Creating pedagogical spaces for developing doctor professional identity
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OBJECTIVES Working with doctors to develop their identities as technically skilled as well as caring, compassionate and ethical practitioners is a challenge in medical education. One way of resolving this derives from a narrative reflective practice approach to working with residents. We examine the use of such an approach.

METHODS This paper draws on a 2006 study carried out with four family medicine residents into the potential of writing, sharing and inquiring into parallel charts in order to help develop doctor identity. Each resident wrote 10 parallel charts over 10 weeks. All residents met bi-weekly as a group with two researchers to narratively inquire into the stories told in their charts.

RESULTS One parallel chart and the ensuing group inquiry about the chart are described. In the narrative reflective practice process, one resident tells of working with a patient and, through writing, sharing and inquiry, integrates her practice and how she learned to be a doctor in one cultural setting into another cultural setting; another resident affirms her relational way of practising medicine, and a third resident begins to see the complexity of attending to patients’ experiences.

CONCLUSIONS The process shows the importance of creating pedagogical spaces to allow doctors to tell and retell, through narrative inquiry, their stories of their experiences. This pedagogical approach creates spaces for doctors to individually develop their own stories by which to live as doctors through narrative reflection on their interwoven personal, professional and cultural stories as they are shaped by, and enacted within, their professional contexts.

KEYWORDS family practice/education; *internship and residency; narration; *professional practice; physician–patient relations; humans; male; female.

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INTRODUCTION

A pressing challenge in medical education, in both undergraduate and residency programmes, concerns helping doctors develop their identities as technically skilled as well as caring, compassionate and ethical practitioners. This is a persistent problem in medical education, as evidenced by the concerns raised by Coulehan.1 One way of responding to this challenge is to consider narrative reflective practice approaches.

In an attempt to refine narrative reflective practice approaches that work with medical students, residents and doctors in the early stages of their careers, the present authors2,3 developed two small-scale studies to explore the most educative approaches. Both studies adopted a narrative view of experience4–6 as well as a narrative research methodology.7 The educational purpose of this work is to engage residents in understanding their experiences as doctors as narrative life compositions through learning to narratively reflect on their experiences in order to develop a deeper understanding of their professional identity.

In the study reported here, we adopted the process of using parallel charts.8 Charon also works from a narrative view of experience in which people both live...
and tell stories of their lives. She asks medical students to write stories of their experiences with patients in parallel charts where students write down those things that ‘are critical to care of your patient that don’t belong in the hospital chart, but they have to be written somewhere’.8

This paper focuses on developing a pedagogical strategy for engaging family medicine residents in writing parallel charts and participating in small-group sharing and discussion about their charts.

METHODS

The researchers invited residents in one family medicine clinic to an information session where they explained that writing parallel charts based on residents’ clinical practice and reflecting on these charts would aid the development of residents’ professionalism, empathic understanding and self-awareness, and would help to integrate their sense of self with their professional persona. They invited residents to write a parallel chart on one clinical encounter each week for 10 weeks and to attend bi-weekly sessions to share and discuss their parallel charts with participating residents and the two researchers. Exit interviews on what they had learned about their experiences were also scheduled. The two researchers are skilled educators with expertise in narrative inquiry and with experience in working with residents, undergraduate medical students, teachers and administrators in narrative reflective practice. Due attention was paid to the particular ethical concerns involved in using narrative reflective practice in medicine.9

In this paper, we include one parallel chart as written and read by one resident. We show the inquiry process into the chart as it was captured in transcripts. The transcription of the first part of the first session with a group of four volunteer residents (Miriam Peretz, Sarah Khorami, Chris Jones, Josh Smith) follows. Names of residents are pseudonyms. Interspersed with the transcription is the researchers’ analysis of the pedagogical process. Initially, Sarah read her parallel chart without interruption. The first response was one of affirmation and validation for her sharing. The researchers and residents prompted Sarah to tell more by asking questions, showing interest, and inviting her to expand on what she had written. After the initial reading and questioning by researchers and residents, the chart was used to stimulate others in the group to use the story as a starting point for wondering about themselves as doctors and for considering what the story triggered for them about their own clinical experiences. Part of the researchers’ task was to bring other participants into the conversation. A similar process was followed in the remainder of the first session and in subsequent sessions.

Analysis is of the whole process, from the oral sharing of the written parallel chart through the group dialogue about the participants’ responses to the chart. The analysis is based on a close reading of both the parallel chart and the reflective and reflexive dialogue that ensued.

RESULTS: READING AND NEGOTIATING PARALLEL CHARTS IN THE RELATIONAL GROUP SPACE

Box 1 shows Sarah’s first parallel chart. Sarah read her parallel chart to the group and the reading was transcribed.

Sarah is an international medical graduate who has practised for several years in another country. From these earlier experiences, she has begun to develop a sense of who she is as a doctor; that is, she has a professional story to live by.10

<table>
<thead>
<tr>
<th>Overview</th>
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<tr>
<td><strong>What is already known on this subject</strong></td>
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<td>Efficacy of parallel charts has been established with medical students.</td>
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<td><strong>What this study adds</strong></td>
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<td>Narrative reflective practice using parallel charts including dialogue groups with family medicine residents positively impacts residents’ professional identity in terms of making them more caring within their professional practice. Using the study process, which includes writing, reading and collaborative inquiry into the charts, creates an effective narrative medicine learning context.</td>
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<td><strong>Suggestions for further research</strong></td>
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<td>Comparative studies with residents in other medical disciplines as well as studies with medical students in the clerkship years may be valuable.</td>
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I will pay more attention to the roots.

A few days later, we, the residents and students, were talking about interesting cases we had. I told them this story and how I felt when I

So excuse my English because this is my second language so there is a problem. Um during a call in obstetric rotation I was called for a
delivery of baby at 11 pm. As routine, when a pregnant woman comes to the ward the resident on call will take the history and physical
exam and then, later on, the nurse can call the resident into the delivery when it’s the time. This time I had no idea who is the pregnant
woman. Not knowing her, I entered the room and saw a young and pretty lady in the delivery bed trying to push out the baby.
I introduced myself and asked her if anyone is accompanying her. She said, ‘No.’ I could not see joy, fear, pain or even sadness in her face.
The nurses were encouraging her to push harder. By this time my staff on call arrived. After about 10 minutes of labour, the baby’s head
was out. I was holding the baby’s head, everybody saw the baby’s head… cranium and … could not breathe. An on-call gynaecologist
shouted at me to raise the baby’s head. I did, to suction the nose and mouth. The baby cried. We pulled the rest of the baby out of the
mom’s body. It was a boy. The Apgar score was not that good. It took about 2 minutes until the baby’s colour was a little pinkish but his
cry, but his cry was weak and raspy. I was worried. Everybody was, except the mom. She turned her head and looked at the other
side. When she was asked if she wants to hold the baby, she nodded no. The nurse took the baby to the NICU [neonatal intensive care unit].
At that moment I had two different feelings. On one hand, I was proud of myself to deliver a baby. On the other hand, I was sad of seeing a new
mom with flat emotion in her face and not wanting to even look at the baby. The gynaecologist asked the mom if there is anyone you could call
to come to the room. She said, ‘I came by myself.’ She said that she doesn’t want to keep the baby and wants to put him for adoption.
The gynaecologist agreed to call the social worker for that matter. When he left I couldn’t help myself asking more questions: ‘Who is the father
of the boy and does he know you are pregnant?’ ‘How come no one is with you?’ She got pregnant after having a date. They broke up after.
And the guy had no idea she was pregnant. She said, ‘I think for adoption I should tell him about the baby.’ She was living with her parents
at that moment. Her mom questioned her a couple of times about her big tummy. She denied the pregnancy. She had no prenatal care at all.
That was, that day was the first time seeing a doctor for pregnancy, had no feeling for the baby and wasn’t sure if she wants to tell her parents
about the baby. I ask her, ‘If, if you did not, if you did, didn’t want the baby, why didn’t do abortion?’ She said she had talked to someone in
supporting group for unwanted pregnancy and was told if she had an abortion she was facing more psychological consequences. I
comforted her and came out of the room.

All the nurses and the staff were talking about her. I was very upset. Being a mom, I couldn’t understand how come a person can let her
baby go for adoption. I had to talk to someone. I called my husband. Almost tearful, but I was telling him this slowly but it wasn’t enough. I
told one of the medical students about her. He is from India, with close contact to mine. I told him that I have hard time understanding
one, why someone could ah be so irresponsible to let get pregnant in the first time and then go through whole pregnancy and then put their
own blood and flesh for adoption. He understand me, understood me. I always think of the worst scenario. What if the adopting family are
not good enough for the baby? What if they abuse him, sexually or physically? How he would feel when he grows up? How long he would
wonder about his mom and asking himself why his mom didn’t keep him. For sure he always would wonder why his mom didn’t like him
because if she did she would not abandon him and one million more questions went through my mind at that night and the following day.

Two days later I saw the girl walking into another unit. She was changed. She was more energetic. I noticed a couple of people surrounding
her. I heard somebody said to her, ‘That is the best.' What was the best? A few hours later I saw her again, this time face-to-face. I ask her why
she was still there. She said, ‘The baby is in the NICU and we have problem feeding him.’ I looked at her and asked, ‘What do you want to do
about the baby?’ She proudly said, ‘I will keep him.’ I could not believe what I heard. Not thinking that this isn’t professional, I hugged her and
told her that was the best thing she could do. Obviously she called her parents. They all supported her and wanted to keep the baby.

A few days later, we, the residents and students, were talking about interesting cases we had. I told them this story and how I felt when I
knew the baby was going for adoption and how I preferred to have abortion than adoption myself and why not her. One of the female
residents commented, not very friendly: ‘You can’t judge people. You don’t know why she did that. She had her own reasons.’ Did she? I
thought about what she said. She was right. I never had unwanted pregnancy and I never did abortion. I did not know about her family
situation, religious, culture, or economical situation. Not everybody had financial and emotional support. Why did I think that she had no
feeling for her baby? Of course she had. She was suppressing it. I learned my lesson. I’m not going to judge a person based on what I observe.
You always see the tree, not the roots.

I will pay more attention to the roots.
Initially, the researchers affirmed Sarah’s reading, and asked questions about the process of writing, encouraging Sarah to give more details about who she talked with, the age of the patient, and the use of drugs. Their purpose was to validate both her telling of the story and the importance of it. The conversation followed this pattern for seven minutes until the researchers began to speak of the importance of finding ‘out someone’s life story’ and needing to ‘know more about them before you can make a judgement’. They drew on their work in narrative inquiry, where individual events are understood within the context of a person’s whole life story. Their comments made a space for Miriam to pick up on the term ‘judgement’, and to gently remind Sarah that ‘we do have belief systems, we all come with our own and it’s important to recognise when we start sort of thinking about those belief systems’. She noted that:

‘…every day is a judgement call. We see someone, we look at them and … we make a judgement call based on their clinical presentation… and it is really hard not to judge… Especially if it’s not your belief system… I would have probably approached that entirely differently.’

Knowing that Miriam’s identity as both a person and a doctor had been shaped on a different cultural landscape than Sarah’s, one of the researchers asked Miriam to expand on her different approach, hoping Miriam would offer something of her story in order to highlight her belief system. Miriam put her focus on the future for the baby:

‘I’d almost be … just as happy or just as satisfied if the mom did give up the child. Because I know it’s going to be hard for the child, it’s going to be hard for the mom to give it up, but at the same time the mom doesn’t want the child… She obviously had no prenatal care… just because she makes that decision to keep the baby now doesn’t make her mom of the year, or make her become super mom all of a sudden… And there’s a lot of families out there who are very good and could have a child and would really care for it and love it so I would, maybe, would have approached that differently.’

Miriam noted that when a patient is making a moral life decision, it is difficult for a doctor to present the options impartially:

‘I find that a lot of the way those conversations play out is very much based on our judgements and our belief system… but how [do] you let someone arrive at a life choice when you’re sort of a snapshot in their life and you don’t really know where they come from?’

One of the researchers picked up on Miriam’s idea that doctors are only a ‘snapshot’ in the midst of a patient’s life. Temporality seemed key, as Miriam suggested that she, as a doctor, entered a patient’s life, in the midst of her own life and the patient’s life. In the moment of entering, the doctor tries to gather narrative threads that link backwards in time in both the patient’s and the doctor’s lives and stretch forwards in possibility. Miriam pointed out to Sarah that it was through her questions to the patient that she discovered ‘how she’d been hiding it… it’s very, very difficult’. Sarah agreed, noting there is much we do not know about each patient’s life situation and how alternatives come to be chosen. Miriam connected a story of her doctor husband to Sarah’s comments about her approach being shaped in a different culture and connected the conversation back to doctor identity.

One of the researchers connected the story back to Sarah’s parallel chart as she wondered whether Sarah acted ‘by chance or was that deliberate and did you have to go and take care of her after the delivery?’ Sarah responded: ‘I tried to put myself in her way to talk to her and see why is she still here.’

Having picked up on Sarah’s comment that she did not see the patient for ‘2 days’ after delivery, one of the authors tried to get Sarah to speak of the narrative coherence of the unfolding events by asking: ‘What do you think happened in between?’ Sarah reported that: ‘She called her parents and they came and they support her.’ Sarah then gave her version of the story: ‘They wanted her to keep the baby. That all she needed was some support.’

Picking up on the temporality of events, one of the researchers noted that doctors often ‘only just get such a little moment; and what happens in that moment makes such a difference’. At this point, one of the researchers asked Chris what he ‘would have done’, hoping Chris would think about who he might have been had he been in the situation. Chris responded:

‘I try not to make that decision. I might have thought that just because of how the situation presented itself but I don’t think that’s my role in that situation so I probably wouldn’t have asked all those questions and would have gotten very little social history from her; she has no prenatal care, no father and what else we really need to know is [who is providing]
the obstetrician service… I probably would have invested somebody else as best I could, certainly called social work.’

Sarah, recognising Chris’s approach as being different from hers, asked: ‘How do we know what she needs if you don’t talk to her?’ Chris responded: ‘Okay, I would have asked what are your plans for the baby, and then I would have known and then probably let somebody else sort it out, to be honest.’ Sarah persisted with: ‘Like who?’ Chris responded: ‘The social worker,’ Sarah continued to question Chris as she reclaimed her story. Under Sarah’s questioning, Chris began to see that the situation may be more complex than his first response suggested.

Before the conversation shifted to the next parallel chart sharing, Miriam returned to the importance of knowing as much as we can about each patient and his or her support systems. Sarah returned to affirming the importance of her skills:

‘I can communicate with people well, like they talk to me, they trust and they say things that they may not tell someone else. That’s why I talked to her… I could talk to her, I was a mom myself and I think it helped her a little bit.’

The unpacking of the transcript highlights a process through which Sarah tells her story and tries to integrate her practice in this setting with how she practised in another cultural setting. Miriam speaks of the importance of acknowledging living in relationship with her patients and the short moments in which life-changing decisions are made with them. Chris speaks of the technical role of doctors.

CONCLUSIONS: THE NARRATIVE REFLECTIVE PROCESS IN SHAPING PROFESSIONAL IDENTITIES

The narrative reflective process from the writing of the parallel chart, through the reading of the chart in the group, to the response and dialogue about the chart is an evolving, improvisatory process that allows doctor learners to compose their own meanings which shape their identities, their stories to live by. Connelly and Clandinin’s conceptualise stories to live by as the threads that link knowledge, context and identity and allow them to be understood narratively.

The process of narrative reflective practice allows each doctor to tell his or her story, which then becomes the starting point for the group’s shared narrative inquiry. The group, with the guidance and support of the two researchers, narratively inquires into the story by asking questions that point towards temporality (what happened before, what happens now and what will or might happen), the personal (what was happening to the person), the social (what events were unfolding) and place. Engaging in this way also directs attention towards the multiplicity of vantage points that can be adopted within the story. However, perhaps more importantly, other group members try to make meaning of the story for themselves through narratively imagining themselves into the reader’s story. We borrow the idea of narrative imagination from Sarbin. Participants search for meaning for themselves in the story they have heard. One of the key differences from the well-known approach developed by Balint is the focus on engaging the narrative inquiry process to inquire into multiple ways to interpret the story. The Balint approach, rather than an inquiry process, uses a psychotherapeutic process to engage in reflection. Often there is a focus on a problematic issue. Similarities between the processes include working towards honing the doctor as an instrument of healing, and attending to the story and making it a transformative process for the doctor. Salinsky noted significant differences in group purposes and leaders’ intentions for the group. The writing of the chart in the narrative inquiry process represents another layer of reflection.

As the pedagogical space is composed, each writer or teller reads the story into the storied landscape of the group, and each participant sees the story differently. The storied landscape is a metaphor borrowed from Clandinin and Connelly’s description of the professional knowledge landscape as a place filled with many kinds of stories which create a context that is both intellectual and moral. As the dialogue continues, the multiple meanings of the initial parallel chart are negotiated, and turned over and over as new possibilities for understanding become apparent. The goal is not to come to a shared meaning, but to allow each resident to come to his or her own meanings and thus to develop his or her own professional identity.

In the example described here, Sarah is engaged in crystallising who she will be as a doctor in Canada; she deepens her understanding of who she is as a doctor, identifies the important skills involved in asking questions and learns that relating to the patient results in the patient becoming more energetic and reconnecting with her family. She reaffirms that there is a place for her life experience in her practice.
As Sarah tells and retells her story in the writing and sharing of the parallel chart and in the dialogue around the parallel chart, she is searching for a kind of narrative coherence in her stories to live by, in effect, for her professional identity. In the writing, reading and inquiry into Sarah’s parallel chart, we see that she is ‘telling and retelling, to ourselves and to others, the story of what we are about and what we are’.6

Carr notes that the unity of self is ‘not a pregiven condition but an achievement’6 and, as such, creating spaces which encourage the telling and retelling of the stories of who we are, our stories to live by, is vitally important in the development of doctor identity. This pedagogical approach creates spaces for doctors to continue to develop their own stories to live by as doctors, in that it allows doctors individually to narratively reflect on their own interwoven personal, professional and cultural stories as they are shaped by, and enacted within, their professional contexts. The stories of others are an integral part of this process, a process which goes beyond identifying role models. A doctor’s role or doctor behaviour can be learned from others and, like a mask, can be worn or taken off, but the shaping of doctor identity is highly personal. Each doctor brings a unique life story to his or her practice, and the meanings he or she derives from the stories he or she tells from those experiences shapes the lens through which he or she views each new clinical experience. As doctors tell and retell stories of their experiences with other doctors, they metaphorically lay their stories alongside those of others. As Bateson17 writes, ‘…wisdom, then, is born of the overlapping of lives, the resonance between stories’. Resonant rememberings created by the spaces between stories are what provide us with ‘multiple lives to test and shape our own’.11 Clerkship and residency years are times when each learner doctor is most intensely involved in the shaping of his or her own doctor identity. In writing, reading and inquiring into the parallel chart, a doctor learner reflects on becoming a good doctor, on the learning from an encounter with a patient and on his or her experiences with others involved in caring for the patient, as well as from the discussion with fellow doctors within a parallel chart group. It is often this discussion which elicits increased self-awareness and the pearls of professionalism.

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