided by Bourdieu (Bourdieu, 1977, p. 72) is as follows, habitus refers to:

> systems of durable transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively 'regulated' and 'regular' without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them, and being all this, collectively orchestrated without being the product of the orchestrating action of a conductor.

Bourdieu says a lot in this definition. Characteristic of his writing, one needs a toolbox to deconstruct the definition's essential meaning. Bourdieu encompasses the life span of the habitus by giving the reader the whole process and factors that play on the habitus. Let's start with 'durable transposable dispositions'. This refers to the strength and constant nature of behaviours, feelings, actions or the way something has occurred, being altered yet maintaining essential features. Thus a person may feel sad however, this does not change them to a depressed person, but it is a feature of a situation that has been maintained by a sad scene in a movie for instance. This has changed the person's perspective, the movie and story line, but not changed the person totally. The 'predisposed to function as a structuring structure' refers to the impact of the habitus in guiding the development of dispositions to structure in the present or future the person's dispositions. The habitus structures the way dispositions are used for the person's place within a field, for example. It is an unconscious process to 'regulate' and 'provoke' a person's dispositions.

Further, this definition suggests that the dispositions are 'durable' because they have endured from the person's earliest experiences, and continue throughout their life as they move in and out of different fields. We see that Bourdieu uses the term 'transposable' to relate to habitus as a system of exchange and compatibility in various social fields. The social goods, dispositions (or deportment) that a person has within their style are carried into social practice by the way a person eats, stands, gestures and even cultivates a conversation, indeed how the person is embodied in the world. Finally, for Bourdieu, the habitus is a part of 'structured structures' because within the field of its production it is bound and a part of the structure that it creates and constantly recreates. With this clarification, we can assume that Bourdieu sees durable dispositions and structured structures as important for social

reproduction, and thus, he finds himself with a "theory of a mode of generation of practices" (1977, p. 72). Bourdieu's interest lies in what individuals do in everyday social interactions; linking individual decision-making to social structures through the concept of habitus and the logic of practice within a particular field.

The interpretation of dispositions provided by Bourdieu relates to how dispositions come from the past, survive into the future and again reproduce or present again in certain practices. Habitus exists inside actors as well as in their practices in interaction such as, physical ways of moving, activities things such as holidays or foods one eats. Habitus as an unconscious expression enables a person, for example, on a holiday, to visit and live in other habitats (Fiske, 1992). It is important for Bourdieu to conceptualise how the habitus organises practice and strategies unconsciously or without genuine intention. Yet, it can be seen that the habitus is still somewhat of a strategy because the agent is still working in a field of struggle (Bourdieu, 1977). Therefore, the person's bodily principles and actions are likely to reflect the social practices of the moment; thus social class, for example, is not abstract or simply demographic, but is embodied by individuals in how they dress, speak, stand, present themselves, relate to various capitals, act, interact and work. In short, social class is embodied through habitus.

Due to the public nature of the life of habitus one of the more defining characteristics is that it tends "to reproduce the objective structures of which they are the product, [and] they are determined by the past conditions which have produced the principle of their production" (Bourdieu, 1977, p. 72-73). This description clarifies how people participate in multiple cultures. This is because habitus recognises the interpretive and active role that people play in their lives, which as the definition highlights, allows people to operate in a range of fields through the habitus (Chan, 1996). In medicine for instance, the habitus may constantly intersect with the structures that doctors are the product and a part of. Understanding how all meaning is situated relationally, it is therefore important to understand how knowledge and ideas are structured to affect people's readings and uses of information (Luke, 1997). What is unique about habitus, then is how it manipulates the field and the relations of power to have meanings that are especially desired by people who do not necessarily occupy positions of power or status in the social structure.

Most important (and most difficult) in understanding habitus, is that it is not about something fixed or about norms that can be attached to fixed recipients (Robbins, 1991). Habitus is located within a habitat, the body; this is where it begins to materialise as marked characteristics or dispositions. The direction that the habitus takes is "afforded by the categories of perception and appreciation" (Bourdieu, 1993, p. 184). This is informative because behaviours and markers of behaviour are not always aspects of the habitus, but are an embodying performance of it. Fiske (1992) asserts in his writings on the culture of everyday life, that habitus locates within social space (the field) dynamic determining forces which materialise in behaviour, tastes and dispositions of those who, because of their differential positioning within the social space, embody and enact those forces differently.

Bourdieu refers to structures which are the agents of reproduction. It is unlikely that linked agents and institutions, such as junior doctors and hospitals, can be

separated. This is because they make up the factors that run and reproduce habitus within a certain field (Bourdieu, 1993). Habitus then, can be viewed as a process of internalised experiences of social agents in the social world (Robbins, 1991). However, it seems that dispositions are still driven by objective signs, rules and structured objects which mediate the habitus (Bourdieu, 1993).

It is important to remember that not only does Bourdieu not give simple explanations for human interaction, but what he describes is not an abstract concept, but something that is a central part of a person's behaviour, behaviour of a collective and has application to activities within social fields. In sum then, Bourdieu's concept of habitus, is almost a mnemonic device where the cultural aspects are coded and embodied on bodies through experience (Jenkins, 1992). The term dispositions as used above, suggests that habitus disposes actors towards certain practices, which are mediated by constraints, demands and opportunities in a field of practice. Here, then a fundamental aspect to understanding habitus is the distinction between the subjective and objective world of people and things. It has been suggested that habitus is an unconscious expression and an articulation of certain dispositions in social space (Lechte, 1994). This unconscious expression represents principles of social practice and dispositions which are durable in terms of reproduction. Habitus thus can be utilised to describe the way a professional belongs to a field of expertise with mastery of practice. Bourdieu (1993, p. 76) explains:

> [the habitus] functions as a system of generative schemes, [and] generates strategies which can be objectively consistent with the objective interests of their authors without having been expressly designed to that end.

This quote above is different from the earlier definition of habitus because it focuses on the internalised 'system of dispositions'. These generate specific practices according to the way individuals form their own representations of the world subjectively with the habitus (Bourdieu, 1993). Further, these dispositions, as suggested above, contribute to the development of the habitus without expressed need, desire or intentional learning. This suggests that Bourdieu "treats social life as a mutually constituting interaction of structures, dispositions and actions" (Calhoun et al., 1993, p.4). The adaptation of the habitus particular to a person, I suggest, is apparently 'natural' in any circumstance and developed in response to address needs of a person in the social field. Here a particular habitus, if unknown to the actor, could eventually appear innate and become cultural capital (only if of value within particular fields) because of its unconscious embodied nature. Further, as a result of a crossover between objective social structures and subjective processes, cultural capital is likely to develop as a result of assimilation of skills and practices over time (Luke, 1990).

Habitus for some is conceptualised in terms of how people use cultural capital and social field rules for success and to their advantage (others, of course, are reproduced into inequality through the lack of various capitals). This is seen in everyday activities of people as they attempt to move or negotiate through many simultaneous constraints and opportunities. Although the sociologist looks to see a whole process, combined with creativity, the habitus may also generate practice,

activity and strategy. It is important that we also understand that we too are actors in certain situations affected by the habitus and fields (Meisenhelder, 1997). Finally, the construction of the habitus may transform into a trajectory towards possible trajectories for other individuals as well (Robbins, 1991).

The sociology of scientific knowledge has often ignored how habitus is an important dimension in cultural predisposition and reproduction (Heaton, 1997). The area of interest here is how the habitus ties into the social field of medicine and in particular the professional development of junior doctors. Further work incorporating sociology of health and illness would be an important contribution to examining the logic of practice and the habitus as an acquired disposition (Williams, 1995). In a similar vein, as Bourdieu's (1979) analysis of the Berber house indicated, the house was part of a symbolic system and organised according to a set of homologous oppositions. The hospital can also be seen as a particular location of medical discourses, for instance, ward design in relation to principles concerning disease. Ethnographic data gathered from hospital wards suggests that there is unusual use of space and time by patients and staff members, such as locking patients away, control over their personal property and use of space (Van Dongen, 1997). Further, hospital staff members also display vague mystique in their work practices (Rhodes, 1991). Perhaps here as Prior (1988) argues, expression of discursive and ideological practices which are bound within the hospital, are likely to not have existence beyond the hospital. Through the habitus, certain practices (eg. building new hospitals), bodily actions (disease), cognition (discourses about medicine) emphasise certain preferred forms of social action and perpetuates agency (building hospitals for sick people).

By the term habitus, Bourdieu (1993) is describing something similar to a person's habit, but excludes repetition in terms of a habit. His emphasis is on a long lasting disposition, linked to a personal history which can be viewed as a product of social conditions and reproduction. Habitus transforms people to reproduce one's own social conditions. People cannot simply and mechanistically develop a habitus from knowledge of the social field. Rather, most importantly, the habitus is a system of schemes for generating and perceiving practice. This scheme focuses on the chance to intentionally copy a habitus, because it is an internalisation of speech, aesthetic choices, gestures, or any other possible practices. For Bourdieu, he looks at how the habitus is embodied within a person without being a simple mechanical response to external factors. Further, it is important to understand how agents inhabit the environment where there are limited options based on those outside field forces (Ostrow, 1990). Therefore, the habitus is a principle of invention, which is produced by social reproductive history, but is also able to be detached from this social history because of the durable dispositions (Bourdieu, 1993). The habitus is difficult to deduce from its conditions of production. That is, because certain dispositions are developed within the limits of the field, our options are not only based on our access to capital, but also our understanding of social activity and the dispositions learned in the social field at that time (Ostrow, 1990).

Habitus incorporates structures of class, semiotics of the body and is powerful enough for subjects to express these codes as social practices. Therefore, these social practices reproduce and create an environment of internalisation of values

where the habitus mediates and negotiates the actor's bodily habitus (hexis), experiences and social production of everyday life. The semiotics of the person, such as their clothing and deportment, distinguish them habitually as a class and as a certain type of person by those practices.

So at this point we try to corner habitual change and in the medical profession, just what are the processes of change and development of the habitus? Bourdieu suggests that the concept of a scientific method to examine these aspects is useful considering the focus on contingencies of agency and time. If habitus pre-empts professional identity, then at some point there must be activities that develop, spur or even foster particular symbols of professional power. It is my assumption then, that habitus is a critical term for understanding practice in a social field and particularly for understanding the practices of junior doctors in the medical and hospital field. This is because the term allows for and encompasses a description of how an affinity among social members in social practice can be adjusted individually and across social contexts. As part of the unity of the habitus and particular (cultural) capital, people surround themselves in items of value such as furniture, books, artefacts, art and particular practices such as sport and entertainment (Bourdieu, 1984). Bourdieu suggests that people bring with them into the field of social interactions, sets of social goods that have symbolic value that signify social class. Therefore, these symbolic goods enable interaction from behavioural and semiotic levels where markers of attitudes, social class and knowledges which are (or are not) of value in the social field are used and displayed (Luke, 1990). It is clear that "in Bourdieu's theory, symbolic aspects of social life are inseparably intertwined with the material conditions of existence" (Johnson, 1993, p. 4), the intersection between cultural and economic capitals. Perhaps the link between social relationships and the habitus surrounding interactions are embodied aspects as well as sociocultural ones (Burkitt, 1997).

In terms of examining junior doctors' professional development, this was traditionally viewed as the way people put together and embodied practice through socialisation. Bourdieu's concept of habitus is informative because cultural change occurs through the field and then in the habitus. The suggestion is that the positions doctors occupy in fields, with cultural capital, their current and future dispositions, mediate a specific habitus, and this perhaps explains how people adopt practices of or even habitus characteristics. Through the lived workplace, junior doctors 'pick up'certain social practices of the medical structure, culture and the habitus. It is my assumption, that residents through workplace practices begin to adopt particular habitual practices while being socialised into certain forms of desired medical practice and structures. The strategies that the habitus engages are "coherent and systematic, but they are also 'ad hoc' because they are triggered by the encounter with a particular field" (Chan, 1996, p. 115). The link here is between workplace practices of professional development, Bourdieu's concept of habitus and the professional development of junior doctors.

The conceptual leverage that Bourdieu provides through using the habitus, generates new tools for looking at how junior doctors, through their professional development experience professional passage and the transformation of dispositions. The development of certain skills, practices and knowledges that people embody can

be developed to become almost an unconscious method of the habitus. The habitus is highly effective in its use to increase the chance of success, reproduction and transformation towards a goal of cultural capital and social order. This takes us back to what Bourdieu was talking about earlier in terms of "the determinants of practices the impact of durable, generalised and transposable dispositions" (Bourdieu, 1993, p. 133). That is, the habitus is a source of objective practices, with a set of subjective principles, produced by patterns of social life.

With the focus on reproduction of values and behaviours within graduate medical training, this may also lead to identification of essential professional developmental processes and specifically data about experiencing and learning about the relevant habitus. The reproduction properties and dispositions by doctors are likely to relate to the field positions in the intern and junior position occupied in the first two years of medical practice. Therefore, professional development may be best theorised in terms of the development of a junior doctor habitus or 'medical cultural habitus'. It is thus, the medical habitus which is the theoretical focus of this research. Hence, using Bourdieu's theorising on sociocultural theory, namely the habitus. We are able to move beyond the traditional socialisation perspectives in medicine as represented in the junior doctor literature.

Bourdieu's concepts are illuminated here through the application to medicine, specifically the educative experiences of junior doctors in a large teaching hospital. Medicine is a highly structured (and hierarchical) professional field, and within the structure there are fields of struggle and structure that encourage practice in a specific way that alters and affects the habitus. Looking at society from a structuralist point, Bourdieu (1989a) sees that within the social world symbolic systems (language, myths, rules), structures (such as medicine) that are independent of the consciousness and will of agents, guide, inform and constrain people's practices. The concepts of capital and field are useful and relevant here for the application to social processes that occur as a result of the capital, engaging with the field and altering the practices and structure.

The Bourdieuian perception of the role of habitus within a field is also appropriate in terms of the teaching hospital experiences of junior doctors. Most notable in the theory of practice is the idea that varying cultural capitals are something that people bring with them into a field for negotiation. Therefore, medical culture has characteristics which through the use of Bourdieu's concepts will assist in the explanation of how doctors come to the field with cultural capital and the habitus changes or alters somewhat.

Medical dispositions are key here because even though this medical culture has what one might call 'Bourdieuian characteristics', the utility of Fox (1992; 1994b), whose ideas on medical discourse and practices, the analysis of the culture, can also be tied into the methods for data collection in this research. This points to a new analysis and tools from which to understand the junior doctor professional developmental changes. Further incorporation of Fox's methods in medical settings and analysis of cultural practice from Bourdieu's theorising will enable this research to explore the junior doctor medical habitus. Many aspects of junior doctor experiences may not be explained solely through a Bourdieuian theory of practice, but may be linked to much of the previous experience of practical early medical

experiences. That is, there are specific medical issues that are best understood from within that discourse, such as excessive working hours. There are many other interesting areas that Bourdieu discusses and are a part of his theory of practice. These include theories and notions about, structure, agency, symbolic violence and so forth. In reading his work these concepts and ideas are brought forward and although fascinating, the concepts of capital, field and the habitus provide more applicability to the work reported.

There is a struggle in medical culture, I have described how the individual habitus is an achievement of a collective process of inculcation (Calhoun, 1996), and as such, this may incline people to act and react in specific situations in a specific manner. Habitus is embodied and evidenced through deportment, cultural, social and cognitive maps. As Wacquant (1992, p. 16) describes it, habitus is constituted in the "form of mental and corporeal schemata of perception, appreciation and action". Through the habitus, learning and playing the cultural game is without calculation and as Bourdieu (1993) suggests, becomes an unconscious process. A set of dispositions, which generate practices and perceptions are the result of a long process of inculcation, becoming a second sense or a second nature (Johnson, 1993). Further, what Bourdieu (1977) describes is that the durable dispositions are apart of the habitus working to reproduce itself. Therefore, within the social field agents, the habitus and the structures within a field are directed by a trajectory (Bourdieu, 1993).

This second chapter began with a discussion of previous medical sociology work, professionalism and the development of beliefs and values in professional culture. Professional socialisation was argued that it does not represent what constitutes professional development. We then moved to a discussion of how Bourdieu would take an analysis of medical sociology further. We concenta ed on Bourdieu's concepts of capital, field, and the habitus. The concept of habitus is a useful perspective and analytical tool for which to view the relationship between capital, field, production and reproduction of the habitus of junior doctors. In the following pages, I extend these perspectives by applying them to junior doctors and postulate that the habitus is altering into a medical habitus within the field of the teaching hospital, an element of the broader medical culture.

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CHAPTER 3

PUTTING IT ALL TOGETHER: THE CULTURE OF JUNIOR DOCTORS

> I want to say 'I've got a position in society, I can actually do something'. So you spend 6 years thinking 'I want to be there', and when you finally get out, you think, 'oh I'm a somebody, I'm a somebody'. And you come to a place like this and you're the bottom rung of the ladder again, and you're still a nobody.
>
> Beginning of second year, male JHO.

This chapter looks at the range of unique and often contradictory characteristics of this cultural-professional group. We highlight and conceptually link to the formation of the 'medical habitus'. Narrative testimony from interview data concentrates on issues in junior doctor professional development, which provides evidence in support of the medical habitus concept. This chapter prepares us for the chapters incorporating theory of practice and the concept of medical habitus.

Essentially this is a theatrical medical stage that we can read through the themes from the interviews. Here we read the doctors' voices and their descriptions of the medical culture. Commonalities across transcripts were initially derived into five themes for discussion. I looked for issues that interview participants raised which highlighted common and key issues in the junior doctor medical culture. The five themes discussed here are what ultimately are important issues in the medical culture. I also include areas that doctors discussed frequently or mentioned as important and issues that are a part of their medical work. Finally, what I knew of from the fieldwork, as well as, knowledge of key descriptive themes that highlighted the junior doctor experiences and medical culture in general, were all deciding points to the organisation of these five major themes.

Table 5. Key themes from interviews.

1) Issues surrounding the training program
2) The 'doctor' mould
3) Medical hierarchy (consultants and registrars)
4) Medical culture including:
    - a) cynicism, ward rounds,
    - b) paperwork, stress,
    - c) critical incidents,
    - d) patients and
    - e) women in medicine
5) Junior doctors' reflections on their early training years

The descriptions of these themes can be lengthy, as is often the case with many qualitative transcript studies. Using the theoretical resources of Bourdieu or previous research in junior doctor professional education, each section of the doctors' voices from the interviews are presented. I begin by moving into the key issues that were brought forward through the interviews and I conclude with some description of the video scenes which complement those from the interview data.

The themes are dealt with in a particular sequence because they follow a logical order around the importance of the issues in medical culture, as well as their relationship to the theoretical analysis. The three major themes which are discussed firstly are done because by asking questions and through reading the interviews, 'issues surrounding the training program' and 'the doctor mould' it became apparent that these themes consume a large part of the junior doctor time and are linked to the third theme of 'medical hierarchy' (consultants and registrars). The fourth theme 'medical aspects' includes issues of equal importance that clarify the medical job and culture. Finally as this was a twelve month study, for the last theme it was appropriate to have the junior doctors' reflections on their early training years.

HOW TO PLAY THE GAME: POSTGRADUATE TRAINING PROGRAMS

Training program issues are a core activity of discussion and mental energy for all doctors and especially junior doctors. After six years of study, it is the very beginning of postgraduate training once the doctor starts work in a hospital. There is a real need and sense of urgency to specialise in medicine. This specialisation can be into the community as a general practitioner, or in other ways, for example, within the hospital as physicians or surgeons. However, many doctors also work privately in the community. It was no surprise then, that the topic of discussion during the interviews related to issues surrounding training programs, such as getting onto a training program and deciding which specialty to choose for postgraduate training.

For many doctors, getting onto a postgraduate medical or surgical training program is a fundamental career move that forms the years of experiences and training to become a specialist doctor. However, it is not a matter of looking at the information booklet from the college and filling out the application form. Here filling in the application form is an administrative act; in contrast, the conditions of medical practice surrounding getting onto a training program are far more cultural, complicated and intertwined. In many instances junior doctors have learned or gained the principles of getting onto a training program by the end of the internship with some deciding to play the game and some choosing not to, at least as yet. One feature of the medical culture that some of the junior doctors have learnt in respect of training programs is getting 'a feel for the game', as Bourdieu would put it.

Here we have a few transcript selections from the beginning of the training year for Dr D, a male intern. In a discussion about what he doesn't like about the medical culture. He highlights how he has found that he has learnt that compliance is a very important part of the early workplace experiences. At the beginning of his internship, he says "yeah, you have to comply. I really see that very clearly that you

have to be part of the mould to get into any training programs." This is linked to the issues of training program because Dr D is learning about the knowledge it requires to become a part of the doctor mould, which is seen as favourable to then get onto a training program. Dr D also discussed how being of the same cultural and ethnic background, and having something in common with senior doctors are all key factors that after 6 weeks of internship he is gaining awareness about. As guiding work principles, these in turn generate certain practices around getting onto a training program. Although race was not a focus here, it is an important part of habitus and this intern doctor's experience. A description of the influence of race on habitus can be found in McNamara Horvat and Lising Antonio (1999). These authors discuss habitus in the context of an elite, mostly white, private school and the six African American girl's experiences while attending an independent school.

In terms of race, Dr D begins to voice his concerns that he might not have the right social dispositions to allow him to be in certain social or work conditions because he is an 'Australian' Southeast Asian as opposed to being an 'overseas' Southeast Asian. He sees that it is harder to compete and be seen as an Australian than it is to be seen as from overseas and compete at these different cultural levels. Dr D voices concerns over different forms of cultural and racial difference.

> "yeah, I think there's a underlying concern that we're quite scared that if we were to stay here, we cannot get any training positions, especially in competitive fields. Because we do see that the people coming out of the other end of the tunnel, they're usually, although they're Asians, they're Australian born Asian, or probably they've been here for 3 or 4 generations. So we're really afraid that people who come here quite recently for about less than 10 years, 4, 5 years, that we may not be able to get any training positions."

Dr D is also engaging his own presentation of himself in a certain way with consultants. The feeling here is that because consultants are seen as very powerful, the aim is to express a desire to get onto a surgical training program by saying the right things, and engaging the right habitus in early interactions within the field. He suggests that he is

> "very formal with consultants, because consultants they're very powerful people. They have a big effect on you, and some of the consultants are in a position, they're very powerful in their college as well, so there are certain things that you say that might not be in their favour, and you might lose a training position because of that, it's not uncommon."

The preselection of training terms, whether they are the elective or compulsory terms seems to already be driven by potential need to please the medical hierarchy. Dr V, in the beginning of his second year demonstrates how the consultant is shown to be all-powerful in terms of having influence on careers. This situation is illustrated when asked why he would choose a specific term: "they might be good teachers such as Dr T which is why I wanted to work for him or umm or maybe someone who'll have influence on your career."

The social connections here, the status of those doctors Dr V works with will reflect back on him, the training program and his potential future career. Similarly, Dr B (a JHO) considered other aspects to choosing to working with certain consultants. Having knowledge on 'how to play the game' around issues of

selecting consultants to work for was important. Dr B knows that interns can be intimidated by it all, but the reality of working with someone for ten weeks, for Dr B is learning how to play the game properly to avoid any potential problems. Dr B states:

> "the fact you're going to be working with these guys for 10 weeks, so you do your best to play the game properly, and eh, I suppose when you're an intern, you're intimidated by them all, eh, you just do everything they say."

For Dr D, the other structures around are also acting as a system to help him understand how things are done. He has heard, he says, that there are certain paths to take which condition Dr D to behave in a certain way or at least understand what is required of his behaviour. He suggests that in Australia, the way he knows about the culture is reflected in the way he socialises and who he knows: "obviously you must have a certain performance standard, but the rest is really up to you, how well you socialise." Dr D highlights how his medical performance has to be of a minimal standard, yet there are other factors (such as socialising) that count for more. The procedures that Dr D has to take are a bit at odds with his current habitus because he does not see that he has all the required dispositions to get him in favour for a training program place. For Dr D, he is picking his benchmark of his likely success based on how many are coming out at the end of the tunnel: "all those people who are coming out at the other end of the tunnel, they are highly qualified but they are Australian born South East Asian."

I asked Dr D only six weeks into his internship about what sort of advice he would give to other interns coming in and would his advice be different to other doctors based on their ethnicity, he answered:

> "I really can't give any advice because I can't see it from perspective of white Australian. I reckon they get on with people very easily, they share the same jokes, they talk about the same things, they have very common friends, they know what is going on with each other. So, I really don't see what can be so difficult about them, I think for them it would be to work hard. Social wise, it's not a big thing. Yeah. I wouldn't say that a lot of them are very hardworking, but probably they don't need to put so much effort into certain things like we need to like reading up on cricket hooks."

Dr D is talking about the markers and characteristics that he sees will boost his chances of acquiring favourable dispositions. If he reads more books about cricket, then maybe things would be different. Here he is anticipating what the requirements are for the habitus. For Dr D he is also considering what sorts of interests he needs to build to align himself with their interests. He suggests that going along with others interests as well as understanding that "they like cricket a lot and they like a few sports like rugby, I reckon I should read up more on some of the matches, and have something common to say."

When asked to consider how he is going to be different at the end of the year, Dr D continues to anticipate the needs of a more general habitus. His practical theory is based on past experiences about what is going to give weight to what he sees is required to get onto the surgical training program. The anticipation is that Dr D is going to have become more 'Australian' and thus modify his existing habitus. He also suggests that "I just hope at the end of this year I can be more Australian wise at

least in the professional sense. So, I can really be well accepted into the surgical culture and I hope I can get a place in the future." For Dr D, the word surgical culture is key, because it indicates that he recognises the cultural aspects of the specialty. The skills are important, but not sufficient for appropriate integration considering the current cultural capital he holds. The access to particular goods, such as cultural/social goods, also 'positional goods' as certain amount of social capital, will be useful to position the doctor appropriately within certain social fields. By the end of the year Dr D's subjective aspirations have modified on the training program idea: "I think, initially I thought um, I thought I know how to play the game, but, getting towards the end of this year, I'm not too sure."

Senior doctors who are members of the specialty colleges seem to look for certain dispositions in junior doctors to eventually take on a training program position. Within the basic medical and surgical colleges there are again subspecialties and a declaration of interest is encouraged early. Dr D evaluated that 'likeable' and 'common topics' as shared cultural knowledge were conditions that also helped people get onto a specific training program. Likeable appears necessary because it is a part of the perception through which the training program conditions are deemed favourable. For him, he sees that there are many doctors who are "very bright but couldn't get into the training program because they are just not as likeable". He has learned that 'common topics' such as rugby, is where the junior doctor 'must know the scores', he suggests that he will get into those things when he starts studying for his exams to get ahead professionally.

Dr D continues to suggest that learning certain dispositions such as unconditionally obeying superiors is in accordance with guaranteeing the correct practices and entry into the right habitus for training program. Compliance here is seen as leading to perceptions of 'likeable'. Dr D feels that if he internalises what he views as an external need to know about things such as rugby and he fits that (obeying) mould, then it will generate the surgical dispositions and he will be 'seen' as surgeon material, suitable for a training program place. The mould for Dr D by the end of the year has to do with making himself agreeable, likeable by putting his interests in line and under the influence of his consultants. In his mind, Dr D is giving of himself selflessly, so as to enable the consultant to claim credit. This is also in anticipation that later on in his career he will benefit from the consultant acting as a mentor for him when he is trying to get a place on a training program.

Dr J also feels that blending in is important because she sees that there is a specific ladder to climb "that serves the use of me blending into the hospital". She also seems to have understood that there are already rules in terms of the way things are done around the hospital. For Dr J, blending in and observation are the best way to manage the unwritten hospital rules. Dr Q, within six weeks of his second year at the hospital, talks below about the 'correctness' of certain practices in terms of not being radical and relating it to getting on to a training program. He suggests that fitting the mould makes people think that

> "you arc more reliable, more trustworthy, maybe they think you are a better person for it, I don't know. Certainly on the training programs, you don't see people who would be considerably radical."

He sees that constancy in light of what the mould is, enables the external forces to shape the junior doctor into a reliable and trustworthy doctor. Total compliance is almost equal to perceptions of 'reliability' and 'trust' - an actor's job. By the end of the intern year, Dr D is a bit more reflective on his 'integration' into the system, and his attempts at gaining socially situated skills. However, he has not given up the practice of 'fighting' for his place in the training program situation. "I think I'm probably integrating, I'm not realising that I'm integrating, I think I'm still, I'm not facing too much problems at the moment, I think a lot of people are pretty open, ok, because I'm not really started really fighting for a training posting yet." He sees that he is doing the right practices in terms of doing the same training terms as others, and people are still (through the limits of the field) nice to him, because he has not started to fight the socially situated conditions of the training program production. Dr D above is also already gaining the more desired medical habitus relevant to this field. He has been compliant and with his cultural capital thus far, he is preparing himself to fight. This, paradoxically perhaps may make him less likeable, but he may find the behaviour of competition after 'learned subservience' is the next capital feather to stick in his medical habitus hat and become well and truly accepted for the coming training program stages.

For Dr E, by the end of the year, she has noticed many political issues, which makes her cynical, her strategy has been to avoid the issues. Dr N a consultant, acknowledges that there is a certain image that needs to be created to get onto a training program, and even mentions something 'non medical' such as rugby as opposed to knowledge of the nerve system. At the beginning of the year Dr D feels that the other important characteristics that a resident needs to know about focus around watching what you say and whom you say it to:

> "there is only one consultant in our unit who is, like he's really not nice, but there certain things you have to hide from him, you have to obey him and comply with him."

Dr J at the beginning of the year already feels that she is likely to be judged and has heard advice from a senior doctor to a medical student on how to get through and make her way onto a training program. She mentions 'this culture' in her answer, which is interesting for her to conceptualise that this is a specific culture to note how she does not fit into the culture. She tells us she overheard advice to a medical student: "how do I get on to a surgical program" and he said "go to such and such hospital and start sucking up as much as you can". That's not how I will ever do it. I am not going to suck up to any one. This all sucks, this culture. Excuse my words. I just – it is just not me to take any part in." Dr J got advice on how to survive on her first day at the hospital at the beginning of the year; she is learning about the rules to 'play the game'.

> "On my first day, on my orientation day, my reg told us about how to survive. So even though he keeps this conservative mould and he does all this sucking and that, he is very conscious of it. That's just the game he has decided to play. He said keep your mouth shut, keep your head down and do what you have to do and you will be fine. Yeah, that's the advice. I mean it is kind of good advice, I wouldn't give it to anyone."

She sees the information of keeping your mouth shut as good advice, but also conveys her sense of how it is contradictory. She can see how her registrar has

decided to play by those rules and she still feels conflicted by it. Early into her internship she does not feel much confidence to go against the advice at the moment because she is junior, so she incorporates it into her own stockpile of advice. For Dr V, other career advice that has been given includes 'private' advice for getting ahead in medicine from other doctors. Knowing what area to specialise in early seems to be common and important advice. Some junior doctors may have been hesitant in answering questions about training programs, but in contrast Dr V tells me he is not worried about answering my questions about training programs because he feels protected: "basically, once you are in [the training program], no one can touch you."

When I asked him about why would someone who had not been guaranteed a place in a training program, yet not answer these sorts of questions? He suggests that the potential for rumours or giving the wrong impression even once could preclude someone from getting a training position and the power of these consultants or senior doctors can 'crush someone's career'. The power that these consultants practice seems to place junior staff almost into 'fear mode' that anything they say or do can have implications for choosing terms, hospitals to work in, and ultimately getting a position on a training program. When I asked how did he learn that some consultants have this power, he told me that people have been assassinated, had their career ruined, could not get the job they wanted or have had to leave the hospital. The 'assassination theory' that doctors careers can be ruined by consultants in power, creates a high level of stress based awareness and concern about watching what you say, who you say it to (even a researcher) and what you do as a junior doctor. At the beginning of his second year, Dr V suggests again that the environment of 'like looking after like', he did not necessarily like that, but was not going to turn his back on the 'Mafia'.

Junior doctors are learning about how to playing the game through innuendo and hidden messages from their registrars. This is mainly in terms of how to get on to training programs, what sort of patients they should be seeing and that a high level of training program behaviour awareness is rewarded if the junior doctor picks up on these hidden messages quickly. Dr B is learning about how to get onto a training program, how to keep his consultants/ registrars happy and learning about workplace politics. He is seeking informal mentors by picking up the politics of certain situations and aligning himself with the 'in group'. The extra social capital that he gains will be useful for getting onto a training program, but he is still on the outside because 'you can't trust anyone'. Dr D is learning varying political issues about his role as an intern, most recently to keep his mouth shut: "I think for me as an intern, being lower in the ranks, I have to keep my mouth shut." His need to situate himself within the surgical crowd and be a part of that network is fundamental. He sees that the process of working in the hospital is like playing a game. He has heard how people win the game, that is getting onto a training program, and how the rules within the game have been played fair and unfairly. Here he talks about a colleague who played all his cards with many consultants and upset all those who supported him for many potential specialty training program places and then chose only one.

> "You see, people have played the game before, and you hear a lot of rumours about people who've played the game well by, every term they've done, they've gone to the consultants 'I want to be a physician', and then they go to Dr W and say 'I want to be a

> surgeon'. Yeah, and all those guys, and then so, I think there's a story of one guy, and he's known as the liar with a capital 'L'. All these guys just know him as 'the Liar' who said 'I want to he a surgeon, I always wanted to he a surgeon' and they went out of their way, got him good positions, good jobs, and then he turned around and did general practice and he really pissed them all off. Doesn't matter to him, he's got where he wants to go. He's got his job, he's happy, um, they all hate his guts. Well he got where he wanted to do, and he played the game very well."

This doctor that Dr B is talking about, is seen as a manipulator, but he won the game because he got onto the training program that he wanted. Presenting the best face in terms of those who you know, working well with consultants, and showing a certain amount of modesty, all seem to be important for getting onto a training program. By the end of the year Dr P, an intern, who knows what he wants to be, indicated very early to his seniors his area of interest before he even started his internship. He has also observed and is aware of the impression factor. Dr P suggests that if he was presenting to a registrar in the area of medicine that he wants to specialise in, he would be doing a much better job and be more concerned about the quality of his presentation of the patient.

For Dr B, he sees that this process of playing the game can be avoided if you 'declare yourself early. That is if you let the consultants know that you want to be a surgeon, the specific type of surgeon, and how you pursue that goal, then you are less likely to 'piss everybody off'. However declaring yourself early is part of playing the game (showing the right dispositions), because you are playing your cards and your intentions for the senior doctors, for others who do not declare themselves like 'the liar', they are still seen as playing the game, even though they are not showing their 'cards'. Dr V also 'made it easy' for himself by knowing what he wanted to do, knowing who he had to speak to and by showing that he was interested, got good assessments and he worked hard. Dr V has a registrar position next year.

As Dr B always wanted to do surgery, he did not feel that he needed to play all his cards across the board. Going for career advice also serves the cultural purpose of the consultants paying attention to what the junior doctor wants to do in either a surgical or medical context and how that relates to the current training term. If he was interested in paediatrics, for example and in a surgical term, consultants would likely not be as interested in teaching him extra or taking the time to ensure that he was learning about what he was doing in theatre. Much of the career advice that Dr B has received from his registrars and consultants started from when he was student and he quickly learned that qualifications were not always the key factor to get onto a training program.

> "Ok, a lot, it runs like this, um, getting on programs, it's much more important who you work tor than what your qualifications are. I've been frequently told, even as a student, as a third year student, when I work with a registrar, I said what can you tell me, and he said: 'be good and just know people, and not in that order'. Eh, you can have fantastic qualifications and all these flash postgraduate degrees, or, but if it's between that person and someone who's worked with a consultant they know, they'll always put the person on they've worked with and know."

According to Dr B it seems that this 'system' of surgery is based on significant trust and responsibility, as well as personal rapport with senior doctors. Passing that

onto junior doctors is a fundamental characteristic of not only working together, but key to getting onto training programs. By the end of the intern year, Dr J has found that she was not ready to get dragged into the training program process. She felt pressured by consultants and administration to declare what her specialty was likely to be, and as well heard that people were actually afraid to not declare themselves in what they wanted to do. She was even afraid 'to declare' that she may not even want to do medicine because of the implications that that will have for fostering any skills or any of her interests.

CATERING TO THE SENIOR DOCTORS

For medical specialties, all doctors sit for postgraduate exams, which gives them qualifications and a fellowship to a college which in other areas of academic study is likely to be equivalent to a Masters degree (however taking approximately five years full time!). There is a part one to the primary exam, which many doctors begin to study for at least one year, and then part two which can occur up to two or three years later. The importance of the first part exams is that it is it the gateway to working in a registrar position in a subspecialty unit. For instance, a doctor who sat and passed her primary exam (part one) can if a position is available, work as a respiratory registrar for a couple of years, as opposed to continuously being a junior or senior house officer, changing wards and fields of medicine every two to three months.

For Dr B he passed his part one, primary exam and playing the game did not stop there. The next stage was to get a good job as a registrar. Registrar jobs have prestige in terms of hospitals, subspecialties, and the consultants that the doctor works under. Dr B was about to indicate his future needs, that is, he is now hopeful for future training positions. Dr B was offered a registrar position, and when I asked him was this because he passed the first part of the exam, he commented: "a lot of the other guys encouraged me, and said "you should ring up and tell him you're hopeful". I asked what was he to say he was hopeful for?" Hopeful of getting a position next year!". So Dr B was harvesting his social network and cashing in his previous social capital by saying he was now 'hopeful'. Consultants are powerful in terms of helping doctors get good, more popular positions and units to work in, learning on the job, and most importantly getting onto a training program.

The process of working hard for your seniors is universal across many professions. In medicine, there is the appearance of working hard and actually working hard. There are activities that cater to the needs of the consultants and registrars that make their life easier, such as having all pathology results checked before a ward round, which also shows the seniors that as a junior doctor, one is organised. The other part of working hard is showing a keen interest in what you are doing or the area of medicine the doctor is working in for 10 weeks. It is through these working skills that many junior doctors learn how to appear interested and get credit in their senior's eyes about doing a good job. Doing a good job will be recognised later on by the senior doctors in the form of good reports and even

sponsorship for a training program. The power of the senior doctor is not underestimated by the junior staff.

At the beginning of the year Dr J knew that she had to cater to the consultants; she felt conflicted about it and now she is still concerned about the power that she sees there may be and thus rationalises the 'gate keeping' characteristics of consultants and training programs. Dr J tells us:

> "powerful people are the consultants. I cater to them by trying to do the right thing and not being noticed that much and working hard. I think that's wrong that there are, there's such a hierarchy in the hospital. I don't think we should have such powerful people, who can do, who can make really big choices about your career."

By the end of the year Dr J feels that she has lost some of her enthusiasm for changing the world on her own and feels that she might have become a little more conservative and has begun to toe the line.

Establishing a place in the surgical hierarchy is an important endeavour (Babu et al., 1998). Dr D at the beginning of the year knew that consultants were powerful, knew that he had to be nice and work hard. By the end of the year, he has not only worked out how he wants to play the game by bringing in muffins for morning tea, but he is working at who in particular within the consultant level hierarchy are powerful. When showed a list of statements asking if he was 'learning who the powerful people were and how to cater to them', he actually elaborated and told me how he is catering to the powerful people.

> "For the moment I think, I think for most of the units eh, it's very obvious who will be…the powerful people are. Obviously the consultants, all the senior registrars. So the more junior they are in terms of hierarchy, the less powerful they would be, is the general rule of thumb. And how to cater to them, I think essentially you just do all the things they wanted. That might entail getting a journal article, whatever, bringing in croissants, and bringing in tea for them…
>
> [I: Are you bringing in croissants for your consultants?]
>
> DR D: Not croissants um, what's that, um, muffins. I brought in muffins."

Dr B is going to be registrar soon. He is in a difficult term (due to the long hours, patients demands) which traditionally is perceived as a prestigious term where interns become known by 'important' consultants. However, this time it is different for Dr B because he already has passed his primary and has another more senior post already guaranteed. Yet he still feels that he has to be able to show that he can do a resident's job even though in three months time he is going to be a registrar. When asked if he thought he needed to impress the consultants and registrars. Dr B suggests that he is not doing any particular 'sucking' sort of activities. When asked why this 'sucking' happens Dr B suggests that it has to do with knowing your place and staying within one's 'authority' as a resident.

In terms of training program positions, from the interviews with interns, JHOs and consultants it is apparent that there is a clear set of relations constantly changing requiring of the habitus to be flexible and specifically contextualised. The institutional field interactions based around 'getting onto a training program' from the junior doctor perspective are constantly changing. Getting onto a training

program according to the habitus is gained by acquiring dispositions that are likely to be effective in registrars and consultants practices. Getting a training program position requires negotiation within particular fields. For junior doctors to achieve a place in their desired training program, they need to compete and fight for the position within the hospital, to defend the position and then be able to justify how they got the position.

This struggle is mediated by particular important and desired characteristics and medical practices for junior doctors to obtain training positions in medical culture. Understanding junior doctor practices in the field and the ways that one can get onto a training program is an intersection of two different developmental ways of practising as a junior doctor. For the junior doctors they bring to the field their current habitus and see the positions they want to occupy and the dispositions that are required. For the senior doctors they know that the junior doctors must learn and understand the strategies for the training program habitus because not only did they have to learn it, but also the system reproduces itself making change seems possible.

For the interns, learning to comply with the consultants and the needs of the registrars is all part of learning about their position in the medical and hospital hierarchy. These are powerful doctors in the junior doctor's eyes and the key to their postgraduate training in the future. This is learned very early on and may even be known from medical school. Beyond working late nights and doing a good job many of these junior doctors are also learning and internalising a particular mould that they have to adopt or appear to adopt in an attempt to 'align themselves with the interests of the superiors'.

The main interesting point from these voices about the medical training program informs us that interns have to learn to become master manipulators of their careers through knowledge of the non medical aspects that are required for their professional advancement. Social connections, blending into the culture, not standing out and complying with their seniors all create a sense that junior doctors are learning more about medicine than a focus on their clinical skills. Additional points discussed later will include how learning about fitting a certain professional identity affects professional and personal development as a junior doctor.

The issues around 'training program' encompass a lot of smaller issues about getting onto a training program. It highlights the different levels of working and organising career plans that junior doctors undergo within themselves and within their medical culture. This is substantial as reported here at a pure and conscious level of watching what it takes in work skill and social skill terms. The next section relates to some of the aspects that many doctors say are important to getting on a training program: 'the doctor mould'. For many doctors it is also about the medical culture and the survival of a particular way of talking, gestures or even posture that contributes to success in the medical culture.

The dispositions of the dealer, that is the junior doctor mould was the second major theme which focuses on how junior doctors begin to see that there is a particular doctor mould from their senior and fellow doctors. Medical habitus transforms and works with and against the rules of the game. The doctor mould is derived from junior doctors learning about fitting a certain type, including how to dress, be in the role and what a junior doctor represents. The first impressions that

junior doctors give off and receive about who they are begin the moment they walk into a ward. For Dr V, by the end of his second year he was convinced that in the first instance, the nursing staff generalise personality traits of interns, and similarly to the relationship with senior doctors, junior doctors have to prove themselves. When asked about a certain style of doctor's dress, Dr Q acknowledges that initially many other doctors start out quite individual, but then it soon wears off for many of the doctors because he says: "I think people try not to stand out." Dr P also finds that some medical people are not only set in their ways but image is equated with issues surrounding competence and being a 'bad intern'. He suggests that "you keep your hair long and you are a bad intern. You know? That's ridiculous!"

In many ways, medical dress is a theatrical costume. Learning about dress style does not just start in the workplace. For Dr D, he still recalls learning about dress sense and appropriate appearance from when he was a medical student. He was not given instructions to wear the white medical student coat: he did not know how to learn about dress. Generally in Australia, only medical students when beginning their clinical years in hospitals wear white coats. Occasionally doctors who studied and went through in more traditional times wear the white coat. I know of only one senior doctor at SUH that still wears the coat. Many doctors who do not wear the white coat recall the times when either as medical students or residents in other overseas hospital they wore them and how useful they were for the pockets, protecting clothes and so on.

After six weeks as an intern a pattern is emerging in the way doctors are dressing and Dr D is picking upon this:

> "yeah, you can see a certain pattern in the way guys dress, a certain colour, blue shirts or white shirts or dark blue pants or dull colour pants -so there's a certain colour."

I noticed that Dr D had worn a bright yellow shirt, which was easily noticeable in a sea of less vibrant colours. When I asked him how his shirt was received he replied:

> "Sometimes I don't really care. There are times it's all right. I don't particularly do that to satisfy people you see. I know there's a certain trend you try to fit in, so probably I try not to wear that too many times."

In addition, Dr J finds her ability to dress appropriately is mediated by time and she finds there is limited time for self-expression. These two junior doctors, Dr J a female intern and Dr D a male intern in the first six weeks of their working paid careers, are sensing and becoming aware of the restrictions on their self expression through their dress and knowledge about the unofficial uniform. This is significant because although Dr D does not always have the time to iron other shirts, he may not be choosing to wear the bright yellow shirt often because he sees that not many others are wearing similar clothes. Dr D does not feel that he should stand out or that he is in a position where he can wear clothes without them influencing what others think of him. For Dr J, she considers that tiredness influences what people are able to gather to wear, but she acknowledges that there is a conservative style to the clothes which reflects the profession as a whole. For Dr J she has learnt that

who she wants to be or who she is at a personal level is restricted by the culture through dress and she cannot be who she wants to be in her dress sense.

Dr S a senior consultant, when asked if there is conservatism in dress or attitude sense, not only let out a big smile and paused when asked the question, but suggests that the mould should reflect what the public expects. He suggests:

> "I think it is the way it should be, in a sense, particularly you know, in a large institution, I don't think you can have, you can allow too much freedom for personal expression in a place where you are dealing with public who have their own sort of perception of what to expect."

Dr S is a consultant and the 'type' of doctor that many of the junior doctors say mediates how they dress. Consultants and registrars bring about these unwritten rules of standards of dress which are reinforced through this medical cultural rule. He sees the rationalisation for a standard professional look mediated by what the public expects. From the interviews, many junior doctors were saying that consultants expect a certain standard of dress to not reflect anything too individualistic. In contrast, the consultants are saying it is from the public and the patients (the people lying sick in bed). For Dr S, he is aware of a slight contradiction in what he is saying, but is also trapped by the expectations of image that a large institution has what the public perceives of what to expect from the doctors. This then filters throughout the institution down to the interns who are not going to wear the bright yellow shirt because the patient in bed 45J is vomiting and expects a certain standard of dress at her bedside!

A common perception of individuality is always the opposite to conservative dress sense and it always seems to involve nose rings. For Dr S, he sees that the way a doctor is dressed relates to the public's perception of trustworthiness:

> "they come and they want to see people who they think arc reliable and they don't want to see people who have got purple hair and nose rings and breasts falling out of dresses or see through gear on and all that sort of stuff. They would be inappropriate distractions, so I think a certain code of dress and behaviour is appropriate. I mean I think when you are on your own in practice, you can then, you can do whatever you like in a sense and people know you, if you are a GP in a town and so forth, your reputation will be known and in the sense, what you do and how you dress, may not he terribly important hut in a large institution like this. I think there has got to he a certain codes that medical staff, both junior and senior, comply to or with."

The code that Dr S talks about above relates to what the public wants to see. For Dr B, he is just beginning to see how fellow doctors influence his style. When asked how he finds himself changing as far as fitting a mould, he suggests almost laughing that he sees himself changing in many ways unconsciously and consciously. He talks about how he sees himself picking up his registrar's inflexions in the voice; he can see how his registrar's picked up the consultant's habits too and how even other doctors around the hospital are similar. Dr B notices that he is changing:

> "just the way I talk, little personality quirks, just the inflexions of the voice. I'm walking down the corridor, I just happened to be wearing the same shirt and the same trousers that same day. You remember Dr Aa, and Dr Bb...and Dr Aa and Bb were just walking down the corridor, with the bluish shirts, moleskins, the boots, and they've both got that same sort of look, that same walk, oh so funny! It's true, you become like your registrar."

This is a good example above of embodiment in relation to habitus. Dr B is surprisingly reflective about his dress and how it comes across as an example of embodiment of the medical culture and is influenced by the senior doctor structures. In this situation, Dr B finds that his dress and even the style of his registrar has been almost conditioned through the place of work, the behaviours, attitudes and medical practices (such as wearing specific clothes). The habitual embodiment of dress here is based on the relationships that junior doctors form with their teachers. Further, it seems to manifest in these situations as part of the hierarchy and through medically defined situations. We can see that particular dispositions (here dress style) are embodied and can be reproduced through the culture. Often it is an internal conflict for doctors when they find themselves becoming traditional. Within the medical culture the issue of becoming or being conservative is interpreted in terms of management of a patient's illness or being old-fashioned in attitudes. The impression that conservatism relates to being traditionalist in terms of medical management as well as dress is of interest. Dr H suggests that it is important to be conservative in medicine as opposed to unconventional treatments.

After twenty-two months of hospital medicine Dr V feels that people become conservative in their dress and attitudes which is almost expected: "Even the most radical people who are students tend to get more conservative. It just happens, that's what expected. When you get to hospital, you are expected to be different and you sort of just assume that mould". Dr V assumes that there are complete opposites of 'the mould' - demonstrated by studs in the nose. The expectation that once junior doctors are in the hospital they are likely to lose their identity and that this actually helps to gain respect which ties in with looking the part to get onto a training program. When I asked Dr V, why the junior doctors assume this mould, he advises us that 'it's what expected'. When Dr V was asked: 'does assuming this mould help the junior doctors at all?' he said: "I think people would look down on them if they didn't fit the mould, dress respectfully, by how respectful they might be." When asked about whether he thought medicine was conservative, by the end of the year Dr B, still hates ties, but sees that they are linked to what the older community expects of their doctor. Dr B notes that conservatism in medicine is linked with possibly right-wing liberal political viewpoints.

For other doctors the dress style such as wearing ties is a barrier for patients and suggests that for many doctors they 'need' the tie for the patent's sake. Dr N, a consultant and is a senior doctor now (one of the powerful people in terms of training programs), she can still see how dress is a site for positioning, but: "you are dealing with somebody who's vomiting? Why do you need a tie for? It's not only bad, I think it instantly sets up a barrier." Dr B believes that the attitude about having to wear ties is seen to be driven by 'older' patient attitudes one that he has to oblige regardless of his annoyance. As Dr N is also aware of the impracticality of men having to wear ties, her concern is that it creates barriers between the patient and the practitioner. For another male junior doctor he is learning from his registrar that people used to wear suits to the dinner table and that ties are more than a fashion item, they have medical meaning. Dr B points out that 'they' like to see the junior doctor wearing it for the patients. Which is essentially the doctor wearing the tie for another doctor, under the auspices of wearing them for the patient.

The practicalities of medicine such as relating to patients are important here. It is not the 'trappings' of medicine and positioning as a doctor expert, but the creation of dress standards or here, in relation to how well English is spoken or how the doctor is representing her or himself. The dress and language create a barrier for Dr N in taking take care of her patients and she does not like the doctors who stand behind falsehoods surrounding ties and the realities of vomit on vests. In contrast, Dr H also a consultant, sees the standard of dress as important. Not in Dr N's area of medical specialty, he may be less likely to be vomited upon by a patient. He stands by the need for doctors to follow the community standard: "I think that my feeling about this is that if you are charged with imparting very sensitive information or difficult to deal with information, then patients are more likely to accept that information if you dress in a conservative fashion rather in a very unusual fashion."

Signifying the sense of dress, Dr H argues this is for the patient's sake and that doctor dress style is going to influence the patient's ability and likelihood of accepting 'very sensitive' medical information. The judgements that dress and style are fundamental for Dr H's patients to accept what he is saying in a dark suit as opposed to his thongs. Learning about dress, appropriate reactions is often learned from other junior and senior doctors. Dress is indicative of many things and when Dr J was asked how she is learning what the important characteristics of being a doctor are, she says:

> "by reactions from other doctors, by observing other doctors in higher positions. I have learnt from looking at other residents and things, things like how they dress and how they act…you've been here for 25 hours but that's ok, you know?"

By the end of the year Dr J, has found that she has begun to put more effort into her dress and act more keen. She felt that her registrars were not telling her directly but she got the message that certain things such as her style and appearance of personal motivation needed to be changed at least on the outside. This is in a manner somewhat akin to Hochschild's (1983) concept of 'emotional labour' where outward appearance can often mask 'real' inner feelings. In January, Dr D was aware that medicine was conservative in terms of belief systems and effected the way doctors' dress, talk, socialise and the vocabulary they use. At the beginning of the year he talked about the need to work hard to get ahead, by the end of the year he learned a lot more:

> "it's just presentation, the way you talk, the gestures, the posture, things, how you come across is pretty important as well and the other thing probably the way you are dressed, I guess. That's pretty important, you need to fit in the general image of the team."

The 'general image of the team', is a key to success for Dr D, he was referring to his clothes colour coordination which was a white shirt and tan pants, the gestures and postures are also important. Being a team player and having an understanding of your superiors who are likely to support the doctor's training program recommendations are even echoed in the advice literature to junior doctors. When I asked Dr V what the important doctor mould like qualities were, he said the problem is that no one knew. For other doctors, how interns learn the important characteristics of being a good doctor is essentially a hidden curriculum. By the end

of the year Dr P found that the interaction with other doctors was important for picking up and developing certain characteristics. Dr P suggests that

> "it's all hidden curriculum, informal learning, I mean, it's not as if you're going to get a lecture on good characteristics. I think it just comes from interacting and working with the people you respect, and picking up some of their qualities, I think that's where you develop your characteristics from."

Junior doctors see themselves as the same person over time, but development of characteristics of being a 'good' junior doctor are important. Characteristics that are fundamental from registrars' perspectives involve clinical excellence, and being respectful to family and not be a ridiculous person of work. The senior doctors depend on their junior doctor as part of the team a great deal. Like anyone managing a team at different levels, relationships and good team work are essential. For a junior doctor, learning what a good doctor is, and what your registrar likes, are both very important. Dr L (a consultant) sees that the important characteristics of being a good resident involve making sure everything runs smoothly. For a second year doctor many of the valued 'doctor' characteristics are coming from different people and are combined and observed to see what works in the workplace and with patients. Learning how to be an intern and/or junior doctor is also more than just observing your colleagues. Dr D found it difficult in the beginning of the year to say explicitly he found that tasks (eg., doing paperwork) did not match with what he thought was the way he was suppose to learn about being a doctor: "all I learn now is really what forms to fill in, what phone numbers to key in at the moment". Dr D is also finds the first few weeks of being a doctor as a role adjustment. He is finding that his voice, the speed at which he speaks, and being close up to people are all issues that are new to him in his role as a doctor.

After six weeks of working in SUH, Dr E has learnt about the important characteristics of being a doctor which include the capacity to watch and learn other senior doctors and also practising respect for patients. However, she has also developed a different perspective on how to learn the important characteristics of being a doctor by being more independent. Dr I, an intern, felt that by the end of the year her preparation for being a doctor from internship focussed on some key characteristics of being a doctor. However a key incident of learning about a male nurse's sexuality in her ward really showed her how being an intern has changed her attitude to what the important skills are. She says:

> "you become flexible in that you sort of accept them for who they are. We have got a couple of gay nurses up on our ward and at first, it's sort of (shows surprised look), and they are lovely fellows, but at first it took me a lot by surprise."

Dr I also in learning the important characteristics of being a doctor felt that she developed over the year just through experience. She reflects on a discussion with the nurse:

> "he was feeling a bit sick and he said "ok, you can do the examination". I said to him 'oh but I am married' and he said 'don't worry, I am gay'. And at first it took me by surprise. I just didn't know what to say. But that, I don't agree with what they do, but they are lovely guys. I like them, I don't like what they do and I think that is important lesson to learn in your intern year because in medicine, you meet lots of people. You

> can't regulate who they are, what they do, what they believe in. You have to you know, you have got to identify with the person himself and put yourself aside."

In medicine often doctors encounter patients they may not otherwise meet in their own social circles. Dr I as new intern, married, heterosexual woman was surprised in her interaction with the nurse, but realised and managed as part of her professional role as a doctor to perform her job duties and carry out the professional working relationship with the nurse. Many doctors in their early working life begin to confront their belief systems and learn to balance their own beliefs with the duties of a medical practitioner. She was one of these. However some doctors do not 'grow' and accept others unconditionally and there can be discrimination in senior ranks which may affect postgraduate training opportunities for homosexual doctors.

The medical culture is also teaching Dr I that there were indeed differences between medicine and surgery. Her understanding of the differences was mediated by the coping strategies that are required for different areas of medicine and how she brings her own style to the situation. By the end of the first year internship some interns were suggesting that a lot of the learning as an intern is about 'fitting the mould'. Dr E feels that there shouldn't be a stereotype in for example orthopaedics and that the areas of medicine that she is interested in, it is unlikely she is going to have to fit into a stereotype because they are becoming more progressive in terms of gender issues. At the beginning of the year, Dr Q suggests among other aspects of doing the job, learning to 'develop thick skin' is part of the important social characteristics of being a resident.

For others, by the end of the year they do not necessarily notice that they are part of the mould, nor does it worry them. Early in the year Dr D was talking about his accent and how he was working on his English and also thinking about learning more cricket and trying to become more 'Australianised'. By the end of the year, he says that he still considers that there is a 'true blue Australian' surgical mould and that his communication occasionally is hindered, but that is not held against him. By the end of her ten months of internship Dr I, sees that a lot of the learning of an intern is about fitting a task mould that was there before her. She sees that she is performing the same duties as interns have always done. Therefore, she sees that she is fulfilling the role of the intern. By the end of the year for intern Dr J, the important valued resident characteristics that she has learnt include being 'super keen', which translates into getting good intern reports. She has also found that in the process of learning it is easier to just fit the mould. Dr J is uncertain whether she is just given up, but has certainly noticed that working at SUH has required her to 'act the part'. She says:

> "I'm very happy to have this kind of conservative persona, not very happy, but it's just easier."

Learning to treat patients well and not becoming egotistical are characteristics that junior doctors pick up from their seniors. Over the course of ten months, Dr E has seen aspects of other doctors that have made her consider the kind of doctor that she would like to become. Dr E has developed an understanding that some doctors are nice to each other just because they're going to get you somewhere. Other doctors, while learning about important or desirable characteristics that are

important in the first two years of medical practice, also consider what aspects they have seen in other doctors. These aspects have made junior doctors consider the doctor they would like to become or not become:

> "then one doctor comes along who's a consultant, and he just talks to the patients and talks about his own experiences and you just think 'oh god, it's a 3 dimensional person' and they just haven't lost who they are., and that really, I really admire that".

Learning to change and accepting responsibility is a fundamental transition from medical student to internship. For Dr I, part of accepting the important roles of a doctor is to accept the medical responsibility:

> "you have to change and you just have to take responsibility. You just have to, you know, you just have to get used to the workplace otherwise you just crumble."

The transition from medical student to intern doctor is a huge role change. For many they are never fully prepared for the change in role. After six weeks of internship Dr I is learning that she is now responsible for patients. Nurses are going to her asking her for approval in treating patients; this responsibility was quite confronting for her. Along with the new experiences of responsibility and learning the clinical skills, junior doctors also want to learn how to retain their individuality while fitting into the medical role. High on the list of important characteristics for a doctor to develop is specific patient management techniques. By the end of the year, Dr J has decided that she will still be who she is in her private life, but how at work she will no longer make such effort to assert her individuality. At the end of the second year, Dr V considers that some doctors may go into certain areas of medicine because their characteristics are agreeable. Dr V states:

> "whether or not things change you, or whether or not you go into a particular area because of the person you are, I mean, the neurosurgeons are arrogant, the orthopods are more arrogant, yeah, there are different sort of areas but, I don't know if they learn or that's the way they are when they go in?"

Many doctors talk about the encompassing nature of medicine, and socialising outside of medicine in the first twelve months can be difficult. By the end of the year when asked about whether socialising with people outside of medicine balances, Dr J suggests that it is important to socialise outside of medicine. The comforting nature to talking to people within medicine about what she has gone through, a commonality almost is equally important. She tells us: "I've basically had nearly all my contacts with non-medical people. It balances me, but I really miss my medical friends, Just understanding. I mean you spend so many hours a week doing this, you need someone to talk about it." The experiences and the initial role change from being a medical student to intern doctor can be quite confronting. Many doctors are unlikely to experience this learning curve again or being at such an entry-level position in their career again. Dr I does not want to ever forget the internship feeling:

> "you just happen to be at the bottom of the pile and I think I don't ever want to lose, knowing that how I felt in my first year, I don't ever want to. Nervous, apprehensive, learning things in the new, for the first time, that kind of thing. Learning how to be an intern, I don't ever want to forget that."

At the beginning of the year, Dr I, a female intern, was suggesting that advice such as having a supportive partner or family and explaining to them what the job required was very important. By the end of the year, the advice she passes on reflects the personal and workplace challenges that she faced earlier on: home help, eating out and looking after yourself. In addition to Dr I not wanting to forget the intern feeling and her role and position in the hierarchy, when asked about advice for the next year of interns who will start in just over two months, she paused for moment. Perhaps she never really considered at this point that there was going to be another class starting the whole process all over again. By the end of the year generally most doctors say that they feel more confident in their medical skills and within themselves. By the end of Dr P's internship the time it has taken to learn about the organisation and working with other people all contributed significantly to him feeling different as a junior doctor. Not all doctors develop positively and relish the change that being a junior doctor brings in them. Dr D originally wanted to be a surgeon. His experiences and change in role over the year has led him to reconsider and question whether he even wants to be a doctor.

Many junior doctors at some point (and even senior doctors) question their role in medicine. The pressure and daily grind of sickness takes its toll on young eager professionals. For Dr D by the end of his eleven months of internship dealing with very sick patients day in and day out taught him that: "general medical arena was the dumping ground of all the terrible patients people that other specialties don't want. And [I was] just rethinking whether should I be doing surgery or should I even be doing medicine." Feeling different by the end of the year was related to constant negative experiences with very sick patients and in general medicine wards, his loss of ideals and becoming more aware of his own limitations which made him reconsider whether he really wants to be in medicine. When I asked 'did he feel different now than when he started as an intern eleven months ago', Dr D emphasised: "beginning of the year I was full of ideals, that you can make everything happen but I think as time goes by, I think I am more aware of my limitations."

For many junior doctors they work with supportive junior and senior colleagues. As a junior doctor, however, some work with a constant fear of being written about in a 'little black book'. As their role changes over the year and they become more independent this fear can make the culture of medicine more difficult to work in. Some factors such as seeing other senior doctors balancing their home life, working under pressure and generally remaining a nice person, help negate the fear and increases work satisfaction. When asked what has made him the person he is today in relation to his internship so far, Dr D's emphasis was on being more conservative and that he felt comfortable playing it safe. Dr E as well has found that, by the end of her internship she had developed an attitude towards conservative medical management. Other issues that have been brought forward for Dr J at the beginning of the year concerned conservative ideas about race. She also brings us back to the point about responding in a certain accepted way. This is in terms of appearing to respond to racist statements in a certain way because her superiors are likely to be judging her for a future training program place:

> "you feel you have to nod politely or you say something a hit non-committal because one day they may he judging you or they are judging you as you speak so you can't, you really feel that you can't have a voice or that you are invisible."

At the beginning of her internship, Dr J knew already that there were characteristics that were important such as not revealing too much about herself. She tells us: "it is important to be able to keep your mouth shut and not reveal too much about yourself." At the beginning of his second year when asked what he dislikes about the medical culture, Dr B suggested that he dislikes the "conservative, very introverted" gossip nature of the hospital. For others, the different medical subcultures in medicine are well known, informally taught and even acknowledged by the end of internship. Dr V tells us:

> "you can get cultures, subcultures like orthopaedic subculture or the neurosurgical subculture or medical registrars have their little culture and the emergency is a culture on its own."

He suggests for instance, that surgery is only going to be taught a certain way if a junior doctor is showing the surgical habitus or intentions towards the surgical habitus. If doctors, turn up with a 'medical' (as in the specialty of medicine as opposed to surgery) habitus they are not going to be let into the 'surgical' habitus and only shown the practices relevant to the pre-surgical field habitus. When asked at the end of his second year, if Dr B had learnt anything political about his role as a JHO that he did not have a grasp of it at the beginning of the year, he understood that opinions were made on other things besides his medical care. He says, "they start to develop opinions of you not necessarily by your job description, but by what you're like as a person, and whether you're efficient and get things done."

The junior doctor 'mould' is linked to issues about training programs and the struggle to get a postgraduate college place by working within the medical cultural rules. By reading how ways of dressing and how expressions of individuality are restricted, this gives insight to further demands to learning about being a junior doctor. For many of the interns after a few weeks on the job they were being confronted in their own minds as to a standard of dress and expression of individuality that was different to what they knew from being a medical student. As professionals now, interns began to see a wider network of reasons to be 'professional'. These reasons stem from the seniors, are linked to the needs of the patients and culturally related to respect. Being and fitting a certain mould is not only what a junior doctor is but also what professional doctors are. Beyond the sense of dress several of the junior doctors began to discuss conservatism in other areas of life such as politics. For the junior doctors this was all a part of learning to adopt a sense of work personality - a way of being - a habitus.

The 'hidden curriculum' as Dr P suggests comes from working with others and begins to form the picture of the medical culture. Beyond the clinical requirements of the job, interns and JHOs are learning about characteristics to fit in with the team. For Dr E she is trying to include clinical skills of respecting patients and clear communication with them, as well as work on her own skills of not just being nice to her seniors 'because they are going to get you somewhere'. Medical culture has different levels of functioning for the junior doctors at a basic operational level of

day to day they have to learn about dress, voice, communication with patients and senior doctors as well as learn about 'the mould' and responsibilities of being a junior medical team member.

All the while, at twenty-two years of age, these doctors are treating patients and balancing their own culture shock with mature life decisions to specialise and get a future in medicine. For some junior doctors, such as Dr D, he questions whether he is suitable to become a doctor, not for any clinical reason, but for the requirements of the role and the political activities of the medical culture. This cynicism is reflected in a later theme. As indicated in this theme of the 'mould', many of the junior doctors realise that they 'better just play it safe'. Next we look at hierarchy. This is distinct because it focuses specifically on how junior doctors are learning about their role and the frustration of being a training professional. However, they feel that they are not getting anywhere because of the strength of the medical cultural rules and in particular its hierarchy.

ULTIMATE RESPONSIBILITY: MEDICAL HIERARCHY

Hierarchy was a concept that came through quite clearly in the research even before I asked my first question. In the context of medical residency training, junior doctors desire different future positions, which they can attain after years working in the hospital system. Many junior doctors wish to be at a level where they are not doing an extensive amount of clerk-like paperwork and endeavour to attain appropriate dispositions that are required for the areas in which they work. When interviewing senior doctors, I used my understanding that the senior doctors had already been through their junior doctor years and were in another time zone almost. Their reflections on the five to thirty years previous were marked by differing responsibilities to date. For the senior doctors that I interviewed, when they discussed hierarchy it was tainted with the fact that they are indeed higher in the hierarchy now and not in vulnerable junior positions.

When I asked Dr L, a consultant, whether having hierarchy was useful or worthwhile he suggested 'yes'. In his answer, Dr L illustrates the strict delineation of duties along with responsibilities, in terms of the medical team being clear about their responsibilities. Dr L discussed how the registrar's teaching position is an important one in terms of medical students, residents (junior/senior house officers) and also as recipients of teaching from consultants. Registrars are enrolled in a college's training program for several years. During that time educational requirements need to be met which include medical experience, and application of key knowledge and skills to practice independently at a consultant level. In this context, Dr L is referring to the registrar as an 'interplay' because of the teaching that registrars receive in a training hospital, as well as their role teaching junior medical staff.

The perception of the importance of dress came from my initial observations where on many of my days at the hospital I noticed an informal uniform in medical staff. Although hierarchy and dress style may not be a common linkage, it seems that in this hospital it is. As the year progressed I saw dress standards change as

junior doctors were able to buy new clothes, and also as they figured out that their clothes might get dirty with vomit, blood and so on. Also the ease of ironing came into many of the choice of fabrics and the comfort factor as well. By the end of the year no female intern was wearing high heeled shoes! When I asked a registrar Dr L about dress, he talked about it for the patient and how as doctors they are likely to be seen by society. Dr L wants patients to know who the 'important' member of the team is by their dress style (no shorts and ties). For the record, I never saw a doctor, in a non-air-conditioned hospital, even in 35°c temperatures wear shorts. In contrast to the earlier discussion on dress, this is different because it marks hierarchy within the medical team and the medical culture. Previously the discussion on dress was in relation to junior doctors learning that dress was an important part of the medical culture and how they had to adopt their ways of expression. Above, Dr L sees dress as part of the hierarchical marker of who they are professionally. Physiotherapists wear shorts, but also have stethoscopes around their necks, nurses wear uniforms, marked by bars on their shoulders to indicate what level they are. The marked differences between a consultant, registrar and junior doctors are not that obvious.

At the beginning of the year prior to the junior doctors making money, there are older clothes and a few interchangeable shirts, pants, skirts and so on. As the money comes in, junior doctors are quick to update their wardrobes and after for many, six years of medical school poverty, they are quick to look to their seniors for professional dress styles and incorporate those in their style. It is a part of becoming accepted as a professional physically, but it still marks out a certain hierarchy. Dr Q, a JHO, suggests that dress plays an important role in how a patient perceives the doctor in terms of trust. Dr Q also finds the medical hierarchy 'frustrating', but will not challenge the system because he sees that it will work for him. He sees the hierarchy as important for his training and support. He does not want to be without it at this point because of the effect it would have on his practice and learning. Dr Q is seeing hierarchy as directly related to his 'apprenticeship' as a doctor.

In terms of hierarchy, the advice that Dr P has received himself and sees as important to pass on to other interns, is about valuing the hierarchy and the way that one can learn from seniors. Dr I also recognises the hierarchy is very important at this particular moment because she sees that senior doctors must have their 'reasons' for doing what they do: "I recognise that I don't know as much as they do and they have got their reasons". Although she may have come across less desirable personalities in senior doctors, Dr I is very respectful of the medical experience the consultants have had. Only if she knows about something that they do not, is she likely to approach them. She respects her consultants and respects the fact that 'they've put in their time'.

The distinctions between intern, registrar and consultant are quite graduated and it seems to be a very strict hierarchy. When I asked a consultant if he noticed this strict hierarchy in the hospital, he suggests that residents learn about this very early on. The consultant, Dr H is not very comfortable with the hierarchy but found that if he tried to change it the junior doctors were resistant. For instance when he "asked them perhaps a number of times to call me by my Christian name -they prefer to call me by my professional title." Professional precedent in terms of name calling here seems to be perpetuated by factors that arm the junior medical staff and they are the

ones in favour of reproducing it. The issue of referring to consultants by their title of doctor or professor as opposed to by their first name is again seen as hesitation on the part of the junior doctors by another senior consultant. When Dr S was asked why a resident does not call him by his first name he smiled because: “no, it’s not me, It’s more them”. Perhaps the hierarchy between consultant and residents perpetuates this insecurity about calling other doctors by their first name. Dr S suggests that it is just a matter of working against that naïveté of starting in a position. Once the junior doctors are more confident and have learned more about the system, perhaps then they begin to address others on a more peer level as opposed to hierarchical level.

It is very important for doctors to learn the knowledge which teaches them to value medical hierarchy. At the beginning of his second year, Dr Q suggests that what he dislikes about the medical culture are the inter-departmental hassles and how doctors are in their niches, like to stay there and protect their territory. When asked why he would not specialise as a physician in medicine, he focuses his answer on how he has learned to remain motivated in being a doctor. His decision process has been mediated by being treated like the ‘bottom of the rung’ and he states that interns ‘do the product’ (which is patient care). When asked whether at the intern level he felt that one reason he would not do medicine would be because he is at the bottom of the rung? Dr V said:

> “its all very exciting becoming a doctor, until you start realising that there’s a lot of crap involved.”

At the beginning of the year Dr B suggests that hierarchy is actually useful and the conservatism may not be too bad because it provides ‘some sort of structure’. However, hierarchy also tends to create difficulties for junior doctors who have to go through a certain set of procedures to get things done. Dr N recognises that occasionally junior doctors do not want to overstep the junior doctor role boundary because of the hierarchy, fear of the hierarchy or difficulties working within the hierarchical system. The suggestion is that junior doctors do not want to ‘step out’ of the roles and responsibilities within the hierarchical system. For others, hierarchy, although important, can make them feel annoyed if they are not treated fairly because of the hierarchy. Dr P tells us: “the interesting thing is that even though I sort of believe in hierarchy, I still get frustrated if anyone higher up treats you as a lesser just because you are not at their level in the hierarchy”. By the end of the year Dr P was beginning to experience more hierarchical issues ranging from taking phone calls and passing messages. However he still feels that hierarchy works, and contributes to teams working like ‘clock work’. The consultant who is the person with most experience, is teaching the registrar to ‘learn the trade’ and the junior doctor is actually ‘running the trade’.

This hierarchy works well for Dr P because he knows his place and is happy with the arrangement. Dr P is also older than most interns and often the same age as registrars, when I asked him if his registrar knew this he said:

> “I say to her when something comes up that I was older than her but she says it is not in medical terms!”

Above Dr P's registrar is pointing out that in medical terms she is older, older with experience in the system and knows what is going on. Dr N, a consultant, also learned when she began as a senior doctor in this hospital that there were hierarchies between different specialties and with levels of doctors across specialties. She tells us: "when I first came here, I actually have pieces of paper in writing from the head of the department telling me that the registrar had authority over me, that medical registrars were higher up the tree in this hospital than myself as an emergency consultant. Totally understandable in the context of the system, emergency medicine was a new specialty. Not only a hierarchy of residents, registrars, consultants, there's a hierarchy of specialty." Knowing where Dr D stands and his place is an important part of learning about his role within the medical hierarchy. He understands that he is junior in the medical ladder and in terms of his medical knowledge: "you must know where you stand and there's a hierarchy. I learnt that even as a student that there are certain things you should not say."

The experience that junior doctors learn about begins in many ways with learning how to act within the medical hierarchy. In medicine, sometimes junior doctors get confused with the 'ownership' of the patient in relation to medical hierarchy of consultants and specialties. Many doctors consider that they have a common goal to help the patient. However, junior doctors learn that there are often political battles over medical issues such as a medical disease process in a surgical patient in a surgical ward, and how to treat and manage specific disease processes in the patient. For Dr J at the beginning of her internship she had already learned that she had to get 'nasty' to get any respect. Then, she was working out ways to play the game, in light of what she'd seen other doctors do. At the end of his second year, Dr V was still aware of who the powerful people were, and now knew how to or had to manipulate people in order to get things done. This was not necessarily a selfish strategy, but getting things done for patients or in terms of 'toeing the line' for consultants. When asked what the important characteristics of being a junior doctor were, he emphasised efficiency, the need to get things done for consultants. Even registrars suggest that certain areas of medicine such as surgery attract a specific type of person and those qualities that are required to do what the doctor has to do as a surgeon. Dr L suggests:

> "surgery attracts very driven, very pragmatic practical people...if you didn't act so confident, you wouldn't be able to go up [and operate]."

Hierarchy drives many organisational cultures, and the case is no different in medicine. This third theme was introduced as hierarchy in general and then the next section below focuses on consultants and registrars. These are the more senior doctors in the medical training ladder. I have separated these because there is a real sense of submissiveness, which I will show in a moment, on the part of junior doctors in relation to the senior registrars and consultants. Briefly to summarise the above theme: medical hierarchy is important to the medical culture so that everyone knows their responsibilities and there is an understanding that there is a team member who is ultimately responsible. This person is the consultant. The consultant, however, knows that the registrar also has responsibility to supervise the intern/JHOs.

Consultants and registrars have often been referred to as power brokers. The relationships with registrars are however fundamental to the postgraduate training experience. For Dr P who started his internship eleven months previously, he feels that he is no longer insecure about asking registrars questions. This is quite a contradiction, considering the first year is supposed to be a time where most questions are likely to be asked, but now that he has gained more confidence he feels he can ask more questions. The concept of the consultant as a power broker initially came up at the beginning of the year in the interview with a second year doctor. Dr B feels that social situations such as 'kegs', which are drinks put on by the hospital residents' society and located on site at the hospital, assists in breaking down the barriers associated with medical hierarchy barriers. However, by the end of the year Dr B had noticed the intoxicating nature of power in other doctors. He suggests that the restriction by the system sometimes allows them to feel that they are just a part of one machine. As a doctor you still have a bit of individuality in a public hospital and this is shown through 'wielding a little bit of power'. As I began to say in my interview question 'power is quite...', Dr B jumped in and said:

> it's intoxicating, it's very intoxicating. Particularly when you're in a job like this where you don't have power for a such a long time, when you finally get it, it tends to go to your head, and you run away with it, and you think this is great."

However with this comes a bit of sacrifice in terms of the image of being a bad resident. If Dr B felt that he has power now that he is moving to another job (and has passed the primary), he does not want to show that he does not care about what he is doing. He feels it is important that he does the right thing by the consultants and his fellow junior doctors. Dr B is learning how to cater to the needs of registrars and consultants. Dr J is also learning about not crossing the line in her relationship with her registrar. When I asked what were the most challenging aspects to the first few weeks of her internship she suggests that:

> "as much as you joke and as much as you reveal about yourself, there are just lines which you just can't cross because you just can't come close to anyone either even though you spend all that time with them because, well, because it's not energy-efficient to become too close to every one person you spend [only] 10 weeks [with]."

By the end of his second year, Dr B is reflective about what the important qualities to be a surgeon are from watching and working with his seniors. When asked what he thought the important qualities were and has he noticed them in himself, he suggests that although they are not necessarily ideal they are the ones that got those doctors ahead in the first place. In reflection later on, Dr B (JHO) jokes about his friend's advice to him:

> "oh yeah. I've already been told by friends of mine, they've said "you know, if you turn out to be like you know the other sort of stock-standard orthopaedic registrar, that's it, we're having nothing to do with you anymore".

At the end of the year, when I asked Dr D whether his impression and knowledge of the medical profession on the whole changed over the year, he replied: "that not everything is as nice as he thought it might be. This experience of seeing what he does not like in attitudes to patients of senior doctors also leads Dr D to

learn what he does not want to be like. By the end of her internship, Dr E has also learnt about hospital politics which she finds irritating when she is trying to coordinate care and the registrar is saying 'no, I am not taking it [the patient]'.

Other aspects of learning about interaction with registrars and consultants includes learning how to present patients or patient information to the registrar. By the end of the year, Dr E had learned to start things on her own, and she feels that she knows what she has to do and she just does it. The importance of the registrar can never be underestimated in many contexts. When asked how she thought things had developed and changed over the year, she suggested that unlike being a student, being an intern allows her to actually work with registrars on a daily basis in the job and get a realistic picture of what being a doctor is about. Her knowledge of the medical profession by the end of the year, she suggests, has improved because she is now actually a part of the team.

Dependence on the registrar for guidance because of the daily working relationship is a key factor in the junior doctor learning experience. When reflecting back on the ward round videotape, Dr J, at the end of the year suggests that she had learnt how to work with a registrar depending on the quality of the relationship. Dr J has learnt a lot from her registrars including how to act on a ward round. The videotape taken at the beginning of the year suggests that she was uncertain of her role and duties. She says: "yup, I've learnt heaps from my regs. I didn't, I didn't know what my function was, I was trying to figure out where I stood on the ward round, what was, where I, where my niche was." Dr J has now learnt to do ward rounds by herself compared to the beginning of the year where her dependence on her registrar was very high. When asked would she have done a ward round by herself at the beginning of the year she suggests that:

> "I wouldn't have known what to do, I wouldn't have felt comfortable. I would have called my reg about every tiny thing. [The difference is] confidence, ability, less willing to please."

Initially in the beginning of the year Dr J did not know where her place was in the hierarchy of medicine. At the end of ten months now, she has a better sense of her medical duties and her confidence has increased. Her way of being and selfhood has developed based on what she knows of from the medical culture, to do in her job and expect from her role as a junior doctor in total. She says that she is 'less willing to please' and is focussing on getting the job done which as a function of hierarchy works for her. Her training has allowed her to work with her registrar and understand what his needs are and what other senior doctors need from her in the medical hierarchy of duties. She is working well and efficiently by the end of the year in relation to her learned sense of duties. Within the hierarchy, her knowledge of the characteristics that make up a basket of certain dispositions, are now suited to the situation and in particular, the medical hierarchy.

Dr J continues to show how at the beginning of the year learning how to foster the relationship with registrars comes at a very early stage. At the beginning of the year, she suggests that many interns learn to be careful about what they are saying around registrars and consultants. By the end of the year Dr J continues to watch which she says around consultants and registrars. In fact she has learnt to keep her

'mouth shut'. Working so close with a registrar twelve hours a day for six days a week for ten weeks, it is not uncommon for some mannerisms or characteristics to rub off on the junior doctor. Dr B describes how he notices his consultant's mannerisms reflected in his registrar and how he is beginning to adopt some of his registrar's characteristics as well:

> "I've seen for myself that Dr L has adopted a lot of the mannerisms that Dr W has, and I'm adopting all the mannerisms of Dr L."

Some of the positive aspects to having a registrar is somebody who is more senior than the junior doctor, yet still junior themselves. Sometimes interns are caught in the crossfire between consultants and registrar. At the end of the year when I asked Dr P, an intern doctor, if he had ever found out if he had overstepped the intern role or the limits of his role, he said that he learned to deflect responsibility. For some doctors they understand that as an intern they are at the bottom of the medical hierarchy and as they progress through the year, they can see how every level has its own starting point.

For many doctors learning to be a junior doctor is also learning how to manage your impression on the registrars and consultants. When asked at the beginning of his second year what the important characteristics of being a resident doctor were and how he had learnt them, Dr B said he has learned 'when to keep his mouth shut'. Also the way that Dr B manages his impressions on consultants in terms of knowing his place, keeping quiet or if he appears too keen, what message that sends to other doctors. He says: "knowing when to keep your mouth shut, yeah, it's part of being important. I suppose you shouldn't really volunteer information unless asked for and if you look too keen, you look too much like an eager beaver, the consultants find that tiring, and they get worried, and they think, I know what consultants think, that's not healthy, that guy's far too keen, mustn't have a life, he's totally devoted".

In many statements by Dr B, he appears to 'know his place'. He knows about walking or 'toeing the line' by playing the game correctly. He knows about the consequences or effect of what it will mean when he says certain things from hearing previous junior doctor folklore. Below he talks about a case of a doctor acting beyond his role as a resident and how it is a difficult situation sometimes where the resident has 'transgressed the unspoken law'. Dr B says:

> "I heard about one of the guys and done his primary, and he had been working in one of the high powered units here, and I think it must be great doing what he's doing, finally finished and working in a good unit, and I said yeah, apparently he's trying to make decisions above his station, he's forgotten he's a resident, he's trying to make registrar decisions, and he shouldn't be doing that. You just got to be really careful. You can get carried away, and sometimes you think you're doing the right thing and you may be doing the right thing, and you've transgressed the unspoken law, and you've taken it one step too far. You've exceeded your authority."

By the end of the year, however, Dr B has learned that he has been able to develop a more even footing with registrars and therefore some of the issues above as far as knowing your place are not as applicable now that he has proven himself trustworthy. The close working relationship and the levels of hierarchy creates all

sorts of interesting working relationships. Overall many junior doctors just get on with the job. However, knowing and learning who the powerful people are is a fundamental aspect to the internship experience. When I asked Dr D six weeks into his internship whether he was afraid of his consultant, he suggested that he could foresee that he needed to satisfy the consultant's needs. In terms of making sure consultants are happy, I asked Dr B, at the end of his second year, was he also learning other things beyond medical issues, like how to keep his consultants happy? He said:

> "how to keep them happy, go to any lengths possible to make sure things are done on time. Get down on your knees, exactly!".

Dr B has learned how to obey his superiors, yet this also makes them think he is either doing what the consultant wants or what he thinks the consultant wants. At the end of his internship, Dr V emphasised that the consultant was the holder of all important medical knowledge. Acceptance of the consultant's knowledge base simply because they are the consultant is common in the junior doctor years. Similar to Dr V, Dr B is learning the important qualities of the consultant surgeons by how they act and react, and also the situations that create difficult personalities. These contribute to a conception of the sort of doctor that he does not want to be. Dr V was able to take this understanding that the consultant's knowledge base was correct and learned to keep his mouth shut and learned about authority; this was the way that he was going to be learning. At the beginning of his internship Dr P saw consultants on the very professional level and felt that getting to know them as people was good in terms of breaking down the hierarchy. He tells us:

> "I guess that's one of the hierarchy things as well, like you know, you lend to speak personally more with people at your own level. Like the interaction I have with my consultants is always over the operating table or you know, outpatient or on ward round. You don't really have that social chit-chat time but then again, that's where it is good in that the unit particularly mates nights where there's staff, physios, doctors, we go out and have a social time together so that sort of thing can happen."

For other junior doctors learning from the consultant allows them to learn what they admire in other senior doctors. This is a key part of learning to be a doctor, by the end of the year when asked if there were any doctors that emulated the kind of doctor that they would like to be, Dr P suggests that he admires non clinical aspects to a particular surgeon. Another aspect of learning about consultants includes how they have specific control over what the junior doctor does. As Dr B suggests, when a RN pages him to come to the ward: "I can't come, I'm in the theatre and I just can't walk out of the theatre with my consultant here." In other situations, Dr B found that he might now be sharing a joke with consultants and because he has not indicated otherwise, he is keeping his mouth shut and doing the job until he is officially approved of. When asked 'would he have been joking with a consultant earlier in the year when they were on a ward round', he replied: "no, until I've been given any other indication, otherwise, I still think we're in the old school that believes residents should be seen and not heard. So I just keep my mouth shut, eh, write the forms, write the notes."

Consultants, even though they may not always reinforce junior doctors' work are very important in terms of role models for either a specialty area of medicine or general education about being a doctor. When I asked Dr H why he decided to become a physician and not a surgeon, he suggested that his role model was very important. However, the fear of (or need to please) the consultant is a common feeling during the junior doctor training years and many learn what the consultant wants. When Dr V was asked was he primarily learning what the consultant wants, he responded: "by pleasing them, you are learning how they do things and you are learning yourself." Many interns learn that being known from when they were students is also important in terms of establishing rapport, and even getting decent ratings on their term reports. Dr V tells us about his consultant's reaction when he found out he knew the intern he was assigned versus the reaction of an intern he didn't: "he was 100% happy with me because he knew me and he knew that I was good, you know what I mean? The other resident he hadn't taught, he didn't know. He was a very quiet sort of guy and Dr W said to me at the beginning of the term, 'Oh no, not another one of these'. Five or six weeks into the term he realised he [the other intern] is very confident and very, very good at his job." Dr V's final point about his consultant was that there are "expectations and if you fall short of that, you go down on your report".

Part of managing the consultant is passing on advice to other interns and JHOs at the end of the term or year. When asked if there was public and private advice that Dr V would give to the new residents, he suggested that the information that they accept from some consultants as opposed to other peers is important: "you learn who the people that you can respect and who you should listen to". This junior doctor tells us that there are consultants that you tell other residents to "worship" and there are other doctors that "everything she says you take as gospel and listen to her coz she will teach you more that anyone else you will ever meet in your medical career."

Consultants and registrars are such a key part of the medical education process for junior doctors. They teach and guide interns and JHOs in learning about the medical job and culture. For many of the junior doctors they have had to learn to manage their relationships with their registrars because they are such close working relationships and have a lot to do with how their training will occur. In terms of hierarchy, junior doctors have to adopt a certain training mould to work as a key and useful part of the medical team. This affects their personal and professional relationships with the registrars and consultants with whom they work every ten to twelve weeks.

The quality of their practical training and therefore fostering their future specialisation is very much dependant on this hierarchal relationship. Through the working relationship, which sometimes develops into personal friendships, junior doctors gain a sense of where the registrars have been to get where they are today. The information about medical survival and characteristics that endure are displayed and learned rapidly by junior doctors through this hierarchical relationship and working conditions. What we have read so far tells us that the junior doctors are learning about issues about their training program such as, how to play the game, the doctor mould, and medical hierarchy in terms of their consultants and registrars. This cultural knowledge that junior doctors are gaining in their first few weeks as

interns and JHOs is laying key ground work for their professional development. What we are seeing then, is how by the end of internship and the second training year many doctors have internalised the cultural knowledge required for success in the field. As we will be examining shortly, this knowledge is also to be transferable and transferred to their roles as junior doctors and incorporation into the processes of the medical culture. The earlier themes presented have been the essential and most common issues around junior doctor medical culture. We move now to look at two more themes as the fourth theme has several sub themes. These are all key issues and part of the medical job: patients, stress, ward rounds and so forth. Let’s talk about medical tasks, characteristics and aspects to the daily job.

Junior doctors are navigating their way in the hospital. While working out how their dress style influences the relationship with the consultant who will help them get onto a training program, they are also trying to foster certain relationship with seniors and maintain a certain image of what a junior doctor should be. Most of the day to day clinical activities of junior doctors are tied up in ‘medical aspects’. What we find here are the cultural elements of the emergent medical habitus. It is not surprising that in the context of medical aspects, there is an absence of major clinical comment. Here junior doctors still discuss how they are learning about managing their cynicism over the year, ward rounds, paperwork, stress, critical incidents, patients and finally women in medicine and surgery.

At the beginning of the year, I asked Dr J (intern) what she liked about the medical culture. She suggested that when she is with medical people, there is not as much explaining to do about what she does; she does not have to defend the medical profession or hear about other people’s medical problems. On the other hand, she can also see that being a doctor is a high stress profession and stress is acted out in certain ways within the medical culture. By the end of the year Dr J found that many of her friendships had changed over the year based on career ambitions. She does, however, consider some aspects of medicine which she appreciates (such as people who are ambitious), but she also sees the effect that it has had on her personally. She reflects:

> “there’s a real risk of being trapped in this whole, have the most, be the most, have the best career, and be the skinniest person and it’s just negative and I don’t want to be trapped in it. I just want to be myself.”

For Dr B a JHO, he finds that by the end of his second year he has learnt about stereotypes and generalisations of surgeons:

> “they think “oh, so he has no neck, and an extension from his forehead, does he?” and that sort of thing, there’s always these particular, prejudices, that they’re you know, footy meathead idiots, and uh, and, they’re all wankers till proven otherwise.”

This is an interesting aspect to medicine where we see character differences and competition between medicine and surgery. The subcultures within some disciplines are useful to consider in the context of habitus, the medical field and specialist fields. The power of being a part of a group of people who go through the same training and have to deal with the same issues can be very empowering for many of the junior doctors. It has both positive attributes as Dr J suggests, an understanding of a commonality, yet is also a trap because there is no variety of

people. Dr J may however be experiencing this because of the people she is meeting in the first twelve months. This power can also be detrimental to the psychological coping mechanisms of doctors. I take this and apply it to the concept of cynicism, which was brought up several times by interview participants. It was found that interns, such as Dr E at the beginning of internship describe cynicism as a total outlook. When I asked her how she thought she was going to be different at the end of this year, she kept saying that she was not cynical yet. However, after ten months of internship Dr E is finds that she is developing cynical attitudes about patients:

> "you know, one o'clock in the morning, Sunday morning or something like that, someone comes in with this sore toe that they have had for 4 months! Why?"

Her cynicism has developed she says, because of trivial patient problems. This intern has experienced change in her cynical feelings, she has found that political struggles surrounding taking care of patients, such as, whether a patient is 'surgical' or 'medical' classifies which type of senior doctor should be called when a patient just needs medical attention. This she feels has taught her "how to play the game." Dr I also shares the perception that patients contribute to development of the cynical attitude and the frustration doctors' experience within the system. Dr I tell us "it's not only cynical about the system, it is cynical about your patients as well. Cynical about the system, you just accept. Oh, just medical administration, the hierarchy that kind of thing. Um, you just, you know, you just know that that's the way it works." We see here that Dr I knows she has had some experiences that have made her cynical. For Dr E below, when I asked her about the profession of medicine at the end of her internship and whether she still likes medicine, she stated: "yeah, no, it's pretty good, I am still not cynical." Her sense of achievement and growth in medicine is reflected in her ability not to become apart of the 'cynical' medical culture.

When I asked Dr E directly what she thought about her cynicism, her first response was a smile. She then goes on to tell us: "you do get a little bit cynical but I said I wasn't at the beginning of the year and I wouldn't get that way but um, I wouldn't get cynical because I thought, I don't know, naïve perhaps, but you are, um, when you have people coming in with what you consider medically trivial problems." For Dr J, an intern, she also mirrors the contribution of patients has classified what is likely to make her cynical:

> "it would be 12 o'clock on a Friday night and you have been on ward call for 16 hours and there will be a diabetic patient who just wants to talk to you and have nothing to say, but just demands to see a doctor for no reason and you just can't help, you just go to the 8th floor, 6th floor to do this and after a while, you just get cynical."

At the end of the year Dr B is also cynical about patients. Dr B tells us:

> "this is where I have become cynical and I've discussed this with a lot of other people. I think people today now expect a hell of a lot, and sometimes I think too much, the expectations are too high for what medicine can achieve."

He really cares about his patients, and find that patients who "are ignorant of their own health, and they take no responsibility for their own health" distressing.

Many doctors talk about their experiences in emergency medicine coming in tor trivial injuries

> "pathetic cuts like paper cuts, and guys coming in um, bruises, sprains".

Next for Dr J, she suggests that her cynicism is likely to come from her superiors and she is threatened by that. When she was asked 'is she is likely to be cynical by the end of this year', she replied: "yeah, I'd be cynical and I'd be a bit more like the people above me. Hopefully I would retain as much of myself as I can." For other second year doctors, such as Dr B, he tells us at the beginning of his second year that "it's like the idealism of youth and you get that all beaten out of you, and you realise why bother." He has realised that he has become more accepting and understands how his cynicism developed. In a reflective moment we see that Dr B has found that cynicism in a colleague twelve months earlier was quite confronting, at this point he made a mental note that he did not want to become so cynical. "It's just that my very strong memory was when I started internship and one of the second years was talking to him, he's a nice guy and I get on really well with him but I just thought he's so cynical, so cynical about everything, and I thought that's really bad, and he says

> "don't worry, this time next year you'll be just the same…and I am. Underneath when you scratch the surface, I do feel the same way and it was only the first week."

Dr B's reflection on his internship reminds him that he was trying to please everyone. As the job started to 'bother him', his patience decreased. Dr B gets angry, a colleague tells Dr B that he is learning! These doctors are sharing the tendency towards cynicism which is being taught and becomes a ritual in this context. For Dr B one of the ways he has attempted to stop his cynicism is actually working in another hospital. He, like many junior doctors, feels helpless with the cynicism and that it is coming from the organisation and that he has no control over it; he foresees that it will get worse, but suggests that perhaps his humour will get him through. When asked does it bother him, he replies: "yeah it does, it bothers me that it's a system that's so caught up in these crappy processes, and you just can't do anything about it."

By the end of the year after Dr B has been working for almost two years in this hospital I ask 'how his cynicism is going', he misunderstands:

> "Has my cynicism grown? Oh I thought you said "has it gone?". No, I'm still cynical, even worse after working at South and East Hospital definitely, [why] ….Cynical about the system, the bureaucracy that goes on, the doubling up and often just downright laziness of certain people in the system."

Dr B is specific now about what is driving his feelings about the system and how it contributes to his attitudes. For Dr V, at the end of his second year, he dislikes being cynical but understands how it can occur and is bothered by why it happens. He feels the attitude develops from hassles at work, with administration and in terms of patient management. Dr V also feels the inability to do anything effectively about it. He tells us: "I hate thinking about administration as being the enemy and I hate rolling my eyes when someone says I have to struggle with pay office to get some back-pay that was missed 3 weeks ago, you just sit there and roll your eyes

and the cynicism isn't why it should work, it's just the way it does work." Also of great importance for Dr B is why he has become cynical. He feels that his job as a doctor is hindered by the insensitivities of administration. Dr B tells us of a medical administration issues where doctors "get shafted irrespective of their personal life". Dr V a second year agrees with Dr B above in terms of the issues surrounding administration: "[they] really don't give a toss, about residents especially." However, Dr V's feelings are not just about administration, but he finds in his own area (medicine), that power and control about particular parts of anatomy is ridiculous and may be it is just a matter of time before he turns into 'what you are working'.

Dr V who is in his second year of medical training finds that

> "it is all about power and control and from the powers that be. And no wonder the residents get cynical, I suppose after a time, you turn into what you are working so you also probably become just as aggressive for your turf as everyone else."

Cynicism comes across almost as an initiation into the workings of the medical-doctor culture. Before the interns start, they are telling themselves and the interviewer that they are not cynical yet. For some of the junior doctors, once they become cynical it is like they have graduated into that professional and accepted way of being. Part of the process for Dr I by the end of the year was learning how the politics of taking care of patients in wards taught her to play the game. So the process of medical management creates an awareness of how to navigate within the constraints of the culture, yet it can also create skills of psychological coping through cynicism. The next theme looks at the day to day activity of ward rounds and how this as part of the medical culture teaches junior doctors about professionalism.

WARD ROUNDS: PERFORMING MEDICAL PRACTICE

Many decisions are made on ward rounds. Here the roles of senior doctors, generally called registrars or consultants in the teaching hospital are pretty straight forward: they are there to provide senior medical management and to teach and guide the less experienced doctors. Registrars are generally fourth or fifth years post internship, but can be as little as three years post internship. As explained in earlier chapters, the career ladder generally moves from intern (first year), JHO (second year), senior house officer (third year), principal house officer (fourth year), also known as a non training registrar. Training registrars are in their fourth or fifth year, and depending on the college training program can work three to five years as a registrar, junior and senior and then there is the consultant (eighth to tenth year, junior and senior) level. At about the third year of hospital practice, depending on the hospital, specialty of medicine or surgery, and whether the doctor has sat the first part of a training college's exams, this will indicate what 'job' or training term the doctor is going to be doing. Some doctors may be doing a principal house officer job in one hospital and then ten weeks later, in the next term return to a JHO job, and then having sat (and passed) the first part of a college exam become a training registrar three to six months later. Being a doctor in a public hospital is quite

distinct. Being a senior doctor, which I have referred to as registrar or consultant, is to service medically the community and train and teach the junior medical staff. Beyond the official support and education of clinical matters, consultants also leave many of the teaching of junior doctors to registrars.

Dr J reviewed her ward round videotape after 12 months of internship, she commented that she was amazed that she was so dependent on everyone else. She explains that she is far more independent now and how insecure she was ten months ago. Her reflections on video of her ward round also focus on her level seriousness, anxiety and how she works differently now twelve months into her job. She tells us: "I hope no one sees that I'm totally out of control and don't know what I'm doing. I carry on differently there to how I do now. I mean, look at me pulling the [patient] stickers off that bit of paper like it's the most important task on earth, and now I just kind of rip them open and just chuck them everywhere"

These comments about ward rounds highlight how the job of writing notes and organising charts are a part of the daily job. Many of the issues that doctors raise were highlighted in the video. For instance, the video demonstrated how doctors witness specific medical issues and particular 'behaviour' as a doctor on a ward round. Through this, they are able to observe the daily organisation of medical work. Other medical work for the junior doctor is paperwork. We highlight some comments from this now.

Registrars and consultants however, rationalise the importance of these experiences, because they once had to do and now, they are not completing paperwork to the degree that junior doctors do. So not only is paperwork 'part of it', but it is a way to learn to be more efficient or else the consequence is that junior doctors are going to spend more time in the hospital.

Many junior doctors are learning their different roles through the conduct of paperwork. Many of these medical challenges during the first few weeks of internship involves doing the right paperwork, writing in the chart and generally just interacting with patients. Dr I an intern suggests that just going up to a patient telling them that you are their doctor is a challenge and "the paperwork is horrendous, has to be done but it's absolutely horrendous and you are just sitting there, figuring out what to write." The paperwork also is seen as an activity that takes away from experiences in other areas. By the end of the year, Dr B he was glad to have a registrar position the following year because he is just "getting jaded at the moment. People warned me about this term saying: "it's lots and lots of paper work, you hardly go to theatre, and so being my last term, it's really good." For Dr B, we see that paperwork "doesn't teach you much about being a doctor, it teaches you to do paper work very well". The tremendous amount of anger towards the medical system stems from the non clinical aspects to his job: particularly paperwork. The clinical aspects for Dr B are not found in filling out forms. He was told in his final medical years "learn all you can in the fifth and sixth years coz when you get out, what you're going to be doing is filling out forms and you're going to learn nothing about medicine in the first year". This is advice that he is likely to pass onto other doctors in the future as well.

Another junior doctor, by the end of his internship, Dr D felt that his career preparation revolved around a tremendous amount of paperwork, how to get ahead

in his career and in terms of political issues such as consultant 'backstabbing' and who to get along with. When asked how he felt the intern year prepared him for his career as a doctor he replied: "I think you are pretty much a pen pusher, I think. You are just a glorified clerk and I don't think I learnt that much except for ward calls where you have to make a few decisions." Paperwork can be distressing for many professionals. For junior doctors it seems to be more so because they do not feel it is a particular medical component to their job. The senior doctors see paperwork as part of duties of the entry-level junior doctor and that some medical knowledge is required to fill out the forms. Paperwork also links into cynicism, because for junior doctors it makes them feel useless in filling out forms in triplicate. However, showing an interest in menial activities such as paperwork is also a part of the attempt to appear to fit the mould of being a junior doctor to get onto a training program.

The daily stress for junior doctors is always there. Increased working hours and separation from social networks outside the hospital impact negatively on junior doctors' levels of stress. The concept of having and maintaining a social life and friends outside medicine to reduce stress is very important. Dr N suggests that doctors who come from families of doctors are prepared for the stress, but that the characteristics of the medical profession in terms of being quite removed from other professions, is where the isolation and need for support is fundamental. At the beginning of the year, Dr J felt that medicine could be quite isolating and she made an agreement to herself early not to let this happen. This is a common coping mechanism where interns see how the demands of the job can 'traumatise' their life. Dr J made an agreement with her best friend intern, to not

> "let medicine traumatise our life anymore because it is just like a trauma. Like the definition of the word trauma and you just allow you to beat you around, isolate you, stress you, give you nervous breakdown, you know. It is just horrible."

One aspect to training in a hospital is that even senior doctors are under stress. A registrar is still training, and largely responsible for junior doctors and their education, even though the consultant is still the person ultimately responsible for the patient and the work of those 'under' her or him. When I asked the registrar what he thought about interns' experiences of stress he commented: "try being a registrar - it just gets worse! That's the scary thing, is that stress being a resident is nothing compared to what it is now." Dr L is emphasising that at many levels of being a doctor there are common issues with different degrees of importance depending on where the doctors are at that point in their career. Being a surgeon in this hospital is a very busy job because this is a hospital with a reputation for a busy and varied surgical caseload. In much of my fieldwork, I came into contact with more junior doctors who wanted to be surgeons than who wanted to become physicians in this hospital. This is because interns who wanted to go into medicine often chose another hospital to start their internship in. Further, of interest to me, was at the time of these interviews there were many women who had indicated interest in surgery as a career. However, surgery has many traditional assumptions within it and I took the opportunity to ask the surgical registrar what his impressions were of women in surgery.

It had been my feeling that many female junior doctors were making the decision not to pursue surgical posts for very different reasons than the male junior doctors. During the interview with Dr L he suggested that by being a surgeon, 'eventually one has to build up a practice and be a full time surgeon'. The issue for junior doctor women, he suggests is 'complicated by the fact that women have to take off time to have a baby and then go back to work'.

Being a surgeon it seems is not only a time consuming specialty, it also requires a personal family sacrifice and significant support at some point by one of the partners. Dr L had suggested previously that he did not like the lifestyle of a certain male surgeon with a family, who was not able to see them, thus completely sacrificing time with the family. This is a common dilemma of being a surgeon: professional commitment which can have a negative effect on a family. Therefore the stress, perceptions and experiences of the junior doctors' registrar is an important part of the informal and formal junior doctor training. Dr I felt less nervous and stressed about her internship because she was

> "knowing the routine of the place, just knowing what to do when, after you see a patient, you know, ok, you got to think this, this, and this and you have got to do these investigations and you don't feel quite so nervous about doing anymore."

It seems that the impact on the doctors' social life is somewhat measured during medical school. It does, however, seem to become magnified during residency where the on call hours, and the time alone and with friends is significantly reduced. The impact on being social also relates to staying within a certain circle of friends, those that understand 'the life'. This may increase the likelihood that the residents become insular and socialise with those in medicine and 'talk shop' because they spend their life in the hospital. Dr V tells us about the differences in his social life as a doctor which lead to stress as part of his life:

> "suddenly you are working and you have to work and sorry I can't make it because I am working. You don't know much about the social life being a Doctor, except from friends who are Doctors, and they say oh social life what's that? Sorta thing. Relationships break down as soon as you become a doctor, that has been there for years, because suddenly you're working 120 hours a fortnight and can't go out every night of the week."

Some of the private advice that Dr J was happy to provide to the new interns in the following year included emphasising what many others have suggested, which is the importance of having a life outside of medicine. She acknowledges, however, the contribution that medical friends make to the process of coping with stress. As well, she feels that enjoying the first year is important as opposed to beginning to study early and race to get onto a training program.

The realities of the job often are mediated by teamwork. We have heard a lot from Dr B and his experiences of stress and cynicism, he had to change by the end of his second year because he found himself losing his cool and he began to be worried about people's assumptions about his nature and reputation. He says: "is it the fact that I'm not getting much sleep, maybe I am getting cranky." The resentment Dr B feels by the end of the year is clear. He is very hassled about the nature of medicine as all encompassing and the toll it is taking on his life both

professionally and personally. He is getting very resentful at the moment, his outside interests such as his girlfriend, his exercise, his social life are

> "all progressively being gradually eroded away and squeezed out and I'm getting to a stage now where I may go home and you know, I'm just stuffed and I have to do a few things, and I'm so tired, I just collapse. I find it a bit depressing in that I can't see it getting any easier".

He is starting to blame himself "I should have known, I thought I knew when I did this, decided to do medicine, and that's what life is going to he like." For Dr B, he did not know about the demanding and stressful realities of the job. He has gained a certain sense of maturity about the viewpoints of not only being a doctor (beyond many of the training program issues), but also many of the effects on his personal life and what the potential decisions (including leaving medicine) he might have to make based on these experiences and attitudes. Looking at stress as part of medical culture, we can see that this impacts on junior doctors private lives. The management of daily stress will characterise how well they perform on the job. By the end of the year, many of the doctors suggested that they have had to learn to manage the stressful parts of the job. It is not the stress of patient care that is overwhelming many of the junior doctors, but rather the ability to perform and work within the culture that is making such demands on their private lives and how it influences what they want to do at work and how they see their future.

Next, although not a specific question in the interview process, the topic of women in medicine and surgery came up several times. Of particular interest was the surgical registrar who suggested that there are hardly any female surgeons because the best years in surgical practice are also the best years for child bearing. When I asked him about the low numbers of women in surgery he says:

> "I agree there are very hardly any female surgeons. You have to make more sacrifices than a man. I guess it's a simple matter of biology."

This surgical registrar also suggested that although some attitudes are changing, a supportive spouse and an understanding of how to create a proper private practice is essential. When asked 'why can a man not make the same sort of sacrifices'. He tells me in a surgical career doctors have to get a lot of surgical practice, take all referred patients, work long hard hours and there is no room to see children.

He thinks that these attitudes are changing, but as a mother and if the roles were reversed women would have to have a very caring spouse. Although, the registrar suggests that there might not be as much sexism these days, at the beginning of the year in her first surgical term, Dr J feels that she is perceived as a token person whereas the male interns in surgery are actually there to 'do the work'. When asked 'is there sexism?', Dr J replies: "when I saw a consultant for the first time on my unit, he said, "oh, another girl". Yeah, I find that the girls like, have a good time hanging around the ward a bit, you know". She says that the impression that she got about women in surgical terms was "like the guys come in and do all the work and when the girl interns come in, they just come and have a look and uh see how they go."

By the end of the year Dr J still found that there were aspects in her surgical terms that made her think twice about women's position in surgery. She finds that

the surgeons "can't help themselves saying things like "we'll get the ortho boys to come and see that", or "we'll get the urology guys to come and see that", and you just think, like if you were a girl and you really wanted to do that, you'd really have to think, do I really want to he referred to as a guy for the rest of my life, because maybe femininity is important. I don't know, maybe it seems calculated or something."

Dr P who is interested in surgery himself, is aware of this gendered position in surgery and came across a situation that bothered him. He tells us that "the girls in ortho cop a hard time but, that's no surprise to anyone." One of his female intern friends in orthopaedics was asked to have all the tea and coffee ready for the surgeons. This female intern did not want to go into orthopaedics, but she did the chore because it was expected. Dr P was very annoyed and told her not to do it, she said "it's easy just to do it". Many of the male doctors are aware of some differences in interacting with senior doctors, but also with nursing staff. Dr B told me that female doctors have problems with female nurses and how sometimes female doctors in theatre 'cramps' the crude joke style. He tell us that

> "nursing staff don't like to. don't tend to like female residents as much as the male ones."

He continues to tell us how the atmosphere is very sexist and a lot of crude jokes go around. He finds that

> "when yon put a woman in there, in the midst of that, it cramps, oh it depends on who the assistant surgeon is. but it cramps the atmosphere. In certain specialties, there is really a lad's mentality, urology and orthopaedics as the biggest offenders."

The conversation earlier with Dr L, a registrar, about women in surgery pinpointed the different priorities that many working professionals encounter in considering partnerships and children. Along with other workplace issues, trying to gain an even footing for many of the young female doctors in medicine is not too difficult, but when it comes to surgery, it seems that there are still barriers to their equality. Gender issues were not a focus of the interviews, but it was important to include the opinions. It is a concern that Dr B can see that having women in the surgical theatre 'cramps the atmosphere', whereas Dr J suggests that the sexism 'seems calculated'. The training of equally talented and caring doctors is still mediated by gender and needs further research at a junior doctor level.

This theme of medical culture touched on several areas of importance that describe and reflect junior doctors' working lives. The daily tasks of paperwork, ward rounds and dealing with patients contributes to their growth as professional doctors. However, some of the critical incidents, stress and dealing with sexism contribute to a negative side of professional development - cynicism. What we have here is a reflection of medicine through the daily activities and practical aspects to the junior medical job contribute to professional development, as well as cement positions within the medical culture. The junior doctors are being integrated into the organisational identity because they are experiencing aspects of the medical culture that mould them towards the role of a medical professional.

REFLECTIONS ON THE FIRST TWO YEARS AS A DOCTOR

Part of the usefulness of the work here was the conduct of exit interviews with the interns and JHOs after 12 months to ask about their experiences over the year. The junior medical job is very busy, so many doctors do not get the chance to be reflective or even notice that months have gone by. However, they are changing within themselves and in relation to their job. This topic elicited a variety of responses. However, the main thrust of answers focussed around increase in confidence in the requirements of the job, especially in relation to knowing their place in the medical team and what needs to be done on a daily basis. Other aspects to the transition and reflection were about how the year has affected the junior doctors negatively.

Dr V suggests that it is important to display an intense desire to get on a training program by learning what is required and to upgrade procedural skills at every opportunity. By the end of his second year, his increase in confidence was essential to enable him to develop competence in clinical procedures and to ask for further learning opportunities. For Dr Q, at the beginning of his second year, has found that he is given more responsibility in his second year. When asked what he has found different being a JHO from being an intern, he suggests that responsibility is passed from the registrars. He says that in his second year he does not get the "feeling that they [registrars] have to look over my shoulder all the time whereas last year, I think, you are probably right, they were keeping a close eye on what was being done."

Dr J's reflection on her internship so far focussed on her acceptance of making sure that the next class of interns 'knew themselves' and not "being someone that you maybe don't want to be." Dr E feels a lot different by the end of her internship because of her confidence in her ability and she has learnt about her limits and what to do if she needs help. Increasing confidence is very important and common for junior doctors. However, other issues such as a deeper knowledge of the profession in terms of 'turf wars' also develops. By the end of the year Dr V shares: "you start to see more the little turf wars, the little power struggles going on between different units and different specialties. Um, so you do learn more and you realise how 'fractioned' medicine really is."

When asked was there any sort of private advice that Dr D was going to pass onto the interns next year, he replied that knowledge of the particular types of groups as well as the practical such as, what certain consultants like or dislike. By the end of her internship, Dr E feels that she has increased confidence. She also feels that she is more a part of the system now and is able to talk to and 'deal' with consultants with less stress. Dr E feels that her confidence relating to consultants has improved by the end of the year on other levels; for example thinking consultants are "not scary people that you thought they were." Confidence in her job was an important aspect to her adapting to stress in her internship. When asked how she is different than when she started, she emphasises her confidence makes the job easier:

> "I know what's expected of me. I know how to deliver that and how to do the best job that I can".

Other intern doctors, such as Dr I suggest they have also undergone their own personal and professional changes, and that they have become 'streamlined' in terms of knowing what their job is and being more focused. For Dr V he has noticed particular professional changes. He has noticed that he is more distant from his colleagues because of the time spent in other hospitals and in more specialised terms. By the end of his second year, Dr B was well aware of the changing social group, how friendships change and how most of his friends are career and study driven at this point.

In medical school many students learn about obscure diseases and when they arrive into a hospital service job, the fundamental change as an intern is learning to manage common medical aspects to patient care. Dr V mentions, in medical school they learned a lot more about rare medical diseases, as opposed to the more common conditions that they are coming into contact with and treating daily as an intern. For other junior doctors, such as, Dr I she is thinking about what second year medicine is going to be like; she considers how she will change and perhaps how she will be different by the end of the following year. Her feelings revolve around increases in her confidence. She believes she is not likely to ever have to repeat a year like her internship, "there's going to be different challenges but this is unique, I think."

Dr I understands what she needs to do when she goes into new terms now, she is more confident and knows about what is expected of her. Her practical skills such as "my mind has become more organised now and what I need to do and how I present patients to people, trying to get the things that I want done - done." In contrast to her first weeks: she tells us that "you just sit there, sorting yourself out. You know, I think you can cope with a lot, so next year, I don't think it would be so much of a struggle."

When I asked Dr J's her thoughts on how an intern learns to be a doctor or a good resident, she suggested:

> "I think my emphasis has shifted, at the beginning of the year I was very obsessed with um, pleasing people above me and around me, which is important, and it still is important if I want to go anywhere with the career, but I'm just a little bit more relaxed, I've got more time to, which I can owe to my patients."

So learning to work with different patients coupled with getting to know the requirements of the job are key to the transition by the end of the internship. Dr B in his second year, is trying to handle the impingement that medicine and the duties of being a resident is making on his selfhood and private life. He is learning to balance and trying to prioritise home and work needs. His feelings about the institution are also changing in terms of wanting to 'get out of here'. When asked if this was just a part of internship, Dr B suggests as interns they would meet in corridors and have a bit of a talk. Now as second years, they say hi and it is understood that they are too busy to talk,

> "we just get it done, because I'm just sick of doing this sort of thing."

For many of the junior doctors, their reflections revolve around an increase in confidence covering their skills, managing the job and themselves as professional doctors. This final theme 'reflections on the junior doctor years', emphasises that

after twelve to twenty-four months, junior doctors have undergone a tremendous transition from naïve freshly graduated medical student to doctor who ‘knows how to play the game’. So much of the early weeks were spent not knowing what do, slowness in organising the results, unsure who to call, feeling quite helpless and at the mercy of the training given by registrars. Several months into the training year, many of the reflections are based around simply knowing what their job is, how they can use their medical knowledge and medical cultural knowledge to survive the days.

Knowing what is expected of them as junior doctors helps many interns and JHOs focus on the real issues. The doctors do not seem to get as worked up over ‘turf wars’ or they know how to navigate within the culture and daily requirements of the job. Therefore, the main two aspects to reflecting on the transition to house officer as a second or third year for these doctors is that they are confident, more relaxed and essentially the culture has done its initial initiating job.

Thus far we have read the interviews from the twelve month study of junior doctors in five major themes: issues surrounding the training program, the doctor mould, medical hierarchy (consultants and registrars), medical culture (cynicism, ward rounds, paperwork, stress, critical incidents, patients and women in medicine) and finally reflections on the junior doctor years. Next we move to a complementary analysis of the videoed ward rounds.

WARD ROUND VIDEO SCENES

Each video scene described here showed a particular level of interaction. Here the video sections are listed as titles and scene description. Approximately three minutes and thirty seconds were extracted from the seven hours of videotape. The video scenes that have been selected for description provide an avenue to consider the way in which medical culture and the interpretations from much of the interview transcripts are layered in representations generating particular aspects for analysis. An underlying approach in this discussion is that through analysis of these selected scenes one is able to use multiple points for interpreting this data. I videoed and observed the doctors and the ward rounds to find out about particular actions and interactions in the natural settings.

Table 6. How videotape scenes were selected.

- 7 video scenes selected for description.
- Taped at beginning of intern and JHO year
- 1 x a week (for 3 weeks), 4 junior doctors (2 JHOs and 2 Interns)
- Approximately 7 hours of videotape collected of medical and surgical ward rounds
- Ward rounds taped focussed on intern's and JHO's initial experiences of the early weeks of a term
- Tapes were reviewed several times over the course of 12 months
- Patterns of interaction and unique moments of activity were examined
- Video collection was not a primary data collection method
- Video supplemented interview themes and highlighted medical practice.

Ward rounds are an activity where the whole medical team is together and key educational aspects are taught, learned and passed on. For instance, when I asked Dr L, who is a registrar who has sat the primary exam and passed, about the differences between ward rounds, he emphasised the differences between doing registrar 'duties' and consultant 'duties'. The registrar and the resident 'manage' the patient and the consultant is contacted if there is anything more difficult. Although the resident also attends the business round, he is directed by the registrar.

Videotaping ward rounds allowed visual documentation of a fluid and mobile medical workplace activity. The ability to establish rapport for interviews was also an important aspect to experiencing and watching ward rounds. Through videotape of the ward rounds, I was able to review the environment doctors work in and view non-verbal expressions. Although as discussed previously, videotaping was not a primary data collection method, it did highlight some interesting aspects to practice and behaviour. The videotape was able to capture social structure, such as medical hierarchy and specific interactions that arise from that structure. Beyond data collection for analysis, videotaping hours of ward rounds video also allowed me as the researcher to reflect on the basics of everyday medical practice, the pace of work as well as the roles on the job. That is seeing, hearing and being a part of the medical setting allowed me to in some ways experience the ward round reality that the doctors do. The nature of text and pictures makes video difficult to present. However I have attempted to describe and show the scenes as best as possible. The doctors and patients faces have been blurred to protect anonymity.

With this video recording, it was impossible to document all the activity of the ward rounds. I did however aim to record (exactly) what was occurring on the ward rounds. Sometimes I could not get all the participants on screen and it was still a challenge to record every moment. However, here we see when I reviewed the

tapes, I was able to find interesting moments of events and the interactions observed on rounds.

Table 7. Videotape scenes.

- Consultant hands the Ophthalmoscope to Registrar
- Registrar has Ophthalmoscope
- Registrar hands over the Ophthalmoscope to Nurse
- Nurse receives Ophthalmoscope from Registrar
- Registrar dictating to JHO what to write in the chart
- JHO listens to registrar on ward round
- Registrar watches JHO complete paperwork
- Consultant dictating to registrar while intern watches
- Medical Charts, Junior Doctor and Registrar

Ward Round Video Scene 1: Hierarchy on video

In this scene after examination of a patient the consultant holds the tool (indicated by an arrow), waiting for the registrar to take it.

Figure 3. Consultant hands the ophthalmoscope to registrar.

The intern is listening attentively, while the registrar points out some results in the chart. The consultant is listening to the registrar. The intern is holding the patient charts and is standing next to the registrar. After a few moments the registrar finally takes the ophthalmoscope (medical instrument to look into the eye). The consultant

is talking about the patient results from the chart which is laying on the bed (not in view). The intern is holding all the charts tor the ward round. The CNC is on the intern's left at the end of the bed (right of frame not in view). One aspect that I have noticed in the fieldwork, was that there was a high level of seriousness and lack of facial expression on rounds. Dr E an intern, told me that she acts a certain way around the patients because it is about maintaining a certain professionalism. When asked what her main concerns were in ward rounds in her first weeks as an intern, she says she wanted to do the job properly and get notes done. She suggested that gradually learning what is expected of her as an intern will come later.

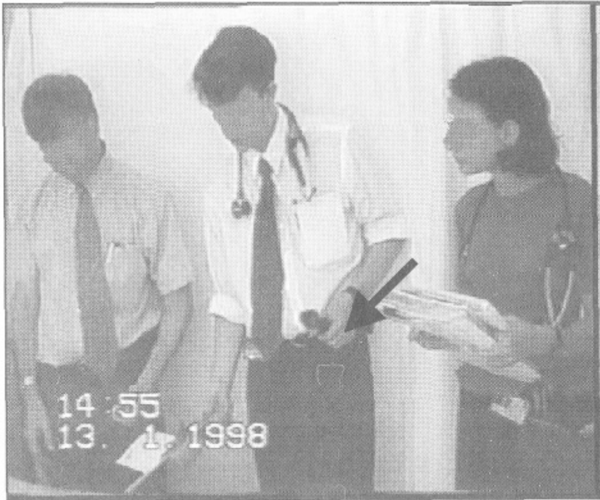

Figure 4. Registrar has ophthalmoscope.

In this selection of scenes we can see how medical practice is constricted, constructed and what doctors do in their role as physicians or surgeons in the context of medicine. Here we see the registrar who has been holding onto the tool, and then in a few moments time once in the hallway, hand it across the discussion circle to the senior nurse in the hallway. At this point, the nurse is now standing next to the consultant.

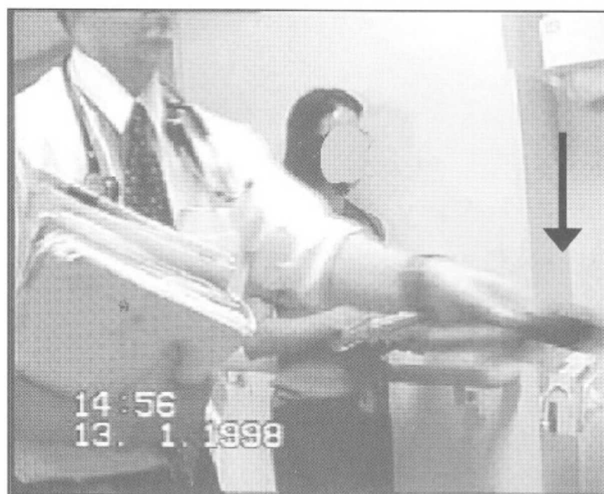

Figure 5. Registrar hands over the ophthalmoscope to nurse.

It is clear that medical interaction and events consist of organised activities of everyday life where there is responsibility to the patient and as a junior doctor, to the senior doctor. This interaction highlights how these actions reinforce the hierarchy of duties. For instance, handling tools here, the registrar's job was to receive the tool from the consultant, take care of the tool and then the CNC's (clinical nurse consultant, senior nurse) job was to put it away in the bag, as opposed to the consultant handing it straight to her at the patient's bedside. This also occurs with handing back and forth stethoscopes between senior and junior doctors.

Therefore, the professional work presumes knowledge of circumstances and relationships. The registrar knows that the ophthalmoscope goes to the nurse, this is a detail that the consultant who is busy thinking about the patient does not do. The mimicry of bodily gestures, stance and expression is evidenced here through the seriousness which is an outward expression, embodiment of the learned habitus. The junior doctor is learning how to be serious when the consultant is talking; she is to listen, watch how the registrar interacts with the consultant and she is likely to start to mimic and begin to embody those ward round gestures, stance and seriousness.

What occurs during junior doctor 'internship' is positioning within the medical hierarchy which produces medical habitus as evidenced in medical practice. During the interviews one of the doctors reflected back on her ward round medical practice, and talked about how 'bad' she looked in the early part of the year and how she almost feels sorry for her registrar at that time dealing with her skill level. The nature of her reflection reminds us that she now practices as doctor with less of the

initial procedural delay; this is her medical habitus. Her learned skills and thus dispositions have over time changed her social position and conditions of medical practice.

Ward Round Video Scene 2: See 1, Do 1, Teach 1

The medical chart or record is also a key point of interaction. It documents and highlights the activities that doctors have been doing around, to or concerning a patient. The practices are all embedded on paper in the chart. In the second scene selected, the registrar dictates to the JHO what to write in the patient's chart about the medical condition and what is being discussed on the ward round. He demonstrates aspects of the surgery. The JHO nods, pauses and listens attentively to the registrar. There is no consultant on this ward round as he is in surgery. Many ward rounds are often run by the registrars.

On rounds, this is also an opportunity for the registrar to discuss and explain part of the surgical procedure with the JHO. However, the JHO's duty is to write down on paper what the registrar has just suggested the patient management plan is, yet the registrar is also conducting a teaching interaction based around writing the information into the chart.

This next scene emphasizes how JHOs learn not always from direct instruction, but they are learning in and through their actual practices the particular reasoning for an action, behaviour or perspective (and certainly medical content) that supports those practices. Here we can see how there is an educational, yet routine interaction taking place surrounding the information that is contained or to be written in the chart. The social properties are taken up in the routine organisation of work practices (ten Have, 1995).

In this scene the JHO learns about his job duties and medical facts through a social interaction of dictation from the registrar. He also learns from the way the registrar dictates. That is, the language the registrar is using for the JHO to write down, and also how the JHO interprets what the registrar is saying and what he actually writes down.

Figure 6. Registrar dictating to JHO what to write in the chart.

Figure 7. JHO listens to registrar on ward round.

All this occurs through this activity of writing patient and doctor management details in the medical chart. In this practice, we have the coming together of being the 'student' doctor and learning about patient management at the level of a junior doctor.

In some of my observations and during the interviews, it seemed that consultants or registrars would foster the learning of junior doctors if the doctor had indicated that they wanted to do that particular area of medicine. A surgical registrar suggests that if a doctor is likely to be more interested in surgery and they are in a surgical term then that is to their advantage. He says:

> "like this morning, one of the residents who's studying for it [the primary exam], at the 8 am morning meeting was asked to draw the anatomy of the arm on the board. Now, if it wasn't known that he was interested in orthopaedics, no one would ask him that question because no one would, it doesn't matter, unless you want to do it."

Ward Round Video Scene 3: Being the dog 's body

On many occasions I noticed doctors speak differently and gesture in varying ways depending on whether they were at the patient bedside or in a separate space, such as the Doctor's Station. These different social spaces such as the hallway or away from patient's bed. allows doctors to discuss with each other patient management and results without patient's input or knowledge of what is being said. Once doctors are near patients, they may include them in the information gathering and management process. Often doctors also take on particular ways of gesturing, standing, looking serious and filling the role of 'doctor' in front of patients.

My description of the next scene relates to the Doctor's Station where the registrar is a lot more casual and chatty with colleagues, while the junior doctor rushes around. So many junior doctors talk about themselves as being just a clerk with medical knowledge based on the amount of paperwork in their working day. One of the key roles of being in an entry-level job as a resident or junior doctor in a teaching hospital is doing the least favourable groundwork. Essentially junior doctors acquire a lot of medical education through paperwork. Paperwork is considered by junior doctors as being 'a clerk with medical knowledge', and by consultants and registrars as essential learning experiences. A senior doctors jokes:

> "if it weren't a teaching hospital you can just have a secretary follow you around to do all the things and you can do the clinical things yourself."

The physical gesturing is more relaxed compared to the previous scenes when they were standing at patients' bedside's writing in the chart and managing patients' illnesses. This fourth scene shows how in the Doctor's Station there is a specific division of duties. The registrar watches while the JHO fills out patient investigations request forms and does the paperwork from seeing the last patient.

Figure 8. Registrar watches JHO complete paperwork.

There are patient labels on the front of his pants. These artefacts (patient labels) are used as a reminder to the doctor to do 'something' with that patient. The patient and chart have become a 'label' to be followed up. Aspects of the physical environment, the labels and chart have become representations of a task, a part of the workplace activities. Patient labels represent investigations that need to be done, need to be followed up, that will need to be checked and reported and then discussed with senior doctors. Patient charts also represent those patients that need to be seen on ward rounds who are medical or surgical cases that need to be managed on a daily basis. The junior doctor role is defined by the relationship to these artefacts of the workplace: patient labels, medical charts and related medical activities of the day.

The usefulness of the learning experience of filling out forms in triplicate and ticking boxes is disputed by many junior doctors. Dr B tells us of his difficulties with the nature of his job as not matching what he thought it was going to be like:

> "there's only 24 hours in the day, and when you have ¼ or ½ of that chopped out by working in a ward writing out little pieces of paper, then you start getting pissed off when you do get home and you're trying to squeeze everything else in".

Ward Round Video Scene 4: Medical apprentice

A strict hierarchy mediates interactions on ward rounds between the various levels of doctors. There are specific interrelated actions such as examination of the patient by the senior doctor, perhaps sharing a heart sound or lung breath of the patient with a less senior doctor, asking the patient questions and listening to their answers and formulating a plan of management, treatment or discharge. Then after seeing the patient, still on a ward round, there is the story for the chart. In this scene, the

registrar is writing in the chart from the dictation by the consultant. The doctors may also be gaining some educational material for their own medical education. The intern is looking on behind the trolley of several patient charts to push bed to bed, as opposed to carrying the charts. These scenes highlight a particular way in which talk, communication and interaction take place. The way in which interaction is organised and accomplished is of particular interest. The interactions taking place here provide an important perspective into the actions, practices and particular reasoning and enactment of those activities on the ward round.

Figure 9. Consultant dictating to registrar while intern watches.

This is the intern's job to do the 'dirty' work having the charts, investigations and carrying the charts during the rounds and obviously at this point not to take dictation from the consultant. Perhaps she is not 'trained' enough and will learn through observation how dictation and writing in the chart should occur. The level of interaction that is goes on here focuses on the knowledge that needs to be heard, written and contained in the medical record, which needs to be scribed by the registrar and not the intern in this instance. The consultant is assembling some sort of specific connection with the registrar about a story, which illustrates the problems and investigations that the patient is undergoing. There is also a certain degree of behavioural seriousness here, which on other occasions, such as at the patient's bedside, are appropriate within the ward round situation and around the medical hierarchy.

Here it can be seen that the registrar is positioning his body in a serious and yet, relevant, accepting way in response to what the consultant is dictating to him for the chart. The intern it seems is outside all of this, as her interaction is not relevant and not regarded as a feature of the activity, thus she is denied the specifics of the professional practices, yet she can still see them occurring. The intern (with a

serious expression) sees the organisation of interaction by looking and watching the performance of the registrar and consultant, otherwise she is almost a non-participant in the activity.

In terms of teamwork, the doctors suggest from the interviews that hierarchy makes the medical team work and 'provides structure'. In a refreshing attitude, one of the consultant's acknowledges that hierarchy also makes the junior doctors less able to be independent in their medical decision making processes. It creates barriers and she has found that she has had to almost reprogram the doctors under her supervision to be more forward and independent thinking. It is almost like they are afraid to step out of their level and they have to 'toe the line'.

Dr L, a registrar, suggested that residency is mainly about learning to do really good paperwork and emphasises that it is an important part of the experience. It teaches

> "you to be organised, and if you want to go on to future surgery, or future training, or become a general practitioner, being organised is very important. So part of becoming a resident is the trial of being organised and running around and just doing the clerical thing."

When I asked Dr V at the end of the year how he thought his cynicism had developed he suggested:

> "you do it [paperwork] in triplicate and then quadruplicate and then you have to do it the fifth or sixth time. It has become so institutionalised, it won't change and not half of the things the way they work, is a need for them to work that way."

The process of doing a lot of paperwork is only one aspect of being a junior doctor; it is also about learning about doctor characteristics one likes or dislikes. Previously when I asked the registrar about what were some of the things he liked in other doctors he was able to pinpoint exactly: to do good work, be a good family person, not be a hypocrite, workaholic or egotistical. In a question to the intern, Dr J had she learned anything political about her role from ward rounds and medical ward work, that she did not know at the beginning of the year, she told me she needed to show senior doctors her career intentions. Other aspects such as that were difficult to learn without experiencing them included: overstepping the intern role. Many doctors felt that this was difficult because the lack of clarity in the working relationship between the intern and the registrar. Dr I suggests: "it makes a little bit difficult sometimes because, because you are so compliant."

Ward Round Video Scene 5: Junior doctor Responsibility

During the interviews, the consultants indicated that knowing about the role as a junior doctor and the limits of it are important. Dr N has experienced getting doctors to think about the decision-making process is fundamental to learning about being a junior doctor. It is important that decisions about admitting patients are made on the basis of experience and that doctors do not act beyond their level as a junior. Dr H, a consultant, he also emphasised the role that learning from the registrar plays in the process of being a junior doctor. When asked how he thought junior doctors learnt the important characteristics of being good residents, he

suggested that they learnt more from the registrar and nursing staff than from the consultant.

This scene is where the JHO hands the registrar charts which are a reinforcement of a particular type of relationship within the medical hierarchy. The JHO is fulfilling her role as the assistant in the medical ward round process by showing the registrar which patients need to he seen. She is also showing her registrar that she has the capability to organise the ward round so far, to allow him to make the more senior medical decisions. There is particularly close interaction between the JHO and the Registrar around charts.

Figure 10. Medical charts, junior doctor and registrar.

As the ward round is being organised and the order of patients to be seen are discussed, the JHO physically invokes the bodily plan or portrayal of an event to occur. That is, the JHO tells the registrar who needs to be seen today and he hands her a chart. She in turn also pulls out charts and is physically representing in which order 'bodies' are to be seen. This illustrates both the doctors' activity, which requires the JHO and registrar to transform the way in which they are engaged in the

interaction. He is emphasising her role as a junior carrying the charts and she emphasises her role to by letting him know who needs to be seen. Her success in encouraging the registrar to watch her organising performance thereby achieves the order of seeing patients and her role to carry the charts. The sequence and relevance of this interaction allow the doctors to respond to the learned context of what needs to be done for the ward round.

Much of the scenes discussed above highlight the ways that medical interaction on ward rounds are socially organised activities, where medical knowledge and behaviours surrounding medical activities are produced and reproduced as specific medical behaviours. Through ward round activity interns are witnesses to specific behaviours relevant to the situation as well as medical issues, but most importantly orientation to ward round behaviour as a doctor. Specific medical work activities, such as ward rounds, are not given much attention in the research literature on junior doctors or in the medical education literature. However, once looked at in terms of specific interactions based on organisation and orientation towards particular behaviours, it can be seen how medical work is enacted within an oral and behavioural culture.

Through the interactions of collegial talk on ward rounds, this allows for observation of the daily organization of medical work. Within ward rounds there are specific relationships based on position, which can be seen holistically as a Bourdieuian field of relationships. Within this field, there are particular hierarchies based on particular workplace capitals. The behaviours on ward rounds illustrate particular hierarchies of interaction which are the behaviours based on organisational seniority (registrar/consultant) and particular ways of behaving based on positions in a hierarchy and related cultural capital.

The interactions on ward rounds are complex. The junior doctors' dispositions as illustrated through these videos scenes, are linked to their behaviours on the ward round which are located firmly within a field of medical hierarchies. The video analysis contributes a position with which to view how medical work begins to develop particular ways of acting and inhabiting dispositions. Particular ways of behaving become embodied by the junior doctor such as: accepted or required formats of writing patient information in the chart and through specific roles and duties of the junior doctor on the ward round. Further, doctors are learning about certain ways of standing, talking and behaving around patients and other doctors, especially consultants because of protocols around medical hierarchy.

The description of these video scenes allow us to witness

- how the embodiment of particular dispositions are displayed within the medical hierarchies,
- mimicking of the consultant's stance,
- seriousness and ward round behaviours
- how seriousness becomes displayed 'appropriate',
- display of embodied relationships within the medically defined situations and the medical hierarchy.

In some instances, some of the scenes show almost an 'aping of behaviours' of elbows resting on hands, fingers over mouths and particular behaviours of seriousness. Once the doctors take leave of the patient and move into the hallway to discuss the patient further or write information in the chart, expressions change to a more explanatory, 'doctor to doctor' discussion where it is quite common for smiles, more relaxed postures or 'in jokes' to occur. The embodiment of particular behaviours through doctor to doctor mimicry is framed by relations within the medical hierarchy. These medically defined situations are where through particular dispositions, the habitus, manifests and is constituted.

This chapter has shown how through formalised and medical rituals (the ward round), junior doctors are privy to and begin to learn certain behavioural dispositions of the medical craft. The patient chart, junior doctors carrying patient charts, observation of registrar consultant hierarchy are all part of the Through observation of senior doctors, it is demonstrated to interns and JHOs particular and appropriate ways of behaving in medical practice. Further ward rounds:

- show how competence and experience is acquired by junior doctors,
- highlight particular medical practice,
- explore the link between medical practice and interactions between doctors
- demonstrate how junior doctors learn about being a doctor without specific clinical input
- learning through observation of medical practice and through the internalisation of appropriate dispositions and activities in the context of the ward round.

In the next chapter, I theorise the concept of medical habitus utilising the data analysed in the previous chapters.

CHAPTER 4

MEDICAL HABITUS

> I think it is the way it should be. In a sense, particularly you know, in a large institution, I don't think you can have, you can allow too much freedom for personal expression in a place where you are dealing with a public who have their own sort of perception of what to expect.
>
> Medical consultant, male.

This chapter introduces the concept of habitus, where we focus on a new conceptualisation of the professional developmental process: habitus medicus. Doctor's voices from the interviews are also used in this chapter to focus on medical habitus, as well as specific and unique aspects to becoming and being a junior doctor. What we have been asking is given our interest in early postgraduate experience of junior doctors, how do Bourdieu's theory of habitus, capitals and field could contribute to an understanding of the professional developmental experiences of junior doctors? In this chapter, we utilise an analysis of the medical training program, hierarchy, the junior doctor mould, playing the game, issues in medical practice (such as cynicism, dress) and reflections on being a junior doctor with the sociological concepts of Bourdieu. We will attempt to work with the interplays of habitus, capitals and field in the medical culture as indicated through the thematic analysis outlined earlier. I recognise that Bourdieu's theoretical work is generative rather than closed in character. Such a generative approach is also taken to the synoptic analysis provided here. The relational and dynamic character of Bourdieu's theoretical approach is also recognised, as is his attempt to eschew an either/or stance in relation to the structural determinism/voluntarism binary.

Categorising the dispositions starts with the structures of power in the hospital and how the organisational field connects with the habitus of junior doctors. This begins to develop unconscious, unacknowledged cultural capital and reinforces the stratified hospital structure and power bases within the medical field. Through the first two years of postgraduate medical training then, experience in one field become compatible with experiences of other doctors and this (re)confirms adherence to common professional, hospital and cultural rules. As Bourdieu (1992; 1991) emphasises, the privileged manipulate reality in accordance with their self-interest. This is especially the case in relation to restrictions on Provider numbers and the medical specialty colleges' limits on training positions (Commonwealth of Australia, 1998).

Providor numbers, in Australia is a heated political issue, which dates back to 1996, when an amendment to the Health Insurance Act was passed by Australian parliament which defined the (training) class of medical practitioners whose services could attract Medicare benefits. Medical practitioners require provider numbers so patients can claim from Medicare for professional services. The purpose of the amendment was to give a provider number to those doctors who have entered a recognised training program. One resident studying for surgery, explained "there are certain colleges, for instance Dermatology which are protecting their industry". This junior doctor is referring to the limited number of college training places. Therefore, the interests of a closed medical culture, as in limits on training positions, are in accord with those within the medical specialty. These limits yield the luxuries of their profession, which are implicated through practices and institutions. Within the medical institution then, the 'social' practices are reproduced by practices of 'forced conformity' within the medical field.

I emphasise that what junior doctors' bring to the cultural table, how their practice is restricted, defined and fostered is mediated by dispositions that have been internalised by the individual. Through their practice and junior doctor experiences they develop further the existing habitus and begin to transform it into a medical habitus. In making this assertion I want to emphasise that the concept of habitus involves a dynamic set of variables. The concept of habitus is linked in with the field and is conceived in relation to both field and capital, whilst also being a construction. The useful component to this concept is it allows us to look at social behaviour as being structured on the one hand and structuring on the other. The dispositions that allow the habitus to produce a change in the person and their social behaviour also become reasons for change. When structures within the field change, this is reflected in a changed habitus. I incorporate the voices of the junior doctors' now to clarify some of these points.

Many junior doctors discuss learning to 'play the game'. Here I suggest that junior doctors are learning to become best at 'the game' because they are most close to 'the game'. That is, they are in the medical culture learning about medical culture. Bourdieu (1990) suggests that adapting to new situations in the game gives a clearer perspective of the field based on the position and dispositions which mediate interactions in relation to the habitus. The notion of dispositions as component parts of the habitus, are expressed by junior doctors in terms of not necessarily automatic reactions to given situations, but in certain conditions which become more useful or developed. For instance, junior doctors at the beginning of the year would generally know that it was important to cater to the professional needs of the consultant. However, as junior doctors clarified their career intentions it became clear that other non-professional needs were catered to. These included: that certain consultants knew them well, liked them and that as juniors, they knew their place in the hierarchy. Therefore, through specific social contexts a further learned disposition developed. The development of these specific dispositions, such as compliance and obeying consultants become reinforced through particular social practices. These include, as one intern suggested, the importance of aligning one's interests with those of the superiors, socialising and making social connections with the right people.

Medical practice here is shaped throughout the junior doctor years. Medical practice inculcates junior doctors into learning about medical culture and how to interact with senior doctors. Senior doctors show junior doctors through medical practice, culture and activities, certain dispositions and even what a 'successful' habitus looks like. This includes watching consultants interacting with their patients, appropriate medical responsibility, maintaining a family life, and balancing home and work demands. A junior doctor commented that he had noticed that his registrar has picked up certain physical characteristics from his consultant (from when he was a junior doctor). This JHO found that he had done the same (including picking up the walk and dress style). This made him consider how adoption of these characteristics is passed on and transferred professionally into the current learning and medical practice situations. In an unconscious way for junior doctors then, they begin to assemble those characteristics. It is easier for junior doctors to just adopt a conservative persona, or as a consultant suggests, there is and should be a certain dress style and image as far as hair, clothes and earings, which, in the above instances, seem to have been imparted through three 'generations' of doctors.

As the habitus becomes embodied, junior doctors begin to not only talk about the features of the first two years of medical training, but also wait to perform within it. Often by the end of their first year, they have advice to involve the next set of doctors below them on how to survive by playing the game. Habitus allows junior doctors to act in the field with a certain non-awareness, which is produced by experience in the field. For instance, starting outside the mould, yet soon enough doctors began to understand the 'undercurrents' of the medical culture. Moreover, junior doctors began to understand that consultants are powerful people who will have influence over careers, access to training programs and positions. That is, once a doctor is on a postgraduate training program, they are 'protected' and it is almost like the Mafia, as one JHO commented. Junior doctors are never being told directly about these cultural aspects; rather it is through interacting and working with people in the medical workplace that allows for informal learning through a hidden curriculum.

Observation and interviews with junior doctors have revealed a certain social structure. Using the habitus to interpret the institution in relation to individual contributions draws attention to the fields that constitute the habitus. For instance, on ward rounds there is a strict hierarchy of behaviour in relation to examination of the patient, reporting of results, writing or holding the medical chart and interaction with nursing staff. Medical hierarchy structures how junior doctors interact learn how to cooperate and work together on ward rounds. It is through these sorts of practices junior doctors' habitus begins to be seen as an embodiment of social structures and of the medical culture. By experiencing the medical life through the workplace, junior doctors are participating in the game that they aspire to play more fully in the future. In this sense, I describe junior doctors as having or seeking to attain a certain medical habitus, which they are also implicitly learning.

Acquisition of habitus still depends on the structure of the field in relation to capital. For many junior doctors the struggle to enhance their cultural capital is through the development of appropriate dispositions and social networks which will be useful in terms of their reputation (being known by the right consultants) and also

on practical levels (such as getting prestigious terms). Analysis of practice, as suggested by Bourdieu, is one, which is not wholly or consciously organised. Practice is formed in the context of the habitus, which serves to reproduce existing social structures. This leads us to think about things or classifying the social world and one's location within it as natural. For instance, as one registrar suggests, if a junior doctor is not interested in becoming a surgeon they are not likely to be taught in more detail than necessary about surgical techniques or anatomy.

It is 'natural' to assume that only those who are interested in entering the surgical discipline be taught in more detail about anatomy. It does not take into consideration a doctor who enters a surgical term not knowing her/his special interest and is working in surgery to see whether they want to become a surgeon. The field is structured as 'natural' here because it meets the interests and needs of the more powerful main players (the registrar or consultant), which according to Bourdieu (1990) is best accomplished through reasoning toward 'truths'. If junior doctors have not yet indicated their pre-existing interest, they are less likely to be taught in more detail and let into the habitus domain of surgery and surgeons.

Habitus is a way of conceptualising determinants of practice in people, groups and organisations. For instance, doctors working in a hospital through the legitimacy of a medical degree, which upon graduation allow doctors to write prescriptions, is capital that is deemed to be of value simply through acknowledgment and legitimacy of those forms of capital in a particular field. However, medical students without the legitimacy of a degree to write a prescription, can only watch the capital laden 'legitimate' doctor write prescriptions. Cultural, economic or social capital are therefore embodied and dependent on characteristics which are results of an interplay between objective social structures and subjective socialisation processes (Luke, 1990). Here the social structure is interplayed within the hospital in terms of medical professional development from medical student to junior doctor which holds with it cultural capital being reinforced through the valued characteristics. The next figure 11 introduces diagrammatically the habitus.

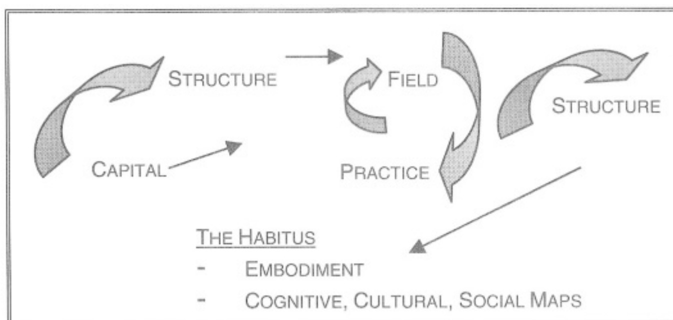

Figure 11. Field - practice - habitus processes.

Figure 11 above, illustrates that structure frames the habitus, yet brings the human body back into sociological focus (Krais, 1996). In a flowing process of activity, this figure 11 illustrates how beginning with capital and through structure, there are fields that engage certain practices which interact with the field and flow to the habitus. Capital and structure also contribute directly to the field. As a starting point this is a very basic description of the process of the Bourdieuian concepts that lead to the habitus. It is meant to illustrate the major concepts and point towards the ultimate conceptualisation of professional development: medical habitus. I build upon this figure 11 throughout this chapter.

Many studies in medicine have looked at dress and attitudes (McKinstry & Wang, 1991; Menahem & Shvartzman, 1998). More recently, research has demonstrated the views of junior and senior doctors on what they considered appropriate dress and address (eg. Ms, Mr, Dr, Sir) were different (Gledhill, Warner, & King, 1997). There is a crucial principle at work, one of reproduction and generative action. In this research junior doctors often suggested that they began to adopt a certain persona which was transmitted to their colleagues and patients physically through their dress sense or stance when addressing patients or colleagues. Junior doctors in the emergency department for example, have a more casual dress code as opposed to many of the surgical wards. Dress and style then, can be one of the most powerful forms of non-verbal communication, which carry valuable symbolic information about a person (Rafaeli & Pratt, 1993). Further images of wearing the traditional white coat has been found to facilitate role recognition and the establishment of boundaries similar to wearing name badges. Here we can see how the body is a source of cultural production, a standing, speaking, feeling and thinking social subject (Bourdieu, 1993). Thus, the way one is dressed and they way others perceive the style is important for cultural meaning.

I acknowledge that the body is a site of significant social markings, which can be seen as a product of careful maintenance and refinement which has been favoured by particular practices (eg. Fox, 1998). Aspects of the embodiment aim of habitus, such as dress, behaviour and deportment are important, but the habitus is also acted out within a social field and expressed through predispositions (Luke, 1998). This enables the concept of capital to link to habitus within a social field. The individual social agent is never really independent, but always a product of the societal rules, symbols and world around them. The process of professional development of junior doctors then, reproduces over time the internalisation of cultural goods that have value, which in turn enables junior doctors to negotiate rules and gain capital (here capital is a social resource) within the medical field.

Bourdieu (1993; 1998) perceives society as a social field saturated with variable field positions created by the distribution of cultural capital and other symbolic resources. I see junior doctors arriving into the field of the hospital with specific cultural capitals (eg, educational qualifications) and as time develops, there is struggle with the hierarchy that is specifically arranged within the structural field (hospital) and between field positions (senior doctors). These field positions are negotiated and formed in relation to other positions within the field. It is here that habitus enables specific orientations and strategies that work within the social field. In the hierarchical, highly structured hospital each doctor begins, through their

habitus, invisible relationships of negotiation to achieve more status or cultural capital. This generates and reproduces the social practices within hospital. Here in this field, "in accordance with its particular laws, there accumulates a particular form of capital and where relations of force of a particular type are exerted" (Bourdieu, 1993a, p. 163-164). Therefore, as time goes on in the life as a junior doctor, variable experiences from working in specific fields occur; this indicates that the habitus of junior doctors may be strategic in the way that it develops, is demonstrated or acted upon. Some junior doctors alter or break the traditional rules of the field and then alter the habitus. This contributes to similar practices and representations where they are likely to find their dispositions in agreement (Hamel, 1998).

Aspects to each habitus in a field are likely to be very individual. However, it is my assertion here that habitus connects with medical practice in the field. The habitus must differentiate itself to have cultural capital and be valuable in differing fields. Are the forms of junior doctor habitus structured similarly? I suggest that junior doctors are not engaging one habitus at a time with fixed and specific rules of that habitus, but what is happening is that all doctors are enacting habitus (unconsciously and consciously) all the time, shuffling between fields. One particular appropriate example is that of a JHO who was working in a training term which traditionally is perceived as prestigious and a very important term to 'get your name known' by the senior consultants. This doctor already had a place on the training program that he wanted, as a result he did not feel the pressure as much to impress these consultants.

In line with what I'm suggesting above about shuffling between fields, it was still important for this junior doctor that he did not demonstrate, or appear to think that he was 'above doing a resident's job'. In this context, it was imperative that he still 'knew his place'. This he demonstrated by continuing to work the excessive hours (much to his partner's dismay) and not claiming the extra hours staying back after his shift completing paperwork (very common activity to show commitment to medicine or not wanting to show lack of efficiency with paperwork). Most importantly, this JHO fell in line with what he thought the seniors would expect of him based on his field position and not his cultural capital or recently altered medical habitus.

In figure 12 next, the medical focus is drawn on into and highlighted to conceptualise structure, the medical culture and the characteristics, linking to the field to describe more about the habitus.

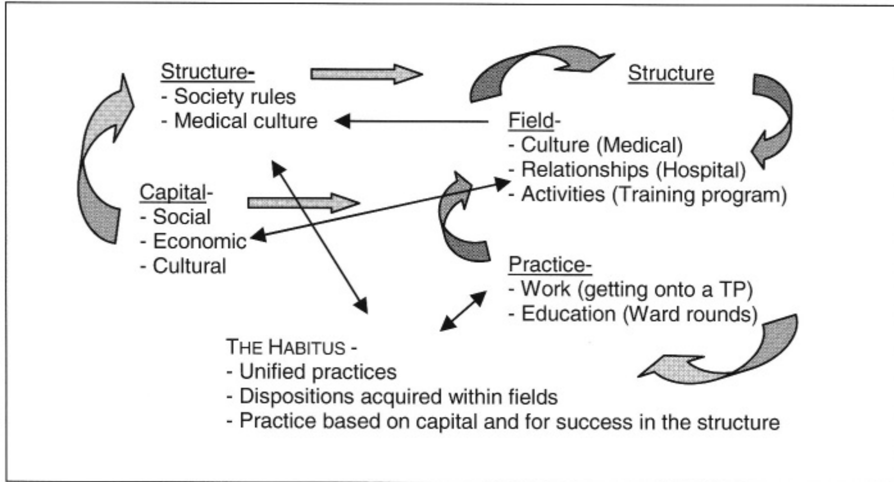

Figure 12. Medicine and the structure - field - practice links.

This figure 12 above is a graphic representation of cognitive, cultural and embodiment maps in terms of how the processes of medical practice and field interact, and are mediated by activities such as relationships in the various fields. Even though there is a direct and strong 'flow' indicated by the large arrows, the thin line arrows also demonstrate how individual elements can affect directly many of the processes. These fields may include relationships or cultural activities. Of interest here is how this contributes to a specific strategy that agents are likely to enact. Additionally, aspects that are brought to situations, specific types of capital which contribute to an adaptation or enactment of various types of habituses are involved through this figure of the relationship to habitus. I extend this previous point and suggest that by the end of two years of junior doctor practice a process of change is occurring. Junior doctor professional development processes have been at work in the medical fields altering or building upon the original habitus.

Previous research on junior doctors indicates that the first two years are indeed stressful and unlike any other medical experience doctors will face in their career. It also shows that there are vast differences in training and quality of training, as well as ideas as to how to view the medical training process. The professional socialisation literature on junior doctors suggests that internalising the role from medical school is valuable. However, as I have discussed previously it leaves many other factors unexplained such as specific characteristics, behaviours and attitudes that junior doctors bring with them to the hospital and the medical culture.

The language of knowledge and learning to play the game is key for medical culture. Habitus functions in relation to the social field. Within the field are particular structures, which allow for competition for places. This is often referred to as a 'game' by Bourdieu (1992). Doctors attempt to reproduce, transform various capitals and compete for places within the fields. By the end of his second year, Dr

B, for example, suggests "you do your best to play the game properly". Many aspects of medical practices emerge from interactions of the habitus within the field. Junior doctors' dispositions and the structures through which they engage the social world are mediated by the internalisation of the habitus. After eleven months of one doctor's internship, she also emphasised that "you learn how to play the game". Thus, the habitus is not only a system of production of certain practices, but also a system of perception and appreciation of those practices. Through the habitus, particular strategies are expressed in light of the social positions in which they are developed. For one intern, he thought he knew "how to play the game, but, getting towards the end of this year, I'm not too sure". The production of certain social practices and appreciation of the doctor's position are in relation to where they think they should be in the field.

The habitus here, is a "sense of one's place and a sense of the others place" (Bourdieu, 1990, p. 131). The 'game' as both Bourdieu and the doctors here describe it, is both a construct and reality of which the doctors are aware, which contains rules and even begins to form a particular set of conditions between doctors in the medical field. On her first day of internship for instance, Dr J's registrar informed her 'how to survive'. This included advice about keeping a conservative mould, 'sucking up', and being conscious of 'sucking up', which she (the intern) suggests was the part of the game that he (the registrar) decided to play. The social practices in terms of either 'sucking up' or 'the game he has decided to play' are reproduction of practices through the field and mediated by the habitus. This allows for reproduction of certain practices and even production of certain cultural markers in the junior doctor medical culture. The game played by the doctors is about control of a situation or knowledge of how to work within the requirements of the field.

Experience and practice are focussed around requirements of working and advice from other doctors. Being a doctor is more than playing a role, the aspects learned are not conscious or always within the will of what being a junior doctor means. The junior doctor embodies much of the socio-historical conditions in which dispositions of becoming a junior doctor were created. The change in many of the natural or automatic dispositions or positions is further illustrated by Dr B who suggests that other doctors have played the game particularly well. The habitus becomes a way of organising and perceiving practice. This JHO's interpretation of good game playing, is in reference to a doctor that went against some medical cultural rules, such as claiming to be interested in a particular speciality and yet keeping options open for another specialty. This doctor got to work in and was allotted 'good' terms. Noting this situation, Dr B appreciates and remarks that "he played the game very well".

The dispositions that work most appropriately within the field, as well as the cultural attitudes and actions, become relevant to the doctor's position within the field. These become embodied which are an important strategy for the habitus to work within. Habitus as cultural knowledge (Chan, 1996) is where junior doctors are learning to play the game and from the game, begin to get a sense of control over what is required of them in these fields. They begin to make moves that are most

appropriate and thus, cultural change is possible through change in either the field, the habitus or both.

This takes us to look at how dressing like a doctor, the professional dress sense brings habitus as a rather unifying force in its action. It brings together cultural knowledge, action in the field and internalisation of specific strategies. However, this does vary depending on what knowledge or information is made available or given to the doctor in the field. For instance, appropriate dress was initially brought to Dr D's attention by a "very powerful surgeon" when he was a fourth year medical student and he did not have his white ward coat. Dr D explains that this surgeon gave the medical students a very hard time (for not wearing their coats), and that the consultant did not know that the students did not have any instructions about what to wear on the first day. The surgeon was distributing information on aspects of distinction that makes up the medical habitus: wearing of the white coat on the wards as a medical student. The value associated with particular behaviours and external markers are the product of particular habituses, yet do not need to be of equal value.

The principles of classification in, for example, medical dress comprise the structural relations transferred into particular social existences through the distribution of particular categories that have symbolic classificatory rules. Six weeks into the internship doctors are noticing "certain pattern in the way guys' dress, a certain colour, blue shirts or white shirts or dark blue pants or dull colour pants". The social practices surrounding these symbolic classifications either are reproduced or transform the field in which junior doctors are either a part of consciously or unconsciously. For one doctor, when asked about a particularly bright yellow shirt he wore, he suggested that he knew there was a certain trend that he tried to fit in, so in regard to his bright shirt, "I try not to wear that too many times". As a player in this game, the intern accepts some particular rules, he decides whether or when to accept the conditions of the game. The experiences are transforming the habitus in preparation for how interns are going to dress for particular social situations and to make plans in the sense of dress. The field structures the habitus (Bourdieu & Wacquant, 1992) and thus, the processes of habitus likewise change.

Habitus changes as the social structure changes and these in turn alter in response to practices produced by the habitus. By inhabiting social situations, which we all do at various points during the day, the characteristics of those situations are difficult to separate our own involvement within them. Further, particular order or rules of practice are effected by doctors themselves working within the social and by their own perceptions of where they are within the social order. This brings us to the conception of hierarchy. This field of hierarchical forces acts upon doctors to confront each other to either contribute, protect or modify particular structures at stake.

The medical hierarchy affects how junior doctors work. It controls dress, use of formal titles of superiors, as well as the ability to make comments about medical issues, ownership and responsibility over patients, experience and maturity 'in medical terms'. The process of on the job learning forces junior doctors to become orientated to the needs of consultants and patients in the field, which become

reflected subconsciously and are reflected as an internal classification system. Dr J at the beginning of her internship, found that she just had to "actually get nasty and get hierarchical to get any respect". The internalisation of the needs of the field here drives the need for power and transforms the habitus for the field. For this intern, she found that she had to 'switch back and start to act like the other doctors' and she conceptualised this as the 'game [they] wanted to play'.

However, she could not understand why they had to be treated like this and, although she was not happy operating like this, she discovered that it was the habitus that was expected by the field and was the only possibility in that situation. Here the hope was that she would not have to 'act like other doctors', but in time found that tension surfaced when she was 'just so nice to people' she had problems getting respect. After twelve months of being a doctor, Dr V found that consultants and registrars practiced within the hierarchy on the basis, that "they will judge you on how well you fit with what they expect of you". The importance of the medical hierarchy cannot be underestimated.

Within the medical field there is a hospital hierarchy beginning with medical students through to the most senior doctors, the registrar and consultants. However, within the standard hospital hierarchy there is also a hierarchy surrounding medical specialties, depending on which hospital one is at. As a junior doctor if you want to be a paediatrician, for instance, and the hospital is primarily one which trains surgeons, this may not have the same status within that hospital's fields of medicine or in the context of this hospital's particular specialties. For junior doctors, when they begin the process of clarifying their career intentions on their own, or by listing preferences for five medical specialty terms (wards to work in) a year, it is in the context of what they know to be more 'prestigious' specialties within the context of their hospital's medical fields. They may be interested in general medicine or general surgery. However, by choosing terms which are primarily for physician training or surgical training doctors may be restricting or maximising their future career options. That is because they are labelling themselves as interested in becoming a 'physician' as opposed to a 'surgeon' based on the type of hospital they are training in, the terms they chose, and the terms that they have worked in.

As junior doctors begin to conceptualise this link between work practice, political meanings and cultural influences, they may begin to play both fields by suggesting to their seniors, medical administration and even friends that they don't know which sort of discipline they want to go into. However, as time and competition become more important, the terms that doctors put as year long preferences and the ones they get allocated often indicate which sort of disciplines they are leaning towards. For instance, if the junior doctor selects transplant surgery (which is one of the more popular terms for surgical experience), as opposed to Gastroenterology (which is more popular for medical experience), the senior consultants who play a key role in training program selection and guidance will be able to see the directions that that junior doctor is heading in. Furthermore, when the junior doctor knows the more prestigious and competitive branches of medicine along with the related senior doctors, they are working with the hierarchy of specialities within the hospital and medical field through the process of clarifying a career specialty.

Understanding the field and beginning to get a feel for the game, imply that the habitus has a transformative capacity. In a sense then, the power of the habitus is seen to transform from conflict (even competition) in the field. The capacity of the habitus is dependent on the field that the agents are in, as well as particular conditions of fulfilment (May, 1996). By the end of nearly two years being a junior doctor, Dr V learned that "you just have to toe the line with consultants" which has become part of his structured and structuring habitus. As such, junior doctors learn the practices of the group that they are a part of to transcend the limits that many originally experience (such as not being able to get an xray done). Some doctors are able to get investigations or procedures done quickly for patients now, because they have learned 'to manipulate people'. The habitus has become a way of organising the world or one which is organised by the habitus.

The limits of the habitus and the dispositions are controlled by social position. When some interns start they often feel intimated by senior doctors and see them as power brokers. The sense of reality that junior doctors become aware of is conditioned by their social position. Dr D at the end of his internship "understands that not everything is just as nice" as he thought initially, and that people "get jaded as they move up the ladder". This awareness is a reminder for junior doctors of the distance between social positions and what is involved in getting to those positions. The place of these junior doctors in the social order is acquired through workplace practices and continues to structure the beliefs and practices of being a doctor. The habitus is an 'in-process' product of interactions with other doctors in the field. In reflecting on her earlier ward rounds, Dr J says that she "didn't know what my function was...where my niche was". However, eleven months later, she can "add a little more of my own personal style of medicine into it now"; the notion of the habitus has accounted for some coming together of her style and practice. The dispositions are tuned into the structure of the field and the individual is experiencing and internalising many of the ideas, practices and objects within that field (Sayer, 1999).

The knowledge or truth that junior doctors have or believe in is, in many aspects, related to their interests and position of being a knower in relation to their current and previous contexts. In the medical culture there is a certain sense of being one with the crowd of colleagues in terms of a 'common denominator' where doctors don't have to do a lot of explaining to others (non medical people) about what they do. The social interaction that occurs in the medical field over the years, transforms the professional oneness that Dr J experienced eleven months earlier. Now she feels that she can be 'trapped' by the medical culture and she just wants "to be herself". The medical habitus here implies a sense of Dr J's place within her medical culture and in relation to her colleagues, but she can also see her place as distinct from the culture and therefore, sees the place of others. This takes us to the concept and experience of cynicism in junior doctor medical culture.

I am inclined at this point to suggest that many of the junior doctors' attitudes based on their experiences can in fact be conceptualised as sociology of (social) practice developing from the meeting of medical habitus and field. Cynicism is in many ways a part of the medical habitus. It is a characteristic which is expected to develop at some point in the early medical experience. At the same time, it is quite

distressing to know that young doctors are experiencing and working with these negative feelings. For some doctors, they are aware before they enter their internship that cynicism develops with other more senior doctors, but they are not in the relevant environment or able to understand how it develops. Becoming cynical about the system and patients as well, becomes more of a reality once interns begin to interact with the hospital.

Through the junior doctor training years, through occupation of the same position, doctors are essentially in very similar circumstances. They are subjected to the same experiences and "have every chance of having similar dispositions and interests, and thus of producing practices that are themselves similar" (Bourdieu, 1989b, p. 17). Patients being ignorant of their own health, not taking responsibility for their well being and being demanding from the health care system for medically trivial issues, increases the sense of cynicism. In terms of having similar dispositions, Dr J can foresee that her cynicism is going to come from the senior doctors, she is likely to become more like them, yet she is also attempting to protect herself against this by retaining "as much of myself as I can". This justification for becoming cynical is mirrored by Dr B, who after twelve months of working as an intern, suggests that there are things that he cannot change and his frustration comes from "the idealism of youth [but] you get that beaten out of you". Dr B recalls seeing a JHO (when he was an intern), being cynical who suggested that Dr B would be the same one day, he made the vow that he would not become that way. Now, he sees it as a long process and when you "scratch the surface, I do feel that same way".

When looking at these situations or internalisation of attitudes, we see it through the eyes of the dominated. The junior doctors come to perceive becoming cynical as 'natural' in the environment as a result of the conditions within which they work. It is not necessarily a desired characteristic, but one which is accepted because they have a model from their seniors' experiences. How doctors cope with the 'hassles' of patients, the system and the demands on them is all based on their realms of power or powerlessness. Doctors are sharing the feel for the game of medical practice. This requires particular social situations to enact the conditions which structure the habitus. For instance, Dr B slammed the phone down, expressed verbally his frustration and one of his colleagues laughed and commented that he was "learning, you're learning real fast".

Junior doctors are deciding in light of the conditions of the field and the habitus, whether it is worth investing themselves medically and psychologically in their working lives. For Dr P, he feels that cynicism "detracts from your ability to care for people", yet Dr V suggests that "there is nothing you can do to change it, so you just live with it". The social reality that Bourdieu talks about is evident here, as it exists in "things and in minds, in fields and in habitus, outside and inside agents" (Bourdieu & Wacquant, 1992, p. 127). Becoming what you are working is a result of "power and control from the powers that be". In this situation, the habitus is being conditioned through the place of embodiment, that is the behaviours, attitudes and medical practices in light of becoming cynical and powerless. When a patient comes into the Emergency Department, many become more "more perceptive … whether it's a serious case" and as junior doctors are not "taken in as much …

[compared to] the start of the year". One junior doctor felt that his colleagues are caught up in the structure of where they are working and are "getting too absorbed in the medical culture".

The medical habitus as a set of acquired dispositions over time, in certain or specific fields acts as a mechanism that generates practice and thus represents the field as meaningful. For Dr P, he is not giving the field any 'cynical' meaning based on the negative experiences. He sees that it is the social field that affects this particular way of being, or habitus. However, in fact, the reproduction of the habitus is working in unique ways for each individual through concealing the "social function by accrediting the illusion of its absolute autonomy" (Bourdieu & Passeron, 1990, p. 191).

Junior doctors have a false sense of autonomy from the structures which they are rooted in. The medical habitus becomes representative of the junior doctors' position within the social structures, the ward, the medical team, the class of junior doctors, the hospital and even the medical culture as a whole. The activities that make up the role and responsibilities of being a junior doctor are both reproduced and considered based on social interactions within the current existing structure. Doing copies of paperwork in quadruplicate, appearing to know your place while completing hours of paperwork "just [to] show them that you are interested in what you are doing" are key skills learned in the medical field. Regardless of the feelings about the horrendous paperwork, being a pen pusher, and 'glorified clerk', management of these demands are key to being seen in the right way and learning what is appropriate for either career advancement or socially.

Junior doctors are defined by their activities and relative position to each other in the medical practices within the field. The hospital as a site of social practices and learnt dispositions affects individual's medical habitus directly by giving them a set of practices and attitudes. The habitus is structured by the social order, structures the way junior doctors work within the field and defines the possible means of action. In the context of medical culture, the responses to the outside forces by the habitus (through the doctor) affect the way dispositions are internalised. Learning about being a doctor through the experiences within the hospital is quite confronting for many interns and JHOs. Medicine is like a trauma "you just allow it to beat you around, isolate you, stress you, [and] give you nervous breakdown...it is just horrible". The space in which the habitus works to internalise certain dispositions is mediated in the medical structure by many of the daily experiences of medical stress and practices. The habitus fulfils a specific function in these contexts; it socialises the body to incorporate the arrangements that are acting within it.

The impact on social lives results in relationship breakdown, reinforcement of those relationships within the medical culture and doctors becoming very resentful at the hours that the job takes up away from their outside interests or even life basics such as food shopping or laundry. Life activities which are "gradually being eroded away" as the job encroaches upon interests outside of medicine, creates significant stress for junior doctors, while also altering the habitus. That is, particular aspects to that field are confronting to junior doctors; the perception of the medical structure as well as the associated actions within it are internalised and transform the habitus. These transformative strategies of the habitus are important in coordinating and

perpetuating the specific aspects and tactics of domination while reproducing the structures of the field.

BECOMING SOMEBODY: GROWING UP A JUNIOR DOCTOR

Wanting to be 'somebody' is a significant developmental aspect to becoming a doctor. The habitus almost cultivates the intern or JHO into being somebody in the medical context. For many doctors it is important to be able to say "I've got a position in society, I can actually do something". Consequently, workplace strategies through the action of the habitus create particular action through socialising, learning and expressing opinions. Within the medical fields these are responded to in particular ways. For one JHO he felt after six years of medical school "I'm a somebody, I'm a somebody". Then he came to this hospital and "you're the bottom rung of the ladder again, and you're still a nobody". The way in which capital is allocated to him will depend on how he expresses his educational and medical cultural inclinations. In addition, how he accumulates his capital on his own or through his habitus will be important. Given that he wants 'to be somebody', he has decided to negotiate his position in the medical culture. Cultural capital which drives this course of action, is achieved through moving into the appropriate field of medical culture with particular social ease, command of appropriate behaviours and attitudes. This will bring him specific cultural advantages (Sayer, 1999) and may even assist him in becoming somebody or what he will think at that point is 'somebody'.

After being a junior doctor for just under two years, some doctors acknowledge that learning to be a doctor cannot be a passive process and some have learned about "the little turf wars, the little power struggles...[how] everyone is fighting for that bit of pie" and "how fractioned medicine really is". Junior doctors, as "even the most traditional peasant plays the game of life like the stock market" (Alexander, 1995, p. 150). Learning to play the game is a survival tactic. Confidence is the most common characteristic that junior doctors report they gained by the end of their first and second years. For junior doctors the critical awareness of the medical culture's construction of knowledge and how their own awareness is influenced, produces knowledge that is separate from the conventions of the medical institution and more likely to reveal specific truths about that culture. Knowledge of the expectations of maturity, practice and becoming 'streamlined' characterise the main reflections of junior doctors on their last twelve months of hospital experience.

As players in the game, junior doctors have struggled over the hierarchies and limits of their jobs and boundaries within which they work. Relationships within the field are driven and influenced by the habitus for each doctor individually, as well as a group or team of players in the game. For many junior doctors, they wanted to become more confident and understand what their job was, and have tools with which to deal with their practice issues (ie. get more cultural capital). Others even wanted to transform the game and some of the rules that they were playing by. Representative of these rules, Dr J suggests that in many ways, her emphasis has shifted and relaxed somewhat from the start of the year where she was "very

obsessed with pleasing people above me" which she suggests is still important if she wants to go anywhere career wise. The cultural capital that is gained, or worked to be gained through medical practice, structures much of junior doctor work and knowledge surrounding what they do.

The junior doctors who have been the focus here have demonstrated a particular level of development across the time of this study. They have moved from being medical students with medical knowledge to being medical practitioners practising medicine. In a sense, this has been a study of the emergent medical habitus, manifest in bodily inscriptions, and the cognitive and cultural maps these junior medical doctors now work with. Their time with the medical field or adjoining fields of a large teaching hospital has inscribed in them a particular medical habitus which allows them to practice medicine. Their position at the bottom of the hierarchy within the medical field to a considerable extent also inhibits their capacities to resist.

Bourdieu is interested in how the social is inscribed in the individual to produce a particular habitus. Much of his work is spent resisting psychological ways of describing human behaviour and practice. In Bourdieu's early work such as *"Reproduction"* (Bourdieu & Passeron, 1990), much of his perspective is structurally determinist. However, in his subsequent work he tries to walk a fine line between structural determinism and individual agency. While the primary habitus is mapped onto the individual through the family, subsequent participation and positioning within particular fields provoke an emergent habitus built upon the primary habitus.

The large teaching hospital in the research reported here is an important aspect of the medical field which has shown how the experience of junior doctors at the bottom of the structured hospital hierarchy all its incessant pressures and demands produces very quickly the required medical habitus. The junior doctors thus move from studying medicine (at an undergraduate student level) to practicing medicine at a fully qualified medical practitioner level. The focus here is on the fields that doctors move through. As I will discuss shortly, the habitus is an individualised aspect of the collective social activities.

Within medical culture as a whole, junior doctors are showing a particular watermark of professional development in medicine. That is, doctors come into medicine from university with particular capitals (social, cultural and scholastic) and use these to engage the habitus. Capital has been discussed previously as a metaphor to allow us to analyse social life. Throughout the cultural field of medicine, we can see how capital converts and engages the habitus of doctors during the first two years of postgraduate training. This, it is suggested here, alters the original (primarily from family and their social/structural location) habitus to become a medical habitus.

CAPITAL(S) AND FIELD IN POSTGRADUATE MEDICINE

The character of Bourdieu's work has, in many ways, been a broad sociological approach with resistance to any psychological reductionism. He has focussed on the social, the self and structure. With individuals working within the structure of the hospital then, practice is based around relationships that also surround medicine as its own social practice with its own logics. Medicine on the whole, is about scientific knowledge and implementing that knowledge into practice. Through the concept and use of capital this allows us to see a 'conversion' in terms of the rate of knowledge that junior doctors' implement and practice with. Reflecting an analysis that takes in the concept of field and the conversion of capitals, it is important to consider the medical field as a whole.

A part of the medical field includes the hospital, the medical organisation, training colleges and also specific medical aspects to the whole medical field (patient care and daily tasks). For junior doctors working in the medical field there is a strong sense of an overwhelming workload, with time pressures based on patient needs. This is also a medical 'system' under pressure, which requires of junior doctors the ability to negotiate their way through, in and around the requirements of the field. These junior doctors can be located in a number of adjoining fields. The medical arena is a field in the Bourdieuian sense, that is, a "structural social space, a field of forces, a force field" (Bourdieu, 1996, p. 40). Further, there may be adjoining fields that doctors navigate within.

Doctors are located within or around many different fields at different stages of their training. Although there are key points of developmental transition such as very early in internship (within the first six weeks), and at the end of their first term (ten to twelve weeks), I suggest that these points of time are a part of the whole medical field. I acknowledge, however, that in other areas of the junior doctor's life there are also fields (linked to capital) such as: the intellectual, cultural and academic field. Thus I consider the medical field on the whole to consist of unique aspects that interact to define the medical field. There is also probably a way in which there is a 'medical capital', consisting of other forms of capital.

As a result, there are different levels and factors involved with the struggle for position or power in the medical field during internship, as opposed to second year or within the whole medical culture. For instance, as a second year junior doctor, based on the training program during that time, and the cultural knowledge that the junior doctor already has acquired, this will change the nature of the medical field that they are negotiating and navigating within. There are then, particular aspects to the medical field that surround interns and second year doctors. In the interviews with the junior doctors, for example, knowledge of how to manage patients and who was important in the hierarchy came across quite clearly as an aspect which influenced trying to get on to a training program of choice. Trying to get on a training program could also be seen as enabling the social networks which form one important component of social capital. These are aspects that within the medical field create a context, which in turn not only defines the medical field, but also how

doctors have to and are likely going to practice based on that cultural knowledge. It is that situation which Bourdieu's theorisation helps us to understand.

It is very difficult not to mention or link to habitus when discussing the medical field. This is because the field and habitus are linked and interdependent and as field changes so does the habitus. This questions the concept of habitus as intentional or not. I suggest that habitus, as in much of Bourdieu's writing, both conscious and unconscious. However, it needs to be noted that habitus is far more sophisticated than socialisation. The criticisms of socialisation have been noted in previously, but foremost, doctors are not just receiving the values of the profession, but experiencing, changing and altering many of the characteristics of the medical field. For Bourdieu the field, the habitus, capital in their relationships allow a move beyond an 'oversocialised' and functionalist view of the individual/social relationship.

The medical field and the habitus link to a continuous process throughout junior doctor training and on the whole, the medical field experiences. Further, as one of the doctors in the study discussed, the 'system' of surgery (in terms of it being a medical specialty), was very difficult to change and it was important to know where as junior doctors they stood. A steep and structured hierarchy is a significant cultural element of the medical field. This is an aspect to the medical field that defines how junior doctors begin to navigate their way through the relations of power and by vying for positions, how the medical field controls their training process and begins quickly to map onto them a medical habitus.

The medical field is best conceptualised as a large field cloaked in aspects of the medical culture and the specifics, as opposed to a larger field with subfields relating to the medical organisation of the hospital. The medical field on the whole, allows us to examine the cultural relationships with nursing or other allied health care workers, which are important, but for this research the focus is on junior doctors in the medical culture. While I acknowledge a wider hospital culture, here the medical field in terms of 'medicine' and the culture are seen to permeate the field primarily. However, there is clearly a 'large organisation effect' on the experiences of the junior doctors in which the organisational and medical are closely intertwined.

The medical organisation of early postgraduate training for instance shows us how using Bourdieu in a generative way, simple aspects to the culture produce a vast array of action. The negotiation of getting onto a training program in the data, shows the processes whereby junior doctors navigate in the medical field, using capitals and the habitus, to get onto a training program. The medical field engages a set of interactions that are required to move from generalist training to specialty training. That is, once junior doctors clarify the medical specialty that they wish to pursue, a new set of relationships, issues and knowledges in the medical field are required, thus new social capitals are acquired. The medical field faces and surrounds the doctor and the particular specialty in different ways.

While it might be easy to see the medical field in a psychological manner, it is also highly problematic. This is because the field is a set of interactions involving constant negotiation around vying for positions of power and prestige. However, it does not work alone – it works through the habitus. This is important because it keeps the social as a part of a social network of collective forces and does not reduce

behaviour simply to individual traits. A key aspect to this is the experience and effect of medical hierarchy.

As noted earlier in this chapter, one of the JHOs in the study wanted to gain a position in society, and become somebody. He identified that as a junior doctor, not on a training program and at the bottom of the medical ladder, he was a ‘nobody’. This strongly reinforces the notion of how powerful the medical hierarchy is and how it locates doctors in the field based on their particular capitals. Junior doctors find that through the medical and organisational hierarchy they struggle within the field, yet are trying to put forward their most favourable dispositions into the profession to guarantee a future. It is here that the medical field can help when the doctors become conflicted by structural relationships. That is structure is put into relationships, which act as a market to establish values and normative ways of behaving. The medical field as a site for negotiation creates a logic, a way of acting that almost organises the doctors in a particular way.

The data from the interviews with the doctors in this book tells us that the forces in the field then, are about hierarchy, which is conservative, focuses on control and power over the junior doctors and that junior doctors have to learn how to play the game within the medical field. Aspects such as competition and ambition to get onto the training program are significant for training, as is having knowledge about and working within the medical hierarchy. The medical market, which is defined by its strict medical hierarchy, initiates junior doctors at a very steep level. For the interns after six weeks of medical practice, they come into contact with regimes of practice that seem almost unbreakable and certainly cannot be changed at a junior level. One of the forces in the field is this concept of the medical mould. A typical cut out of what a junior doctor is – in a sense a medical habitus. Here the body is actually disciplined and inscribed to behave and to practice based on the medical cultural way. For instance, one of the interns felt that he had to learn or appear to know more about cricket and rugby to fit in with what he thought the medical field, mould and knowledge requirements were, also indicating the masculinist character of surgery with the medical field.

The social arena within the medical field, then, intensifies the process for junior doctors to very quickly (even within the first six weeks) build aspects to the habitus. The strategy of the habitus as both intentional and unconscious is to ‘fast track’ the doctors to the ‘right habitus’, the ‘required habitus’, what I call here a medical habitus. It is at this point that we see that field mediates medical cultural consumption as an intentional and structured system of social positions. The hierarchy as I have suggested above, is a force in the field, which acts as a system to exist and mediate entry and navigation around the medical field and between the positions. Junior doctors stand in relationship (based on prestige) to each other and within medicine based on their ‘seen’ or known relevant resources.

There has to be a sense that what people, and here, the junior doctors do, is productive. The intensive, methodical medical training binds doctors who are the product of similar training. This is the habitus. It is behaviour that is legitimatised through the behaviour of peers and for junior doctors through what they view as ‘successful’ conduct. The body as an intimate and personal experience becomes a site for building and reorganising ways of acting, thinking and moving. It is through

the medical habitus that junior doctors find their world organised in a certain way and one that produces certain actions. These organised ways of being have some reflexivity, but the power of the medical field and the habitus, are tuned into the interests of the doctors and reproducing the medical culture.

These cultural conditions based around medicine then, create a feel for the game for the junior doctors. However, as the data has shown, the junior doctor 'class' or group also can begin to inculcate social limits through what is interpreted as capital (economic, cultural/social, symbolic and scholastic). That is, as junior doctors make their way through the hierarchy they still need to know their place. As one doctor discussed, he was on a training program, but still had to work late, work in a demanding ward, and continue to show that he could do the hard work even though he didn't need to because he was already on a training program - he had to show that he knew his place. These are the social limits to habitus and networks in relationship to the medical field.

We have learned several components about the medical field and how junior doctors have learnt 'a feel for the game'. The medical field is very hierarchical, clearly defined and has clearly defined roles/positions. Junior doctors see themselves as a group of juniors, entering the wider network of 'medicine'. We have learnt that junior doctors do not know initially very much about the (required) struggles involved in being a junior doctor in the first few weeks of their internship. However, by halfway through their first term (6 weeks) they begin to get a taste for the need to negotiate their position politically. For instance, they begin to learn that appearance and meeting the criteria within their expected role and other or minor cultural aspects (may) guarantee them certain benefits in the medical culture. Here, we can say that through doctors' identification with the field, they also have personal and group theories about how the culture works, models of medicine, their place in it and eventually how it should be.

The socialised body, as the junior doctor is learning, is indeed socially constructed through the medical field's organisational principles, which are acquired through medical activities and practice. In instances where doctors become cynical about their position and role, I suggest this is where they may become out of place. Medical practice allows interns and JHOs to create their own history, even if it is to become cynical about the medical field. Of course, it is possible that cynicism is one coping mechanism for a profession which encounters serious human suffering and illness on a regular basis, cynicism could be a mechanism of neutralisation of emotions. It is then through junior doctors' habitus that they are negotiating constantly changing positions and dispositions.

INTEGRATING DISPOSITIONS: HABITUS

The habitus is a set of integrated dispositions such as bodily action, cognitive thought and social practice that change, endure and are transferable or adjusted across a range of fields. We can say that habitus is also a physical embodiment and set of characteristics that we can see in junior doctors' professional development. Given that habitus describes ways of talking, walking, moving or making things, I

suggest that habitus is a part of behaviour. In the video of junior doctors on their ward rounds, we read how the intern learned to move patient bed to patient bed. She learned how to listen attentively to the consultant. Junior doctors are learning how to hold themselves physically and to embody how a doctor stands, moves, talks and practices at a physical level. Habitus as a way of living also generates particular ways of behaving. That is, because the interns have seen how to talk to patients, registrars, consultants and each other, habitus becomes an embodied history of those skills which in the future now produces individual (the intern) and collected practices (of the junior doctors). Bourdieu's (2000) refers to this as quasi-bodily anticipation.

In this context, then what can we say habitus is? At its most basic description, I suggest that habitus refers to the way that people internalise unconsciously and consciously characteristics to negotiate their position within certain environments or fields. The habitus constantly is in a relationship with the social world; indeed habitus refers to the inscription on the individual of the social. The unique aspect to habitus is that as a concept it experiences life; is learned and a part of a process of personal development. The practices that the junior doctors perform on a daily basis, such as taking bloods, working after hours, discussing patient care, is where the habitus, becomes a physical state of unconscious practice and eventually will be embodied in those practices. Bourdieu asserts that we learn bodily and through the body. Drawing on Bourdieu, I suggest this is where we can conceive of the body as a memory note pad where we are likely to carry on rules, behaviours, thoughts, ways of sitting, standing, talking and the structures that correspond to what and where we learned about how to do these things.

The medical habitus includes how doctors practice and how they act in their jobs and in themselves as individuals. It refers to the way that doctors work and the ways they act in their lives. In this research early professional development at a non-clinical level was researched. That is, in terms of the medical culture, habitus became a tool of investigation which showed how in learning about the non-clinical aspects of being a junior doctor, doctors began to internalise ways of acting, negotiating and attainment of success in the medical culture and field. Learning these social and cultural aspects, were central to doctors being able to practice. This is learning well beyond that of clinical practice.

As I have said above, the habitus can account for and be a testament to group social processes and activities. In *"The Logic of Practice"*, Bourdieu (1991) asks us to consider how the habitus produces practices. In this research I have found that junior doctors, for instance, in considering the training program that they want to apply to or specialty they want to study for, will, with intent, consciously adjust their desires and aspirations to what they foresee their chances of success to be. This then generates the appropriate dispositions that are going to be compatible with the requirement of the medical field, as well as for them to feel that they have control over the conditions of practice and a sense of the medical cultural fields. However, habitus can have a system error, moments out of place, where it readjusts itself towards the practice that was the cause of the 'bug', but not towards the junior doctor as the agent of those practices. This can be seen in the doctor who doesn't want to do medicine anymore and would prefer to do medical journalism.

Another aspect to medical habitus that this work has raised, questions whether it is just the doctors' medical practice that is what habitus is all about? I have to suggest that although tempting, habitus is and has to be more than practice just as a doctor; this is because being a doctor engulfs almost the whole life as a person. The habitus is a result and a constantly changing component of the production and reproduction of the medical culture. Because medical habitus is not always conscious, the dispositions have to be a part of the habitus that produces practices. The generative nature of Bourdieu's work is that habitus, here, can be seen as an adjustment of the medically required dispositions to the junior doctor positions. However, it is important to note that the medical habitus that is a constantly changing one which has been developed earlier from the location within particular class structures and primary experiences in the family.

Therefore, from the doctors we can see that the medical habitus has been internalised from the experiences which are unique to being a junior doctor. These experiences include: dealing with patients, learning to practice independently, trying to clarify future career directions, working collaboratively within a medical hierarchy and so forth. The strategies of the habitus then comprise primarily a physical representation of internal cognitive structures or mental maps, which are displayed or expressed in behaviour, speech and physical ways of behaving. The physical representation of the internal set of rules allows the junior doctor a certain path of professional development or success in specific/certain medical fields.

So where does this leave us as to the decision-making processes of junior doctors? How are the cognitive and cultural maps engaging with the embodied actions which allow a certain set of practices? I suggest that because the habitus helps to determine what needs to be done, on many levels, junior doctors have to abandon themselves to their dispositions and the rules of the field. It is difficult to separate free will when it comes to habitus. Some doctors in this research suggested that if they observe hierarchy, work hard and cater to the needs of consultants by doing a good job they will be able to achieve their goals. This may already be a result of the emergent medical habitus. It is possible as well, that this may be a process of the habitus to create a sense that the doctor has control over 'being nice' to the consultants. The illusion of choice in the medical field, is where junior doctors negotiate positions of prestige, which then drives the medical field, and organises the dispositions around the habitus. One of the interns tells us how she is happy to "plod along" at the moment in terms of choosing her career path. When it comes to explaining behaviour, in relation to her habitus, her dispositions function as a watermark for what the medical culture wants from its members.

The specifics of medical habitus can also be seen in preferred medical skills and patient management, such as efficient time management, efficiency with results, paperwork and a clinical knowledge base relevant to the level of the junior doctor, but, perhaps with a couple more advanced snippets of knowledge. One of the second year doctors reflects that "you learn nothing about medicine in the first year". He is suggesting that the medical knowledge is minimal and that medicine is dominated by appearances and social and cultural aspects. The habitus engages medical culture and the practice of particular dispositions which comprises both the key cultural and medical knowledges.

We have seen and read that doctors have habitus (from primary family experiences) and that their habitus develops in the medical field in conjunction with the redemption of capitals. Habitus is inscribed within and on doctors' bodies from the experiences of the medical field. Interns learn after six weeks, that they need to dress in a certain way, listen on ward rounds, know their place within the hierarchy and also begin to politically work their way towards a place on a training program. Does it stop there? The junior doctor mould and medical habitus have degrees of integration and separation. The doctors have told us that they struggle to gain positions in the medical field/culture initially, and once they gain an understanding and aspects to favoured dispositions or medical habitus, success in the medical culture is made easier. Embodiment here is displayed through consultants who see that junior doctors should act, dress and learn in specific ways. These senior doctors are themselves predisposed (through the habitus) to defend the cultural, hospital and internal beliefs of the medical field through their (medical) hierarchy. The conformity that the habitus requires in the medical field is where doctors compete within and about the medical culture. The research has shown that this is sociology of cultural competition and consumption.

After the first twelve months or at the end of two years, most junior doctors feel that they are at home in medicine; this is because their world is medicine. They are now used to sleeping, eating, walking, thinking and talking medicine. It is a '24-7' job and way of life. The culture has put medicine into the junior doctor and now their world is medicine. The medical field is a web that has collectively inculcated another set of individuals. Habitus comprises the socialised body and functions to generate, unify, construct and classify behaviour. The junior doctors have gone from studying medicine in the abstract to practicing it. Junior doctors have come from playing the role of 'student' studying the clinical aspects of disease and treatment to practicing now as 'doctor'. Being a doctor, and here starting as a junior doctor, are roles that medical students have not been able to experience and ones, which cannot be studied for. This is because the impact of the whole 'real' medical culture can only be experienced by arriving as an intern, growing as a resident and becoming a 'doctor'. These required factors of achievement are prerequisites to entry into the initial field of the 'real' medical culture. These junior doctors quickly learn that particular characteristics, dispositions and skills are needed to gain success as a doctor in the wider profession of medicine.

Medical habitus is clear in junior doctors' practice during their internship and certainly at the end of the initial two years postgraduate training. We can see medical habitus in the practice (writing in the chart, ordering tests), talk (specialisation, rosters), dress (crumpled clothes, no suits, comfortable shoes), and in their perceptions of the hospital, peers, medical culture and the wider world around them. The data has shared through junior doctors' interviews about their practice, that they try to 'do the right things' to please and gain senior doctor approval, as well as observe and reinforce the hierarchy. In junior doctors' talk they begin to become obsessed about getting onto 'a / right / preferred' training program; they are preoccupied with choosing the right career path in general (for life as a doctor); and they watch what they say around their colleagues and even fellow junior doctors.

In terms of dress and physical habits, there begins a junior doctor uniform with men following certain shoe brands, specific colours of shirts (for men white, blue), pants (tan/navy) and for women (mono-coloured pants, shirts, flat shoes, limited jewellery/makeup) and around seniors a degree of workplace seriousness and reduced animation. Amongst peers, the after-hours behaviour is remarkably different. The individuals come out, dress is loosened, jokes are make and people are individuals again. As one of the JHOs commented, the social times are important because this is a time when senior doctors are seen without their "façade on", and where they realise senior doctors are "all human, just older" and not the intimidating power brokers they see initially!

The junior doctors' medical habitus is also evident in their perception of medical culture. They have ideas as to what it will take, what it takes and what others should do to achieve success and to attain a training place. This affects their own ideas of the profession as one that they have chosen to work in and continue to work in. The effect of the medical habitus also relates to the junior doctors' opinion and perception of the outside or wider world around them. Coping mechanisms of cynicism, ideas about healthcare, patients and disease and their role as practitioners develop based on and become part of the habitus. It is in these aspect to the medical culture that habitus is in its element, as it were. The characteristics and experiences of the medical culture for junior doctors move towards a generalisation of dispositions.

This then leads us to consider is habitus subconscious? Are junior doctors not able to reflect upon it once it becomes medical habitus? I suggest that habitus is both subconscious and unconscious. At one stage Bourdieu has referred to habitus as part of an infraconsciousness. Junior doctors have told us how they are able to reflect on how they have changed professionally and personally after the first experiences of medicine. There are some areas of medical habitus, however, that they are unable to conceptualise which have already been internalised in the way they practice. Junior doctors know after a few weeks of internship how to work on the ward round, that it is their job to carry the charts, hold the registrar's stethoscope (if asked to/ handed it) or retrieve lab results beforehand. These are areas of practice that become automatic, and the registrar, for instance, doesn't have to ask the intern to make sure they have the results for the ward round available, as they do in the first few rounds.

CULTURAL KNOWLEDGE AND THE DIRECTION OF HABITUS

The behaviours the junior doctors take on and act out are in part products of the cultural knowledge and experiences that are revealed in the medical field. The initial development of medical practice is located in a very short, but intense time period, almost a hothouse effect. Here interns are thrust into a visible and practical medicine and they begin to learn about dispositions that are required, and the consequences of their work life. In this sense, junior doctors have been described here as having or seeking to attain a certain medical habitus. Medical habitus becomes a central element of the bodily and cognitive ways of being a doctor.

Habitus as a theoretical concept is very useful to interpret early medical professional development. The embodiment of dispositions through the hierarchy of skills, knowledge and practices are, as the doctors have suggested in their interviews, part of what is mapped in the first two years of junior doctor medical practice.

Examination of medicine and certainly junior doctor culture, from the sociocultural perspective of Bourdieu, makes a unique contribution to understanding how the habitus works within this medical and hospital context. The combination of developmental interviews, video of ward rounds, enable cultural analysis of the hospital and experiences of junior doctors here to be unique in its methods and approach. Moving beyond a strict Bourdieuian analysis, I have built upon the concept of habitus to establish the concept of medical habitus as a distinctive aspect to early years of development as a junior doctor. The data itself is revealing, due in part to the rapport and solid relationships that were developed while in the field and in the way that the case study was designed. While much of the previous literature has been on professional socialisation theory, the developmental process is seen here in a more interactive sociocultural way.

In summary then, junior doctors are discovering more in their first two years of postgraduate medicine than just experiencing and learning about the processes of becoming competent medical (scientific) doctors. Many of the categories of perception and appreciation acquired from professional experience are through and within particular social contexts. These specific (social) conditions are crucial for the production of medical knowledge, practice and more 'social/cultural' issues. In making this assertion, I suggest that through this early cultural and professional process junior doctors are:

- learning about the standard medical aspects,
- learning more social aspects of becoming a doctor,
- becoming and understanding about becoming 'social doctors' through the process of internalising a medical habitus,
- experiencing transmission of particular schemes and dispositions of the habitus through practices and in codified knowledge.

In this context, reproduction of specific junior doctor medical knowledge(s) and specific practices occur within the social field. Junior doctors become habitually medically conformist to a more social junior doctor model.

CHAPTER 5

FUTURE OF MEDICAL HABITUS: MEDICAL IDENTITY

> Yeah, you have to comply. I really see that very clearly that you have to be part of the mould to get into any training programs. I probably chat with people more and try to go along with their general interests. They like cricket a lot and they like a few sports like rugby. I reckon I should read up more on some of the matches, and have something common to say.
>
> Beginning of the year, male intern.

The chapters here have documented the empirical evidence in support of the theoretical argument, which enables us to consider a new conceptualisation of medical culture. What is key here are the implications for educational and medical program directors to help study issues of professional development, medical cultural difference and institutional power which cannot be underestimated. This chapter concludes the book and offers recommendations while providing a concluding commentary on the research reported and expands on the contribution and the value of this research. Most importantly the take home message of this work has been to consider the concept of medical habitus in the context of an embodiment of becoming a 'social doctor' with particular dispositions which are evident in medical practices and cultural features.

Medical culture is rich with areas for examination and carries implications for medical practice improvement. Our focus has been on medical practice, specifically junior doctors' experiences, attitudes and changes during the first two years in a teaching hospital. The approach has been qualitative in orientation where the my role as the researcher was key to the data collection process and for continued access to the year long study of professional development and change. Previous research on junior doctors' psychological and physical stress, coping, workplace training, gendered experiences and general medical experiences provided a background to strict medical experiences and understanding of the junior doctors' work and private role experiences.

The aim has been to provide and examine in a rich manner the voices and experiences of junior doctors. As explained earlier, a cultural theory of practice provides a most useful focus for studying junior doctors. The main methodology, included semi-structured qualitative interviews at the beginning and the end of the initial training years for two levels of doctors: interns and JHOs. Also at the beginning of the year, several hours of ward rounds were videotaped of interns and JHOs. The ward round videotape highlighted some interactional aspects to themes that were raised during interviews. Theoretical analyses of the interviews were done using a sociological analysis focussing on the cultural aspects to the profession.

That is through using Bourdieu's theory of habitus, I looked for themes that focussed around issues directly related to the embodiment of cultural experiences and social group processes. There are other aspects to junior doctor experiences that were found and which replicated 'findings' from previous research on junior doctors. Junior doctor literature suggests that the first year of medicine is very stressful, a time of great change and with a variety of unique experiences. This has been confirmed through this research, which is no surprise, but it has been extended in a few ways. The theoretical framework and data here provide the point of view that the early junior doctor experiences provide a fundamental ground for future practice and attitudes in medicine. From the interviews with the junior doctors it is apparent that the first two years are significant for learning to become a doctor where a steep social learning curve occurs in specific areas, such as medical hierarchy and knowledge of the medical culture.

There were major themes that arose in relation to being a junior doctor. Firstly, issues surrounding the postgraduate training programs, secondly, doctors' mould, thirdly, medical hierarchy, fourthly, medical culture including, cynicism, ward rounds, paperwork, stress, critical incidents, patients and women in medicine and finally reflections on the junior doctor years. These key themes and issues related to the practice of medicine are open to medical sociological interpretation using the sociocultural theoretical perspective of Bourdieu. It seems junior doctors work simultaneously within professional, hospital fields and social medical rules. The analysis derived from the interviews was complemented by analysis of videos of ward rounds. The synoptic analysis of the data collected in the research demonstrated the complex interplays between the medical field, specifically the large teaching hospital, medical habitus and emergent professional practices. It was shown how the medical habitus as corporeal schemata (Wacquant, 1992) induced certain required practices ensuring the reproduction of the medical field and its structured hierarchies and flows of power.

The research reported here has shown how the unofficial medical curriculum is a major contributor to junior doctors' learning about and becoming doctors. Early medical education in medical school is seen as the essential 'socialisation' process for clinical medicine. However, as junior doctors inhabit their environment of the hospital and the medical culture, much of the junior doctor experience begins to revolve around stress from their long work hours, demands of their job and the vast knowledge base required for essential medical tasks. Final choices about career, the effect of work on their personal life and the responsibility for patients contribute to junior doctors feeling inundated by the responsibility of clinical medicine. Previous research suggests that these experiences in the professional context can lead to medical mistakes, psychological illness and inappropriate coping behaviours. Further in a sociological context, junior doctors experience particular limits and options that are demarcated by the field, the habitus and capitals. These are termed 'objective' in that we can see actual physical experiences of junior doctors (eg. tiredness), or in 'subjective' terms of what the psychological aspects involve (eg. learning how to get on with a certain consultant). It has been suggested that these practices are differentiated according to the habitus. This drives the habitus to

essentially become the subject of practices and which necessitates action in a particular fashion and of a particular kind.

Figure 13 below illustrates how the habitus enters the conception of the first two years of medical practice. Capital, such as cultural knowledges that junior doctors begin to develop in the hospital structure, can lead to more favoured characteristics, dispositions and success in the field.

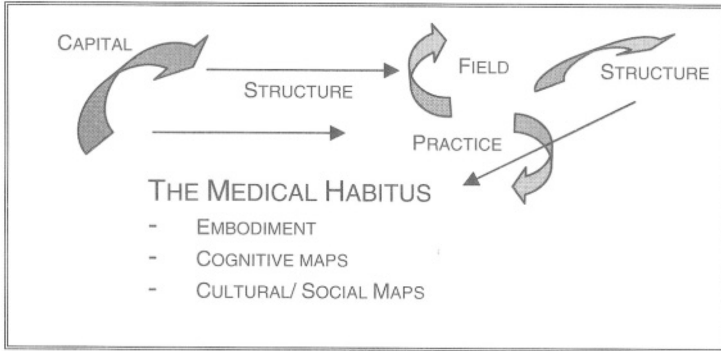

Figure 13. Field - practice - habitus processes.

This figure 13 above illustrates a process of what contributes to the medical habitus. It begins with capital, which in this context would be the goods of value that the person brings to the structure (the hospital). Within the hospital are various fields of interaction, such as a morning ward round meeting, which then translates into particular practice, as in seeing patients on a ward round. These key processes bring capital to a structure in the context of the field. This leads to particular practices that contribute to certain ways of being, which as suggested here is the medical habitus. This strategy, in terms of how junior doctors orientate their practice, is not necessarily completely conscious. It seems that learning to fit the mould to get onto the training program, for instance, is a product of the game. Incorporating one of the key themes presented earlier, the training program, figure 14 illustrates how particular issues fit into structuring fields which enable or provide significant opportunities for junior doctors to adapt towards a certain habitus. Learning about getting on a training program, is an important factor that junior doctors are learning about. In particular, those opportunities to gain capital to be successful or get ahead in the field are of primary importance.

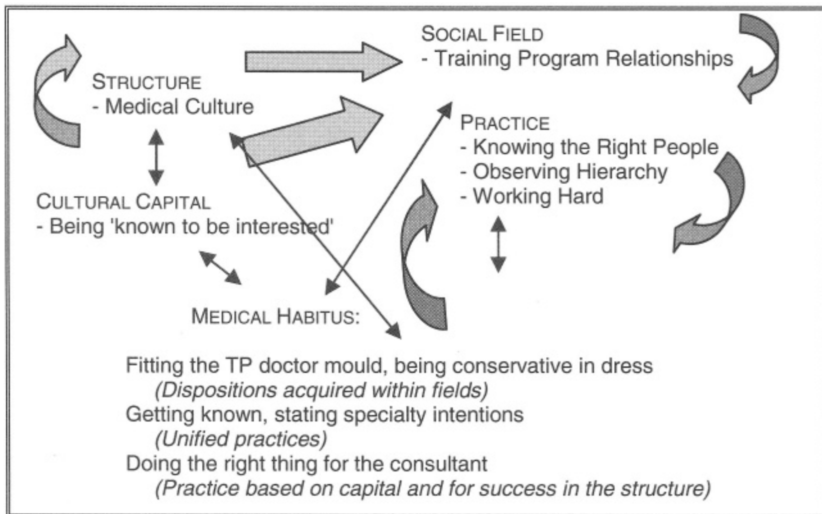

Figure 14. Training program: Illustrative example.

Starting with cultural capital in figure 14 above, a junior doctor who is 'known to be interested' in a particular specialty such as surgery, has something of value within the structure of the medical culture. Cultural capital can have a direct effect on the social field, which here includes the training program relationships. It can also link back to the medical habitus. In this previous figure 14 the larger arrows show the more direct relationships. Thus, although there are arrows linking major concepts to each other, the core of the process is represented through the larger arrows. Returning to how structure affects the social field, the medical culture sets rules and particular ways of being which lay the groundwork for the field and the relationships within that field. For instance, junior doctors who say that they would like to become a paediatric surgeon to a consultant in surgery, have declared their potential worth to that consultant within the structure of the medical culture. Alternatively, if the doctor suggested general practice to a surgical consultant, the responses are likely to be different.

In the context of the social field and relationships surrounding training program issues, junior doctors will engage and surround themselves with specific practices through their work to carry through a training program intention. For instance, the consultant may teach junior doctors more specific surgical procedures in theatre, or the consultant may 'back up' (to administration) the junior doctor when they would like a specific subspecialty training term. Other specific practices that junior doctors may engage themselves in include: making efforts to know the right senior consultants, working extra long and hard hours without claiming them, or asserting their career intentions to surgical doctors to become a surgeon.

It has not been clear how the capital, field and practice process will engage a particular habitus. In the previous figure 14 above, the medical habitus is internalised in terms of dispositions towards enacting these practices within the

context of the structure and the field. Junior doctors, who want, for instance, to become paediatric surgeons, become surrounded by particular practices. The medical habitus then, becomes the centralising agency for controlling and moderating the interactions between the field and practices that junior doctors enact. Medical habitus therefore, in this context, unifies junior doctors' practices such as stating career intentions and becoming known by the 'correct' consultants. The dispositions, such as being conservative in dress sense or appearing to fit the mould of a future paediatric surgeon, are acquired within the field, and provide opportunities for success in the structure based on particular ways of being.

The processes of adaptation and change for junior doctors are based on development, change and alteration of the habitus. This becomes a specific (medical) habitus, which when the next class of junior doctors comes onto the hospital within twelve months, the professional developmental process starts again. At the end of each year of junior doctor medical practice, there has been a precedent for a medical habitus. That is, the previous doctors adapted, changed the rules, regulations and processes required to maintain a specific habitus for specific situations. It is my suggestion here that the 'successful' medical habitus is one now that has been carried and was brought into new fields in the medical and hospital context.

By this, I mean that the interns and JHOs came into the hospital with ways of being a doctor based on their previous four to six years of university study. Once they have spent time, even six weeks, in the hospital and within the professional medical culture (as opposed to the student medical culture), they learned about particular ways that were necessary and appropriate to behave and act. Therefore, I suggest that the medical habitus determines survival of particular ways of being and practicing within the medical culture beginning at a junior level. Learning to be a doctor also confirms much of the medical sociological literature in relation to issues such as, stress, coping and other physical training issues.

Learning about the medical hierarchy, the junior doctor mould, and issues in the medical culture such a cynicism, paperwork and patients, provides a particular perspective on being a junior doctor. Through the habitus, I suggest that there is an incorporation of the practicalities of the medical job, along with the embodiment of learning to become a particular type of doctor, a more social doctor. By the use of the term 'social doctor', I mean to describe the non-clinical/medical aspects to the profession, aspects of the medical habitus. That is, I am not discussing how working 120 hours a week affects the ability to cope and stress levels of the doctor, but during those 120 hours a junior doctor is learning much more about the medical culture and what is required of them to exist, survive and play the game. What is more, they are learning these things in a very concentrated fashion. This professional development experience in the first twelve to twenty-four months of professional practice, is mediated by junior doctors' knowledge, their ability to exist and succeed within the field. Success within the field is moderated by a successful habitus as a cultural theory of practice. The implication of this is in terms of shedding, becoming successful or simply gaining a new medical habitus.

There are two major conceptual contributions of the work presented in this book. The first is the notion of 'social doctor', and the second is the concept of 'medical

habitus' and they are intimately interrelated. Junior doctors are not proceeding to the next level of being a doctor simply because of their clinical skills. Each year of their medical careers junior doctors are gaining more experience in becoming and learning about being a social doctor. The clinical components are essential, but not the whole picture of what they are being taught and learning about.

In terms of the notion of social doctors, junior doctors are learning about the more social aspects of their role within the culture and organisation. The themes discussed previously illustrated:

- that junior doctors are learning how to get onto a training program by working well with their registrars,
- fitting in with a certain mould or dress sense,
- fulfilling the needs of the job to keep the 'bosses' happy,
- how culture, social issues and the full professional development of the social doctor occurs.

The notion of social doctor also comes into play from other themes derived from the interviews and video; for instance, when the intern was learning how to listen to a consultant and follow the registrar's way of looking into the chart. In many of the interviews, the interns and JHOs discussed how the relationships with registrars and consultants are fundamental. These are key functions of medical culture, to which registrars and consultants provide important gate keeping roles. That is, educating the doctors about managing their clinical role with the appropriate social professional development.

For junior doctors they are often challenged clinically; for instance, by trying to help a patient who keeps smoking or when they have been at work for twenty hours over the weekend. Junior doctors are learning here that they may become cynical towards patients, stressed out and have to do too much paperwork. However, at the end of the day these are the demands within a large medical organisation that they have had to learn about in order to achieve a place within the medical culture and medical hierarchy. In the process, they are trained and have learned to become social doctors. Training to become social doctors needs to be durable. This leads us to this professional development process and arrival at the door of a new professional persona through medical habitus.

Medical habitus as a theoretical construct shows how junior doctors grow, change and pass on professional and cultural developmental aspects to their medical culture. Junior doctors are conditioned to train in a certain way and with certain conditions to their working weeks. This makes them submissive to professional rules which they are forced to act under because they are junior and in the least powerful position. At the same time, the medical field, including the large teaching research hospital, is very hierarchically structured and as junior doctors they are at the bottom of this steep medical hierarchy. Being without particular freedoms to challenge the system or the training, many doctors adopt a particular medical habitus to be successful in the field. Freedom from these medical culture restrictions can perhaps occur through acknowledgment of these cultural restrictions. However, this can be costly and as many have suggested, playing the game, is the best way to get ahead.

Junior doctors want to become senior doctors. Often there is no way to reject learning the more political ways of becoming a social doctor and internalising a particular medical habitus. The medical habitus consists of durable dispositions which, once embodied are difficult to change. Therefore, many of the junior doctors adopt what they perceive as successful ways of acting, standing, talking and dressing. Medical habitus is one of continual adaptation and change. Figure 15 below illustrates this point.

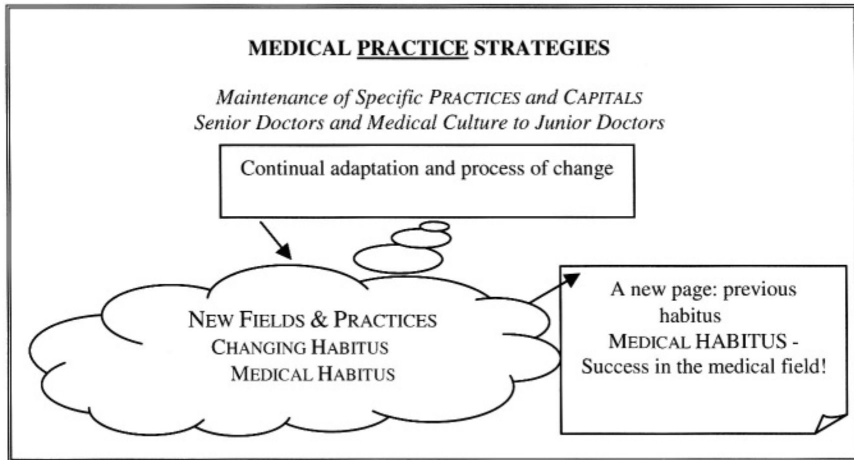

Figure 15. Professional enculturation of the medical habitus.

Figure 15 above, illustrates a coming together of a sociological interpretation of medical culture and the sociology of medical practice strategies. This diagram suggests that the medical culture has specific fields and organisational processes where junior doctors have and utilise specific cultural knowledges. In combination with a continual adaptation and process of change through the junior doctor years, there are particular practices in and surrounding the medical culture. While this is going on, as illustrated by the 'cloud', junior doctors are also experiencing new fields and new practices, which contribute to the process of professional change. This translates into new cultural strategies, new practices and as a result, transform the original habitus. Junior doctors therefore, modify behaviour, attitudes and professionalism around medical habitus. This provides for further success in the medical cultural field.

CONCLUDING REMARKS

Medical sociology looks at how health and medicine affect the way society functions on a social or holistic basis. Medical psychology on the other hand, might focus on how individuals within society are affected by health issues. Through examination of specific cultural transformations, this research has been focussed on

the sociology of the junior doctor medical profession. As a reader of other sociological work, I have brought my own medical / sociological (not medical / scientific) point of view to the interpretation of this research and application for junior doctors. Sociologists are likely to perceive this research in different ways, given that issues that are of interest to us are usually based on our field position. Further, junior doctors may also read and view this research in a particular way. It has been my aim to satisfy an inquiry based on a sociological framework, while also doing justice to the positions and mind-set of junior doctors. I have suggested one way to comprehend and understand junior doctor professional development experiences.

The main theoretical contribution of this volume has been the extension of Bourdieu's concept of habitus to that of medical habitus through the study of the professional development of junior doctors. The main assumption of this work is that through the Bourdieuian concept of the habitus, we are able to extend the work towards a conceptualisation of medical habitus as a principle of most modes of professional development and junior doctor medical practices. The theoretical refurbishment that the medical habitus provides about junior doctors allows further explanation and application of the original concept of the habitus. As a subject of particular practices, junior doctors have been carefully incorporated to explain how they can be determined (through the medical habitus) and yet be actively acting in the context (professional development). Therefore, the medical habitus and the particular dispositions which are acquired through early junior doctor professional developmental experiences, not only have the capacity, but also produce, particular modes of behaviour in the hospital context of this research.

In line with theoretical underpinnings, we have utilised particular research methods appropriate to the field. Given that this was a cultural analysis of a particular subculture, making the most of access and entry to the research site was fundamental. Being a part of the culture prior to detailed investigation about professional development, and having the ability to observe without formulating a particular perspective on why things were occurring in the setting was very useful. Consequently, qualitative semi-structured interviews optimised the methodology and access to gain insight into junior doctors' perceptions and experiences. It cannot be emphasised enough that using methods appropriate to the field and the units of analysis particularly, in a medical cultural context, contributed to the quality and the interpretability of the research data.

This research data consisted of particular (junior) doctors' perceptions of what was happening to them on a personal and cultural basis during the period of investigation. The junior doctors are still practicing today. This research provided but one 'snapshot in time' of their lives as thinking, feeling and experiencing human beings (and medical clinicians) and not just as conceptual units of analysis. As a final point, being a part of the culture by having a phase of exploratory formulation, using methods appropriate to the field and allowing the voices of the doctors to be heard, were all critical. The purpose of this was to contribute to the theoretical understanding of medical culture, as well as make a practical contribution of knowledge about junior doctors' professional development.

My interpretation of the original concept of the habitus was built upon as medical habitus through analysis of the role it plays as an embodiment of the hospital and medical cultural structures in the practices of junior doctors. The medical habitus is then a representation of particular dispositions, an internalisation of structures and ensures junior doctors are 'learning how to play the game'. Having a feel for the game then, it follows that those junior doctors through the medical habitus lay the groundwork for making (limited) choices in the medical cultural context. For this reason, the social and cultural knowledges that junior doctors utilise through their medical and cultural practices are used to achieve strategic (or unconscious) planning. That is, through the medical habitus, doctors focus on how to use their skills to play the game. The reproduction of particular ways of being and interacting as a junior doctor are thus located within a larger system of social hierarchies and distinctions within which junior doctors actively manoeuvre on the basis of an appropriate habitus - the medical habitus.

I hope this book is useful for medical sociology, postgraduate medical education and junior doctors in a practical sense. This is provided that the sociological interpretations of the way in which junior doctors are learning to become 'social', as opposed to 'clinical' doctors are valued. Supervisors of postgraduate medical training can provide support and services geared to the needs of overworked junior doctors. On the other hand, training and support need to be incorporated into consideration of many of the nonmedical components of junior doctor professional development. I have illustrated that as a fundamental learning experience over the first twelve to twenty-four months, learning about the junior doctor mould and what is expected as an intern or JHO, is a professional priority for junior doctors.

Learning about these expectations can be just as demanding, take just as much mental time and energy, as learning which forms to complete for which clinical investigations. So much emphasis is placed on doctor-patient communication. In spite of this, it is actually skills in communicating with colleagues, senior doctors, hospital administration and those in the medical hierarchy that cause the greatest amount of worry and contribute significantly to the experiences of being a junior doctor. It has been emphasised that:

- senior doctors can be the most influential to junior doctors' experiences daily on the wards,
- appropriate and maximal utilisation of these positions in the medical hierarchy is likely to be invaluable and facilitative educationally,
- it is important to do this without junior doctors sacrificing personal identity so that they can focus on the medical and clinical learning components of being a junior doctor,
- this will alleviate much of the anxiety and cynicism that develops early in medical training.

Junior doctors love their work; most go into medicine to help people and heal the sick. On the job training through ward rounds, surgical theatre sessions and patient care are fundamental and invaluable experiences at a junior level. What is needed is a practical postgraduate medical education that focuses on and values the contribution that junior doctors make. This in turn, can mediate much of the stress

and exhaustion which may lead to medical mistakes or negative critical incidents. Additionally, as the years roll on through medical practice, reflections aboout how hard it was, the experiences or reflections about personal development tend to dim. It is anticipated that this research can he incorporated into the medical culture as work, which provides the opportunity to facilitate the early entry years and recognise the powerful and influential role that the medical culture plays in the professional development experiences of junior doctors. Junior doctors in many hospitals are an at-large group of apprenticeship like trainees. Across the country their contribution to healthcare and future of medical practice cannot be underestimated.

An important point is that as a reflective researcher, I acknowledge that I have been a part of this medical field investigating the junior doctor medical habitus. I need to consider how my habitus was separate from this process of investigation. Perhaps it was not. In my process of investigation and my perceptions of junior doctors' medical habitus were also part of my habitus and the fields, within which 1 worked and researched. Therefore, with an ethnographic research method, I was a part of the medical hospital field before conducting the research. As such, I did not so much enter the 'field' but perhaps was part of it. This leads me to consider how this work may be extended. Aside from the obvious indulgence of a longer-term study, I make the call to other researchers to extend the research in location and cultural contexts. More hospital sites internationally would be a useful extension of this work. To date, there are still limited articles and books specifically on junior doctor cultural development. A comparison of UK junior doctors, where much work is done with them as a workforce, to the unique aspects of postgraduate Canadian and American residencies in similar sized hospitals would be valuable. The same issues in medical education, medical habitus as well as potentially the habitus being mediated by similar processes in the cultural field would be beneficial for further examination.

Every year, thousands of junior doctors enter internship fresh out of medical school. They bring with them medical knowledge and a cultural gap. The mismatch that occurs is based in a need to know much more cultural and social details to survive in the hospital organisation, medical culture and health care system. Medical habitus and becoming a more 'social doctor' are two central concepts of junior doctor professional development. The concept of medical habitus provides a particularly refreshing view on the unique phenomenon of professional growth of junior doctors. Junior doctors practice and conduct themselves based on the influence of external medical cultural factors. The consequence of this on the habitus is transformation of particular dispositions, which have been structured, and structure both the medical practices and cultural representations. As a result, the medical habitus regulates appropriate conduct and performance of junior doctors in the medical culture, which unconsciously and collectively transforms practice and representations within the bounds of the medical culture. It is through embodiment and learning of particular 'successful' dispositions that manifest in many of the medical situations which leads to construe the historical conceptualisation of socialisation as one developed towards a cultivated medical habitus.

APPENDICES

APPENDIX 1

Phase one interview Schedule (intern/JHO)

1. What is important for residents to know for and about ward rounds?
2. What would you consider important characteristics in being a good resident?
3. How do think a resident learns the (important) characteristics of being a doctor?
4. How do you think you changed by the end of your intern year?

Career Decisions

5. How have you come to your medical career path decision? Has it changed?
6. Have you ever done (or wanted to do) anything else besides medicine? Why/Why not?
7. How do you think medical school prepares residents for the clinical work role and the effect on their social life and the stress effect aspects to being a junior doctor?

Working

8. Why did you become a doctor?
9. If you had to do it over again and knew what you knew now, would you still become a doctor? Why?
10. How would you define or characterise the medical profession?
11. As a resident what sort of cases or events do you think effect residents personally or professionally?

Learning to be a Doctor

12. What advice do you give to residents about first few weeks of internship?
13. Are there any doctors that emulate(d) the kind of doctor you would like to be? Who/why?

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APPENDIX 2

Phase one interview schedule (consultants/registrar)

1. What is important for residents to know for and about ward rounds?
2. What would you consider important characteristics in being a good resident?
3. How do think a resident learns the (important) characteristics of being a doctor?
4. What sort of expectations do you have for interns and JHOs this year? (Clinical/Social/Personal)
5. How do you think residents will change and be different by the end of this year?

Career Decisions

6. How did your decisions about your medical career path change throughout your residency?
7. Have you ever done (or wanted to do) anything else besides medicine? Why/Why not?
8. How do you think medical school prepares residents for the clinical work role and the effect on their social life and the stress effect aspects to being a junior doctor?

Working

9. Why did you become a doctor?
10. If you had to do it over again and knew what you knew now, would you still become a doctor? Why?
11. How would you define or characterise the medical profession?
12. As a resident what sort of cases or events do you think effect residents personally or professionally?

Learning To Be a Doctor

13. What advice do you give to residents about first few weeks of internship?
14. Are there any doctors that emulate(d) the kind of doctor you would like to be? Who/why?

APPENDIX 3

Phase two interview schedule (Intern/JHO)

(Questions for end of year interviews)

1. Remind participant what the project is about again…
-This is a study on how junior doctors are being professionally trained and what the important aspects of learning to be a doctor are.
2. Consent; Confidentiality, Tape Management / Names used etc
3. Any questions?

Change

1. Has your area of specialisation/ medical interest(s) changed over the year? Why?
2. Do you feel at all different now that when you started than when you started as an intern/ JHO? In what ways/areas?
3. What sorts of overall personal and professional changes have you noticed in the intern/JHO group generally? Some people suggested that they might be more cynical by the end of the year...
4. How has your impression/knowledge of the medical profession on the whole varied? How has this occurred mainly?

Important Events

5. Have you learned anything 'politically' about your role as an Intern/JHO that you really didn't have a grasp of at the beginning of the year?
6. Have there been any key incidents clinically or socially that has effected other residents or you? (eg, problems with other staff, losing your cool, particular incidents: would you have done this 6 months ago?)

Learning to be a Doctor

7. How have you found that being an intern/JHO prepares you for a career as a doctor? What does it teach you work wise and as a person?
8. Have your thoughts on how residents learn the (important) characteristics of being a doctor differed at all?
9. In what ways have you found out when you have overstepped the intern/JHO role (and the limits of it)?

10. If you had to do it over again and knew what you knew now, would you still become a doctor? Why?
11. What 'public' and 'private' advice will you be giving to the new residents for next year?

On the job learning

12. Some people have suggested that a lot of the learning as an Intern/JHO is about fitting the mould? Have you experienced any of this yourself?
13. What aspects of other doctors have you seen that have made you think about the kind of doctor you would like to be or not become?

Video

14. So generally, do you feel a bit different now that when you started than when you started as an intern/ JHO?
15. How and what do you think has contributed to this difference?
16. Are there any other aspects of the last 10 months do you want to talk to me about?
17. Have I missed any important points or issues?
18. Do you have any further questions or questions for me?

Learning (if time in interview …)

19. These are some of things that junior doctors suggesting they are learning, can you pass a quick comment about them. Are you learning about:
    - Conservative medical management and being "conservative" generally
    - Stress (Physical and Psychological)
    - How to Obey superiors
    - Being a Doctor generally
    - How to get onto a training program
    - Being flexible & dynamic
    - Empathy for/with patients
    - The important/valued resident characteristics
    - The different roles, responsibilities and limits of the junior doctor
    - "Toeing the line" (putting up with shit)
    - Dealing with the 'system'
    - Keeping you mouth shut and to shut up
    - Put up with potential discrimination (racial/gender)
    - Who the powerful people are (e.g., consultants) and how to cater to them

20. Are there other things that you would also suggest that residents are also learning about? Any questions?

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