

HEALTH ADVOCACY AND DOCTORING

HEALTH ADVOCACY AND DOCTORING:
A MERCURIAL RELATIONSHIP BETWEEN OLD FRIENDS

By KERRY J. BRUNER, B.A.

A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the
Requirements for the Degree Master of Arts

McMaster University © Copyright by Kerry J. Bruner, September 2012

McMaster University MASTER OF ARTS (2012) Hamilton, Ontario (Health,
Aging & Society)

TITLE: Health Advocacy and Doctoring:
A Mercurial Relationship Between Old Friends

AUTHOR: Kerry J. Bruner, B.A. (Hons.) (University of Windsor)

SUPERVISOR: Professor James B. Gillett

NUMBER OF PAGES: vii, 124

ABSTRACT

The Royal College of Physicians and Surgeons recognizes the role of health advocate as a central aspect of doctoring that can greatly impact the quality of care one receives. Current social science literature discussing physicians as health advocates is sparse, particularly in the area of medical training. This study aims to identify how medical residents negotiate between their identity as a physician, which is bound by the narrow confines of biomedicine, and a more comprehensive vision of health care that incorporates advocacy. Residency is a critical aspect of medical training, as physicians-in-training are no longer considered medical students and are directly involved with patient care. A thematic narrative analysis of four weblogs (blogs) authored by medical residents and interns was employed to complete this study. The culture of medicine and the hidden curriculum surfaced as impediments to advocacy in residency training, resulting in residents experiencing a crisis in caring, compassion and communication. When residents were not able to care for their patients in ways that met their moral expectations of what it means to be a healer, they felt depersonalized and became disenchanted with medicine. Arthur Frank's theory regarding the demoralization of medicine is used to illuminate the importance of dialogue within the doctor-patient relationship, as well as its impacts on health advocacy. This study brings forth the question: Given what we know about medicalization and the culture of medicine, should physicians be health advocates for their patients when their training is restricted to biomedical interventions and notions of care? Sociological literature on health and illness, and interdisciplinary health journals, may benefit from this research as it explores the concept of advocacy, as well as advocacy and medicalization.

ACKNOWLEDGEMENTS

Writing a thesis is more than just putting ideas onto paper. It is collaborative experience involving the efforts of many people. First and foremost, I offer sincere gratitude to my thesis supervisor, Dr. James Gillett, for knowing when to let me roam free and when to rein me in. I would like to thank him for lending his expertise to this research and encouraging me to think more critically. His good humour and approachability has made my experience as a graduate student one that I will reflect on fondly. I would also like to thank my thesis committee members, Dr. Christina Sinding and Dr. Lisa Schwartz, for dedicating their time and energy to this endeavour, including the provision thoughtful advice and helpful suggestions.

I am indebted to my fellow Health, Aging and Society graduate students for creating a nest of support, creativity and thought-provoking conversation, as well as encouragement when writing a thesis seemed like an unconquerable task. I would also like to extend wholehearted thanks to Kristine Espiritu and Lori Ewing, the department administrative team, for gently motivating the graduate students when necessary and believing in the phrase that “no question is a stupid question”. I am grateful to Dr. Vic Neufeld for his assistance in the early stages of this research.

Many of my family members and friends have assisted me in my educational journey and I thank them for their interest and support. In particular, I would like to express my heartfelt gratitude to my mother, Sari, for being my health advocate at a time when my physician was not. Her belief in my skill and intellect has given me the confidence to achieve more than I would have thought possible. She has also acted as my primary editor for this paper and many others, and has dedicated a great deal of time and resources to my education, for this I am grateful. In addition, I would like to thank my aunt, Linda Bunn, who deserves recognition for offering helpful advice and providing thorough spur-of-the-moment editing when deadlines were looming.

I would like to express appreciation for my partner, Igor Osorio-Román, for understanding when my thesis had to be a priority, for putting up with my moments of delirium and for doing everything possible to ensure the survival of our international relationship. Despite being on the other side of the world, Igor has always been close to me. Last, but certainly not least, I would like to thank Marigold for relentlessly enforcing break-time, nap-time, bedtime, playtime, snuggle-time, dinnertime, etc. and for being my partner in crime. The dog hairs in my laptop will serve as a reminder of your companionship.

I dedicate this thesis to my parents, Sari and Walter Bunn, and Ken Bruner, who have been my steadfast advocates throughout all my adventures in life.

TABLE OF CONTENTS

Chapter One: Introduction	1
The Role of Health Advocate	2
Chapter Two: Literature Review	5
Doctoring as a Profession	5
Medical Education and Professional Socialization	9
Social Responsibility and Health Advocacy Training	14
Morality and Medicine	16
Medicalization and Pharmaceuticalization	20
Summary	28
Chapter Three: Methodology	29
Narrative Analysis and the Importance of Stories	30
Physician-Writers	32
Internet Research and Weblogs	34
Method: The Present Study	35
Thematic Narrative Analysis of Weblogs	35
Profiles of Medical Resident Bloggers	39
Advocacy as a Concept	40
Analytical Setbacks and Successes	42
Summary	43
Chapter Four: Negotiating of the Role of Health Advocate	46
The Hidden Curriculum	46
Efficiency	46
Competence and Competition	53
Support and the Hierarchy of Medicine	59
Paternalism	72
Summary	77
Chapter Five: The Demoralization of the Role of Health Advocate	79
Frank's Theory on the Demoralization of Medicine	79
The Crisis in Caring, Compassion and Communication	81
"I Would Have Been Far Better Off had I Played a Doctor on TV"	98
Summary	104
Chapter Six: Conclusion	106
Summary	106
Theoretical and Substantive Contributions	107
Directions for Future Research	109
References	111

LIST OF TABLES AND DIAGRAMS

Table 1. Profiles of medical resident bloggers	39
Table 2. The hierarchy of medicine as described by Internal Medicine Doctor	67
Diagram 1. The CanMEDS Framework of essential physician competencies	2
Diagram 2. The demoralization of the role of health advocate	98

LIST OF ABBREVIATIONS

ACGME- Accreditation Council for Graduate Medical Education

AMA- American Medical Association

RCPSC- Royal College of Physicians and Surgeons of Canada

WHO- World Health Organization

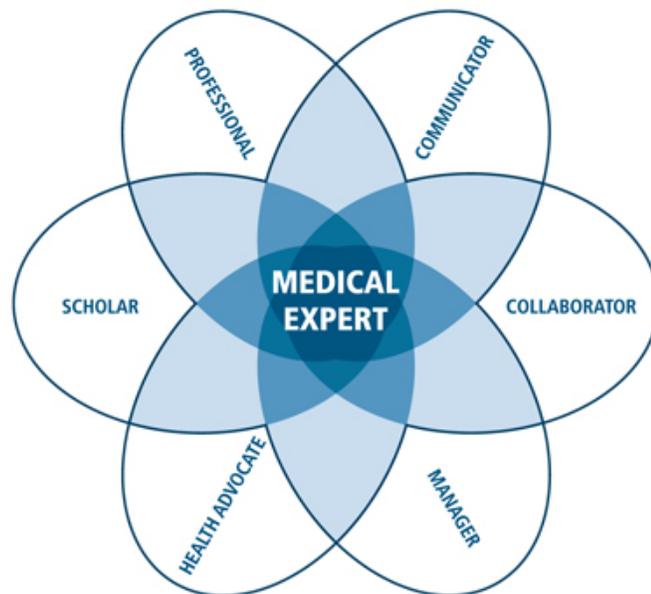
CHAPTER ONE

Introduction

Residency is a unique time in the professional socialization of doctors, where medical students make the transition to physicians and devise treatment plans for their patients for the first time. It is within this segment of their training that they learn to care for their patients, and establish their own personal understanding of what it means to doctor. This study explores one role of physicians as determined by the Royal College of Physicians and Surgeons of Canada (RCPSC): the role of health advocate. Specifically, this research aims to identify how medical residents negotiate between their identity as a physician, which is bound by the narrow confines of biomedicine, and a more comprehensive vision of health care that incorporates advocacy. To begin, the role of health advocate will be explored and the necessity for this research will be established. The following two chapters will discuss health advocacy as it is currently situated in sociological and medical education literature, and the method implemented for this study-- thematic narrative analysis. The remaining chapters discuss the impact of professional socialization on the ability of medical residents to advocate for their patients, and how this effects their negotiation of the role of health advocate. The demoralization of the role of health advocate is explored, as well as the implications of encouraging advocacy in medicine. Additionally, current definitions and understanding of the concept of advocacy will be explored and challenged throughout this research.

The Role of Health Advocate

Keniston proffers, “we know that medical care requires from the physician not only detachment and technical competence, but humane sensitivity and wisdom, plus a high sense of social responsibility” (1967, p. 354). In September 2005, the RCPSC launched a framework of core competencies that represent the abilities recognized in highly skilled physicians and has since been adapted around the world (2010). The CanMEDS framework of essential physician competencies, as it is called, was designed for medical education with the goal of improving patient care (RCPSC, 2010).



Copyright © 2009 The Royal College of Physicians and Surgeons of Canada.
<http://rcpsc.medical.org/canmeds>. Reproduced with permission.

Diagram 1- The CanMEDS Framework of essential physician competencies.

Although the competencies designated within the framework overlap, individually they comprise seven distinct roles of a physician, with ‘medical expert’ being the central role, as outlined in Diagram 1. The six additional roles are:

Communicator, Collaborator, Manager, Scholar, Professional, and Health Advocate (RCPSC, 2010).

The CanMEDS framework is integrated into the RCPSC accreditation standards for medical education and is continuously upgraded to meet the requirements of contemporary medical education and practice (RCPSC, 2010). According to the CanMEDS framework, as a health advocate a physician should, “responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations” (RCPSC, 2005). The framework describes four key competencies that physicians must be able to demonstrate as health advocates including responding to individual patient health needs and issues as part of patient care; responding to the health needs of the communities they serve; identifying the determinants of health of the populations they serve; and promoting the health of individual patients, communities, and populations (RCPSC, 2005). Working in tandem with the RCPSC’s definition of ‘health advocate’, is the social accountability mandate of the Association of Faculties of Medicine of Canada (AFMC), adopted from the World Health Organization (WHO) in 1995, that stipulates:

Medical schools have the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The

priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public. (AFMC, 2011)

Recent studies of medical education have indicated that the definition of health advocate and the expectations required of physicians in this role require clarification and direction (Dharamsi, Ho, Spadafora, & Woolard, 2011; Verma, Flynn & Seguin, 2005). The present study supports this claim and illuminates the necessity for a rejuvenation of humanistic aspects of medicine, not only for the benefit of patients, but also for physicians. The following chapters demonstrate how the culture of medicine creates a crisis in caring, compassion and communication for medical residents, and ultimately prohibits them from advocating for their patients beyond the limits of biomedicine. With their moral expectations unmet, the residents become disenchanting with medicine and contemplate their future in the profession. To begin, sociological literature and previous research on medical education will be presented to provide a basis for this argument.

CHAPTER TWO

Literature Review

Among the literature in the sociology of health and illness, only a paltry amount of attention has been given to the study of physicians as health advocates. As such, this literature review will incorporate ideas from sociological literature focusing on doctoring as a profession, medical education and its influence in shaping doctors through professional socialization, as well as medicalization and pharmaceuticalization. Additionally, this review will include an examination of literature on morality in medicine and current trends toward social responsibility in health care, as they relate to health advocacy training. The broad range of literature presented in this chapter is intended to provide an adequate base of knowledge within which to situate the study of the role of health advocate.

Doctoring as a Profession

Work in the sociology of professions has developed simultaneously with the rise of industrialization and the increase of corporatization (Hafferty & Light, 1995). In the course of the Progressive Movement, those belonging to a profession were perceived as experts who sought to advance public welfare (Hafferty & Light, 1995; Light, 1989). For physicians, this duty included improving licensing laws, opposing commercialism and improving standards in medicine (Hafferty & Light, 1995; Light 1989). Many sociologists, including Durkheim, regarded professions as a source of standards and moral authority that

served to protect the public from corporate interests (Bledstein, 1979; Durkheim, 1933; Hafferty & Light, 1995).

Parsons writes that health care in North American society is organized in a way that promotes an asymmetrical hierarchy, in which the physician is considered to be the highest grade of health care expert (1975). The physician obtains this degree of status due to the fact that he/she has been institutionally certified as being capable of carrying out the responsibilities with which physicians are entrusted (Parsons, 1975). These responsibilities include confronting, without apprehension, some of the most uncomfortable and stressful circumstances a person can go through involving intolerable pain, sexual function (or dysfunction), mental disintegration and terminal illness (Keniston, 1967). Physicians are also required to be knowledgeable not only in the biological aspects of health, but also the related social and economic consequences (Gruen, Pearson, & Brennan, 2004). Parsons further states, that a high intelligence and moral probity are imperative characteristics of a 'good' physician, to a degree that is higher than most other occupational roles in society (Parsons, 1975). As a result of the hierarchal structure of the health care system and the fact that medical schools receive public funding, medical schools and physicians have a social contract with society in which they are given special status and privileges, and in return they are expected to advocate for the health and well-being of society (Beagan, 2003; Cruess, Cruess, & Johnston, 2000a; Cruess, Cruess, & Johnston, 2000b; Dharamsi, Ho, Spadafora, & Woolard, 2011; Gruen, Pearson, &

Brennan, 2004). This commitment to the public is reflected in the values embraced by the Hippocratic Oath which medical students recite upon graduation (Cruess, Cruess, & Johnston, 2000a; Stern, 1998).

Hafferty and Light find fault with Parsons theory by pointing out that it ignores the fact that the profession relies on the “enlightened paternalism of doctoring” which fosters incompetence, ignorance and helplessness in patients as a method of social control, thus perpetuating the collective power of the profession (Hafferty & Light, 1995; Light, 1979; Waitzkin and Waterman, 1974). Schwartz elucidates that paternalism is in conflict with advocacy as the type of treatment a patient desires might not be in their best interest medically and physicians often need to distinguish between advocating for patient wishes versus the best medical option for their health (2002). Often the assumption is made that the sick individual is ill and therefore does not know what their best treatment option is, but the “doctor-father” does (Zola, 1975). Conrad states medical social control was first conceptualized by Parsons with his analysis of the “sick role” as a means of social control, and he has discerned three types: medical ideology (imposing a medical model), collaboration (doctors as information providers, gatekeepers, institutional agents and technicians) and technology (drugs, surgery and methods of screening, such as genetics) (Conrad, 1992; Conrad, 1979). Conrad adds medical surveillance or the “medical gaze” as a fourth type of medical social control, based on the work of Foucault, whereby under the panoptic gaze of medicine, the body becomes docile and something to be used,

transformed and improved (Conrad, 1992; Foucault, 1973; Foucault 1977; Williams & Calnan, 1996). The power of medicine is illustrated by the “deselecting” of people, for example in deciding who is fit for military recruitment and insurance companies determining who is well enough to receive health insurance coverage (Zola, 1975).

Sociological literature has debated over the dominance of medicine as a profession, with some putting forth the notion of the deprofessionalization and proletarianization of the medical profession. The latter refers to physicians being deprived of control over their work and the former, the demystification of expert knowledge (Lupton, 2004; Weiss & Fitzpatrick, 2004). Some argue increased corporate presence in medicine and the central role of technology have contributed to these changes in medicine (Hafferty & Light, 1995; Haug 1988). Challenges that have led to this prognosis are increased bureaucratic organization in medicine, expansions in the responsibilities of nurses, the fragmentation of the medical profession due to sub-specialties, the growth of complementary medicine, increased questioning of medical decision-making through litigation, the transition of ‘patients’ to a consumer status, the growth of self-help and advocacy groups, and greater media attention to medical issues (Lupton, 2004; Weiss & Fitzpatrick, 2004). Scientific research and knowledge has been fundamental to the social structure of modern industrial societies, but postmodern thought has led some to question what constitutes legitimate knowledge, giving increased credibility to the importance of lay, folk and practical knowledge as ways of

knowing, which help people understand the world around them (Gillett, Cain, & Pawluch, 2002). In a study of the negotiation of responsibility for treatment decision-making, Sinding et al. identified that although the patient-physician relationship may have been 'reformed', many patients accept significant responsibility for their health care decisions, but still beseech physicians that will offer their medical opinion and "make their experience, intuitions and stake in patients' lives apparent and available" (2010). Lupton discovered in a study of Australian physicians' perceptions of the medical profession, that physicians were not opposed to the notion of a reduction in their 'god-like' status and felt that patients possessed more realistic expectations of what physicians can offer (Lupton, 2004). Despite suggested changes to the dynamics of the patient-physician relationship, most sociological observers agree that medicine is retaining its dominance as a profession (Hafferty & Light, 1995).

Medical Education and Professional Socialization

Sociological literature on medical education primarily focuses on the professional socialization of medical students (Becker & Geer, 1958; Becker, Geer, Strauss, & Hughes, 1961; Conrad, 1988; Merton, Reader, & Kendall, 1957). Medical schools are powerful institutions that exert tremendous influence on the outlook of their students. Medical students typically adopt the professional culture of their school, as well as its value system, including beliefs regarding what it means to be a 'good' physician (Conrad, 1988; Coulehan & Williams, 2001; Keniston, 1967). Academic medicine has been criticized for focusing

mostly on technical skills and its scientific mission, meanwhile the interpersonal skills and values of social accountability required to be a physician have become a secondary concern (Bloom, 1988; Coulehan & Williams, 2001; Faulkner & Layton McCurdy, 2000). Bloom notes that during the 1960s medical students began to challenge conventional medical education and ‘powers’ that organized it (1988). At the same time, medicine became divided into two schools of thought, one being the conventional orientation or “reductionist approach” which focused primarily on biomedical knowledge and technology, and the second being the “social ecology” orientation which focused more on medicine’s social contract to respond to the needs of those it serves (Bloom, 1998). A balance between the two has been sought, with some superficial revisions occurring within the curriculums of some medical schools, while others have taken a more radical approach to reducing the dehumanizing effects of the biomedical model through the reconstitution of medical education, such as Michigan State University, McMaster University and the University of New Mexico (Bloom, 1988). Despite this, the conventional orientation to medical education prevails (Bloom, 1988).

Many have recognized the “hidden curriculum” as an aspect of professional socialization in medical education and how it distorts medical students ability to master the humanistic values that are intrinsic to the practice of medicine, including advocacy (Anderson, 1992; Assor & Gordon, 1987; Crib & Bignold, 1999; Hafferty, 1998; Hafferty & Franks, 1994; Lempp & Seale, 2004; Marinker, 2001; Stern, 1998; Stevenson, Higgs, & Sugarman, 2001; Woloschuk,

Harasym & Temple, 2004). The hidden curriculum is defined as, “the set of influences that function at the level of organizational structure and culture, including, for example, implicit rules to survive the institution such as the customs, rituals, and taken for granted aspects” (Lempp & Seale, 2004). This tacit type of learning involves the socialization process that inculcates professional values and sense of professional identity without explicitly or overtly articulating those values (Coulehan & Williams, 2001). Coulehan and Williams identified that tacit learning in medical school fosters three characteristics that impede the development of a caring physician: detachment, entitlement and non-reflective professionalism (2001). In short, detachment helps students to cope with their clinical training by establishing an “us versus them” mentality, and entitlement derives from the notion that medical students have paid a high price to obtain their education (long hours, tuition, deferred gratification, responsibility) and therefore warrant high benefits in return (Coulehan & Williams, 2001). Non-reflective professionalism is a belief system whereby physicians consciously uphold the traditional values of medicine (caring, empathy), but are unaware much of their behaviour is based on beliefs at variance with traditional values (Coulehan & Williams, 2001). Some feel that medical education teaches individualism, efficiency, competitiveness, and deception, which are qualities that do not delineate the ideal physician (Stern, 1998). The negative effects of the hidden curriculum or tacit learning are inimical to the goals of health advocacy as outlined by the RCPSC.

Studies have determined professionalization for medical students entails the use of symbols and symbolic behaviour for the purpose of creating an image of competence, coined a “cloak of competence” (Haas & Shaffir, 1977; Haas & Shaffir, 1982). Fueled by the desire to be successful, donning the cloak of competence is typical in occupations that place high value on cognitive skills and abilities, whereby aspirants are required to pass through various rites of passage, such as learning arduous amounts of medical information, before being assessed as successful by legitimating audiences, particularly senior medical staff (Haas & Shaffir, 1977; Haas & Shaffir, 1982). Once achieved, this elevated status creates distance between physicians, their patients, and other hospital staff, generating a ‘we’ and ‘they’ mentality (Beagan, 2001; Haas & Shaffir, 1977). The anxiety, trauma and uncertainty that accompany this part of the professionalization process are important because they nurture the idea that special competence is difficult to achieve (Haas & Shaffir, 1982).

The loss of the humanitarian aspects of medical education can be attributed to various factors. Wilkes and Raven argue that medical students are more susceptible to social influence because they are at the bottom of the hierarchy of medicine (2002). They contend that some of the predictors of a trainee’s receptivity are: a drive to satisfy intrinsic and extrinsic goals; low self-esteem; a desire of the inexperienced caregiver to do no harm; a desire to adhere to social norms; pressure from higher authorities; concern for image, status or grades; and a desire to learn or to be influenced (Wilkes & Raven, 2002). Conrad

explicates that earlier sociologists have noted the intense workload of medical students, who are forced to absorb too much information in too short of a time frame (1988). As a result, the social aspects of medicine are the most readily disposed of because they are not likely to be a part of student tests and evaluations of their skills (Conrad, 1988). Medical training is typically set up in a way that does not encourage or even prevents physicians-in-training from caring for their patients, and the patient often becomes the disease: “the lymphoma in Room 303” (Conrad, 1988). Bloom contributes to this discussion by adding that humanistic educational values and teaching competent physician behaviour come secondary to the bureaucratic requirements of the modern medical centre (1988). Bloom states,

The incorporation of modern science requires large multipurpose organizational structures; these, in turn, produce competitive divisions internally. When the general mission of medical education is subordinated to the operational requirements of the social organization, the protection of territorial domains supersedes the achievement of educational goals as the driving force of the institution. We refer to this phenomenon as the dominance of structure over ideology. (1988, p. 301)

By focusing on operational requirements, modern medicine has de-emphasized the necessity for humanistic aspects of caring, and, as a result, medical students are not supported in learning how to care for their patients beyond provision of biomedical treatment.

Using Weber’s theory of rationalization, Ritzer & Walczak claim that the medical profession is moving away from substantive rationality (the most rational

means to an end is determined by social values) toward formal rationality (the most rational means to an end is determined by rules, regulations, laws, and structures) (Ritzer & Walczak, 1988; Kalberg, 1980). The increase of external control in medicine, it is argued, contributes to the deprofessionalization of physicians (Ritzer & Walczak, 1988). Ultimately this could place limitations on a physician's ability to act as a health advocate, either for individual patients or within their community.

Social Responsibility and Health Advocacy Training

Working to serve public interest is a key component of the RCPSC's description of a physician acting as a health advocate (RCPSC, 2005), and social accountability and responsibility are receiving more attention in medicine (Dharamsi et al., 2011). In 2005, Sir Michael Marmot, Chair of the WHO Commission on Social Determinants of Health, published an article expounding that health status should be a concern for all policy makers, not just those working within the health sector (Marmot, 2005). Promoting an argument based in social justice, Marmot explained the health of a population is a reflection of the social conditions in which it lives, and if health is suffering social change needs to occur (Marmot, 2005). Marginalized and vulnerable groups of people will not be adequately served if medical systems centre the role of health advocate solely on the patient-physician relationship (Dharamsi et al., 2011). The final report of the WHO Commission on Social Determinants of Health states many inequities in health are avoidable and are born as a result "of the circumstances in which

people grow, live, work and age, and the systems put in place to deal with illness” (2008). Essentially, it is the political, economic and social spheres in which we live that generate inequities in health (WHO, 2008). The social determinants of health not only affect the spread of infectious disease, but also have ramifications for non-communicable diseases, which represent the highest number of deaths worldwide, and do not discriminate between high-income and low-income countries (WHO, 2008). Medical schools have been provided a social accountability framework by the WHO, which emphasizes the importance of working collaboratively with governments, health care organizations, other health professionals and the public to meet the health needs of society (Dharamsi et al., 2011). As part of the medical profession’s social contract with society, social responsibility is a moral commitment that has developed over centuries (Dharamsi et al., 2011).

Although recognized only recently by the WHO, the social determinants of health have been the primary focus of social medicine since the Industrial Revolution (Waitzkin, 2001). Rudolf Virchow first linked social conditions and illness by presenting pathologic observations and statistical data, concluding that fundamental social change was the remedy for society’s physical ailments (Waitzkin, 2001). Through his studies of major epidemics such as typhus, cholera and tuberculosis, Virchow concluded that advocating for social solutions to disease was a necessary compliment to clinical work (Waitzkin, 2006), in contrast to Gruen, Russell, & Brennan’s argument mentioned previously that classifies

advocacy in the realm of the broader social determinants of health as professional aspiration, not obligation (2004). Virchow saw physicians as “natural attorneys for the poor” and recognized medicine, social science and politics are intertwined (Waitzkin, 2006). Since Virchow, social medicine has flourished in other parts of the world, particularly Latin America, but it has yet to make a large enough impact to cause structural social change in developed countries (Waitzkin, 2008).

Dharamsi et al. report that despite competencies regarding social responsibility and health advocacy being adopted by the Accreditation Council for Graduate Medical Education (ACGME), American Medical Association (AMA), the RCPSC, and Health Canada, it is still unclear how best to integrate the competencies into medical education (2011). Additionally, effective teaching methods and learning assessments have yet to be discovered (Dharamsi et al., 2011).

Morality and Medicine

A conflict arises between morality and medicine. As established earlier, ‘good’ physicians are expected to possess a high moral probity (Parsons, 1975), but what happens when the physician’s moral compass is not attuned to that of the patient? Zola uses the example of abortion to demonstrate that although there is assumed moral neutrality in medicine, often “personal views march forth instead of medical wisdom” (1975). There is no explanation or guidance within the RCPSC’s definition of health advocate as to the effect of morality on a physician’s ability to advocate for his or her patients, communities or populations.

Should physicians advocate strictly according to the biomedical model of what is considered to advance health and well-being, or what is deemed morally appropriate for the patient? Zola illustrates the prominence of morality in medicine with the statement:

There is no medical or scientific answer as to when life begins or should be ended, how it should be or who should live it. These are ultimately socio-political questions-- no matter how much we might like them to be otherwise. (1975, p. 85)

Literature on courage iterates there are two types of courage: physical courage and moral courage (Clancy, 2003; Kidder, 2005; Lachman, 2007, Miller, 2005). When we speak of courage, it is typically physical courage that comes to mind, and it is often associated with battlefield heroics and acts of bravery in the face of physical harm (Kidder, 2005; Miller, 2005). Kidder simply describes moral courage as the courage to be moral (2005). While physical courage can be value-related, moral courage is value or principle-driven, with the five core moral values being honesty, respect, responsibility, fairness, and compassion (Kidder, 2005; Lachman, 2007; Miller, 2005). Therefore in comparison to physical courage, moral courage works more to protect the intangible (Kidder, 2005). Kidder argues that physically courageous people are most often acting in tandem with social norms, whilst morally courageous people are often challenging them (2005). Risks associated with being morally courageous can include humiliation, ridicule, unemployment, shame, social disapproval, loss of social standing and rejection (Clancy, 2003; Kidder, 2005; Lachman, 2007). Kidder defines morally

courageous action as a commitment to principles, awareness of the dangers associated with supporting those principles, and a willingness to endure that danger. It is believed that moral courage can be developed through habituation (Kidder, 2005; Miller 2005) or becoming ‘ethically fit’ (Clancy, 2003), and the fears involved with morally courageous actions can dissipate with training (Clancy, 2003). As Lachman points out, not all decisions requiring moral courage are a matter of right versus wrong, and when a situation consists of a right versus right scenario, and core values between two people conflict with each other, it is important to know professional ethical obligations and be aware of non-negotiable personal values before making a decision (2007). As advocacy can require challenging social norms, it is reasonable to think a health advocate should possess moral courage, and should be aware of professional ethical obligations, as well as their own non-negotiable personal values.

Kidder states that having values is different from living by values (2005). Moral distress is defined by Jameton as “the feelings and experiences which result from a moral conflict where one knows the correct action to take, but constraints lead to either an inability to implement this action or an attempt to carry out moral action which fails to resolve the conflict” (as cited in Gutierrez, 2005, p. 229; Jameton, 1984). In health care, moral distress can have implications for health care workers, as well as their patients (Gutierrez, 2005). Health care workers experience moral distress when decisions need to be made regarding resources, when rules and praxis don’t coincide, when there is a lack of support, when time

is a constraint and when conflicts of interest arise (including conflicts in values) (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Sundin-Huard & Fahy, 1999). Nurses report that constraints such as discrepancies in patient care goals between nurses, doctors, patients and their families lead to nurses feeling reluctant to come to work, decreased contact and communication with patients (occasionally resulting in nurses requesting not to care for the patient involved), a loss of self-worth, various psychological effects (feelings of frustration, resentment, sorrow and powerlessness), effects on personal relationships and the coinciding physical symptoms that people experience when under stress (Erlen, 2001; Gutierrez, 2005; Kälvemark et al., 1988). When communication is decreased between health care workers and patients as a result of moral distress, the quality of patient care is at risk (Erlen, 2001; Gutierrez, 2005). Improved medical and pharmaceutical technology designed to prolong life have also contributed to moral distress in health care workers, as ethical guidelines regarding their implementation are sparse (Gutierrez, 2005). Not surprisingly, nurses have identified over-aggressive medical treatment as a leading cause of moral distress (Gutierrez, 2005). Efforts to decrease moral distress could include improved support resources and structures to be provided by organizations, increased education regarding ethical decision-making, improved environments that foster communication and the creation of forums for discussing ethically troubling situations (Erlen, 2001; Gutierrez, 2005; Kälvemark et al., 2004).

Communication is particularly important because, as Miller notes, values and principles are often taught through the use of stories (2005).

Sundin-Huard and Fahy claim nurses may attempt to alleviate feelings of moral distress by taking up the role of patient advocate, but are typically unsuccessful when confronting doctors, and left feeling more distressed, powerless and frustrated (1999). The barriers to advocacy experienced by nurses include traditional power structures and institutional hierarchies, lack of support, time constraints and concerns for personal security (for example, risking employment by advocating) (Sundin-Huard & Fahy, 1999). It is anticipated that medical residents experience similar barriers to demonstrating moral courage and alleviating moral distress through advocacy. Education and training in ethical decision-making plays an important role in their ability to succeed in ethically challenging situations.

Medicalization and Pharmaceuticalization

Thinking critically about physicians as health advocates, it could be argued that advocacy in medicine perpetuates medicalization or “defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem or using a medical intervention to ‘treat’ it” (Conrad, 1992; Conrad, 2005). The problems referred to in this definition are typically social problems and Illich describes this as the “medicalization of life” (1976). The medicalization critique initially surrounded deviant behaviour, such as the classification of homosexuality and alcoholism as

diseases, and later included natural life processes such as menopause, aging and attention-deficit disorder (Conrad, 1992; Williams, 2001; Zola, 1975). Conrad postulates that three social factors underlie the emergence of medicalization: the power and authority of the medical profession, activities of social movements and interest groups that support the use of medical definitions for problems (e.g. Alzheimer's Disease and Post-Traumatic Stress Disorder), and organizational or professional activities that propagated medicalization, such as expansions in obstetrics which abated the use of midwives (Conrad, 2005). Medicalization can occur on three different levels (Conrad, 1992). On a conceptual level, a problem is defined using medical terminology and this may or may not involve medical professionals or medical treatments (Conrad, 1992). On an institutional level, organizations may utilize a medical approach to address the problem in which they specialize, and thirdly on an interactional level, involving the patient-physician relationship, medicalization occurs when a physician provides a medical diagnosis for a social problem (Conrad, 1992). It is easy to see how a physician acting as a health advocate could be accused of advancing medicalization. Considering that many sociologists view illness as a social construction (Brown, 1995), any medical diagnosis made by a physician could be considered the medicalization of a social problem. In today's neoliberal political climate, the responsibility for maintaining one's health lies not on the shoulders of the physician, but on the individual to avoid 'risky' behaviour (Nye 2003). Castel

points out that an expanding opportunity for medical intervention exists as a result of this health doctrine of risk prevention (as cited in Nye, 2003).

The medicalization critique has received much criticism itself, mostly for portraying medicine as a practice only detracts from one's health and describing individuals or the lay public as passive victims of medicine (Lupton, 1997; Williams & Calnan, 1996). Studies have shown that people are more skeptical of modern medicine and technology than medicalization theorists depict them and medical professionals are weary about further expansion in medicine (Williams & Calnan, 1996). Strong contends that with the medicalization analysis, sociology has attacked medicine with the benefit of hindsight by focusing on failed attempts of medical colonization (e.g. masturbation) (as cited in Williams, 2001). He also argues that patients decide whether or not to visit the doctor, and if they do, they retain the right to refuse treatment (as cited in Williams, 2001). Strong, Fox and Bury argue that medicalization has been overstated and considerable constraints to medicalization do exist (as cited in Williams, 2001; Conrad, 1992). Conrad identifies two instances of medical resistance to medicalization, the first being the resistance of the medical profession to participate in lethal injections for criminal executions as it is considered a threat to their interests as a profession (1992). The second instance of resistance is among emergency department personnel to medicalize the battering of women (Conrad, 1992). Williams illuminates the need for balance, and that biomedicine has largely been portrayed in a negative light in sociological literature (2001). Sociologists often refer to 'the application of a

medical model or disease ideology', and Strong contends that this assumes the problem is at the level of individual biology and ignores the multi-factorial approach of modern medicine (as cited in Williams, 2001). It is suggested that medicine is more holistic than sociologists realize (Williams, 2001). If this is the case, then there may be room for advocacy to co-exist with medicine.

Recently, pharmaceuticals and their role in medicine in the last 15 to 20 years have been given attention by sociologists (Abraham, 2010). The medical profession is no longer the only driving power in medicalization, as the pharmaceutical industry has become a major player in health care (Abraham, 2010). Pharmaceuticalization is defined as "the process by which social, behavioural or bodily conditions are treated or deemed to be in need of treatment, with medical drugs by doctors or patients" (Abraham, 2010). Pharmaceuticals and biotechnology are largely involved in medicalization (Conrad, 2005), but Abraham argues that pharmaceuticalization does not necessarily have to occur in conjunction with medicalization as it can describe instances where drugs are prescribed for medical conditions that are already in existence (2010). Current research has established five explanatory factors for the emergence of pharmaceuticalization: biomedicalism (including drug research, development and innovation), medicalization, pharmaceutical industry drug promotion and marketing, consumerism and the policies of the regulatory state (Abraham, 2010).

The biomedical argument for pharmaceuticalization postulates that biomedical science is progressively able to discover pharmaceutical solutions to

new or established medical problems, in other words, the increase in the availability of new drugs results in increased use (Abraham, 2010). This stance ignores the remaining factors, particularly the increase in promotion and advertising of pharmaceuticals to physicians, as well as to the lay populace (Abraham, 2010; Conrad, 2005). In the United Kingdom, staffing for research and development for pharmaceutical companies has declined by two per cent, whereas the number of marketing staff has increased by 59 per cent (Abraham, 2010). Conrad describes how the pharmaceutical companies now spend almost as much in advertising to the public as they do to physicians, especially for what he calls “blockbuster” drugs that are prescribed for common complaints, such as Viagra for erectile dysfunction (Conrad, 2005). In addition, diagnostic criteria for many ailments have become broader in order to include a larger market for the drug necessary for treatment (Abraham, 2010; Conrad, 2005). With the example of Attention Deficit Disorder (ADD), Abraham identifies that the diagnostic criteria overlaps with normal experience or other psychiatric diagnoses so much that almost 50 per cent of children in the United States fit the criteria (2010). Medical professionals play a role in the changes of diagnostic boundaries and are often on the payroll of the pharmaceutical companies or are influenced by them in other ways (Abraham, 2010). Abraham claims that medicalization and pharmaceuticalization have a symbiotic relationship and refers to this as the “medicalization-pharmaceuticalization complex” (2010).

The “off-label” use of drugs, or using drugs to solve problems other than what they are meant to be prescribed for, has also been a tactic that has led to an increase in the market size for drugs, and hence pharmaceuticalization (Abraham, 2010; Busfield, 2006; Conrad, 2005). Abraham notes that this occurs even when there is no scientific evidence to suggest a drug’s efficacy to treat additional diagnoses, and physicians have prescribed drugs knowing that it is not being used for its intended purpose (2010). The indiscriminate use of drugs leads to pharmaceuticalization through the use of drugs to treat problems that might be better treated using other means (may also cause unwanted side effects as well), drugs are prescribed in dosages that are too high, and, if the drugs are necessary, the course of treatment prescribed is often far too long (Busfield, 2006).

The medical profession’s role in medicalization and pharmaceuticalization is also symbiotic and physicians are often willing allies (Busfield, 2006). Busfield proffers that physicians have a shared interest in prescribing drugs, as they want to be able to help their patients, in some cases in the most time efficient way, and drugs provide them a way to achieve this while alleviating a wide range of problems (2006). The involvement of drugs in medical treatment also adds to the scientific mystique, which contributes largely to the power of the medical profession (Busfield, 2006).

The result is that patients have become consumers in health care, and increasingly are beginning to act as such (Conrad, 2005). Privatized medicine, the pharmaceutical industry and certain types of health care, such as cosmetic surgery

are adding to a shift in the role of patients (Conrad, 2005). Health care is becoming increasingly commodified, and health care institutions are now competing for patients, particularly in the United States (Conrad, 2005). The Internet has also contributed to pharmaceuticalization and consumerism, as all major pharmaceutical companies have websites, as do advocacy groups for particular illnesses, that often include self-assessment or diagnostic tools so the patient can decide whether or not they are at 'risk' (Conrad, 2005). Add to the mix chat rooms, blogs and web pages, and a wealth of health information can be found online regarding symptoms and treatment, empowering the readers as consumers (Conrad, 2005).

In 1983, Betz and O'Connell postulated "dissension, conflict and distrust" have emerged within the patient-physician relationship, resulting in the separation of professionals (physicians) and clients (patients) into two "communities": producers and consumers. In the last decade, the UK Department of Health adopted a discourse using the terms "informed patient" and "expert patient" to promote a consumerist ideology, arguing patients are capable of evaluating marketing claims put forth by pharmaceutical companies (Abraham, 2010). The danger of this is a reduction in the physicians' role, and their power, to that of a gatekeeper of drugs, rather than a professional who initiates discussion of therapy (Abraham, 2010), and it could close the door on opportunities for physicians to advocate for their patients. This leads to patients self-diagnosing (Abraham, 2010) and is encouraged through pharmaceutical advertisements on television that

regularly conclude with, “Ask your doctor for...” (Conrad, 2005). Conrad refers to this as “self-medicalization” (Conrad, 2005). These characteristics are more prominent in younger people, as they are more demanding of doctors and more likely to seek a second opinion (Lupton, 2004). Lupton notes that specialists are less likely to encounter a consumerist attitude in their patients due to the specialized knowledge required for their medical practice (2004). Challenges to the professional autonomy of physicians have eroded the power of medicine (and led to deprofessionalization and proletarianization), although some sociologists have traditionally thought that this would improve quality of care (Annandale, Elston, & Prior, 2004).

Although pharmaceuticalization has augmented self-surveillance in health care, health promotion programs following World War II initially placed the duty of health care on the individual (Armstrong, 2004). Health promotion programs target diet, stress and other aspects of daily life in order to encourage people to maintain or improve their own health (Armstrong, 2004). Armstrong notes that the ‘ultimate triumph’ of surveillance medicine would be for the population to internalize its mission (2004).

Discussions of medicalization and pharmaceuticalization open up many questions and opportunities for physicians to act as health advocates, at all levels. The intention of this review is not to generalize what is represented in sociological literature to all medical professionals, nor to health care in all western countries, as most will experience the issues represented in varying degrees, particularly of

pharmaceuticalization, due to the health care systems and government regulations and policies, that are in place. The point is also not to completely ignore the successes of medicine and the advances that have been achieved in medical technology (Williams, 2001). With that said, the role of the physician as health advocate does come into question, especially with regard to whose ‘best interests’ they might be representing, as well as what their capacity is as an advocate.

Summary

In this chapter the foundation was laid for the study of health advocacy in residency training. Literature on doctoring as a profession and the role of medical education in professional socialization, revealed the social contract that physicians hold with society, and how the hidden curriculum of medicine works against notions of advocacy that are imperative to the contract. Despite competencies regarding social responsibility and health advocacy being adopted by major health care institutions, integrating them into medical education has been a challenge. Moral aspects of advocacy were also explored, in particular, moral courage and the necessity for health advocates to be aware of professional ethical obligations, as well as their own non-negotiable values. Lastly, medicalization and pharmaceuticalization pose a challenge to advocacy as physicians may be inclined to propose medical and pharmaceutical solutions to social problems. The following chapter will outline the methodology employed by this study and discuss how narrative can be used as a vehicle to facilitate advocacy and improve health care.

CHAPTER THREE

Methodology

In the previous chapter, a review of literature revealed various aspects of the medical profession that do not support health advocacy, despite the obligation, or social contract medicine holds with society to act in this role. Through the implementation of a thematic narrative analysis of online weblogs (blogs), authored by medical residents, the present study builds on this foundation by examining how residents negotiate their role as health advocates. Residents were selected as the target group for this sample due to the fact that residency is an important, but understudied phase of medical training involving a great deal of professional socialization. Furthermore, residents are at the stage of medical training that involves treating patients for the first time as doctors, and patient interaction is critical to the study of advocacy. Blogs were an optimal medium for this study, as the posts were written anonymously, which allowed the authors to be candid in their stories of residency. Thematic narrative analysis, as a case-centred approach, permitted an examination of long sequences of text in order to gain a comprehensive understanding of the residents' stories. This chapter provides further detail on the importance of stories, physician-writers, the value of online research, thematic narrative analysis, the concept of advocacy, as well as a profile of each resident blogger included in the study, and a discussion of analytical setbacks and successes.

Narrative Analysis and the Importance of Stories

Narrative has been defined by Labov as, “one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred” (Franzosi, 1998; Labov, 1972, p. 359-60). Narrative can be heard, seen and read, and be presented in many ways and forms, including paintings, sculptures, performances and written texts (Riessman, 2002; Sandelowski, 1991). Franzosi takes Labov’s definition a step further by adding it is the story that provides the basic building blocks of narrative and without the story there is no narrative (1998). A story insinuates, by an unfolding of a sequence of events, a change in situations (Franzosi, 1998). Narrative analysis is described as the process of interpreting stories, whereby people tell stories, and narrative is extracted from the analysis of stories (Frank, 2000). Therefore, the researcher's role is to interpret the stories in order to analyze the underlying narrative that the storytellers may not be able to voice themselves (Frank, 2000). There are a number of ways to analyze stories, including content analysis (the “what” was spoken), the analysis of form and structure (“how” it was spoken) and dialogic/performance analysis (“who” it was spoken to, “when” and “why”)(Sparkes, 2005; Riessman, 2002). Choosing which type of narrative analysis to utilize depends on the research question being asked.

People, as active social beings, construct their personal and cultural realities through narrative and storytelling (Sparkes, 2005; Williams, 2000). Many argue narratives (and stories) offer description not only of the inner world

of the storyteller and the person about whom the story is told, but also provides insight into the identity, intentions and feelings of the person telling the story (Cortazzi, 1993; Crossley; 2000; McAdams, 1993; McLeod, 1997; Murray, 1999; Sparkes, 2005). Murray states a narrative identity is created when we tell stories about our lives to ourselves, and others (2003). As such, personal experience and meaning can be systematically studied through narrative analysis, as well as the power of stories to create and re-forge identity (Riessman, 2002). Group belonging and collective action are potential products of storytelling (Riessman, 2008).

Finding the simplicity in narrative order, that when one thing happened it was followed by another, puts the mind at ease through the illusion of sequence and order, the appearance of causality and necessity (Kermode, 1967; Sandelowski, 1991). Sandelowski states the goal of narrative explanation is to generate a rendering that is well grounded to provide an explanation of why something happened (1991). Frank offers, “the local and contingent solutions that people have found to how they should live are expressed as stories that recount past attempted solutions to how they should live and are part of their ongoing attempts to seek present ways of living” (2002b, p. 110). Referring to Weber’s theory of disenchantment, he argues narrative is an attempt at re-enchantment and the collective patterns present in narrative can offer solutions to how we should live by providing moral education (Frank, 2002b). Narratives remind people of who we are, and who we are not, and the value of identity (Frank, 2002b). In

disenchanted times it is our responsibility to listen to these “sparks” of re-enchantment (Frank, 2002b). Similarly, Williams discusses the use of narrative and storytelling by people with chronic illness and disability and how narrative reconstruction helped them to make sense of their disease in relation to their life as a whole (2000). Narrative reconstruction allowed them to get past the biographical disruption of being ill, and recreate meaning and a sense of purpose in their lives (Williams, 2000). Frank contends narrative analysis goes beyond knowledge production brought forth through people’s stories, but the process of narrative research itself is participating in storytelling (2002b). Williams warns, in medicine “it is important that we do not let our enjoyment of a good yarn to deflect us from thinking about both the knowledge a story contains and its emancipatory possibilities” (2000, p. 139). The present study is participating in storytelling by retelling the residents’ stories and generating new knowledge with regard to the values and meanings they associate with the role of health advocate.

Physician-Writers

The study of literature has been a part of medical education in the United States since the 1970s, a time when the human dimensions of medical care became more recognized (Charon, 2000; Coulehan & Hawkins, 2003). In present times it is not uncommon to see stories and poems written by physicians for their colleagues, or with the general public as an audience (Coulehan & Hawkins, 2003). By including the study of literature in medical education, five broad goals are met: 1) physicians can learn powerful lessons about the lives of sick people

through literary accounts and learn to listen more completely to illness narratives; 2) physicians are able to recognize the power and implications of the work they do; 3) patients' stories of sickness can be better understood, as well as the physicians' own stake in the work they do; 4) expertise in narrative ethics can be improved; and 5) schools of literary theory can address problems physicians confront in medical practice and help them to understand the texts of medicine (for example, the hospital chart that accompanies each patient) (Charon et al., 2003). A physician's narrative competence is crucial for medical practice as skills of observation, perception and interpretation are improved through reading and writing (Charon, 2000).

Charon contends there are at least 5 distinct genres of narrative writing in medicine: medical fiction, the lay exposition (written to inform the lay public about health issues, health promotion and/or to encourage social change regarding how medicine is practiced), medical autobiography, stories from practice and writing exercises used in medical training (2001). Informed by medical training and practice, physician-writers possess a larger perspective than most writers (McLellan, 1997). In line with Virchow's description of physicians as natural attorneys for the poor, physicians make indispensable authors because they are privileged participants and witnesses in human experiences that are emotionally and physically intimate, that involve all the trials and tribulations of life and death (McLellan, 1997; Waitzkin, 2006). Writing stories about medicine and medical practice enables physicians, their patients and the lay public to gain understanding

and create meaning out of illness experiences (Reisman, Hansen & Rastegar, 2006; Verghese, 2001). Charon states that writing about patients who bestow her grants her access to knowledge she feels she would not otherwise have, about herself or the patient (2001). Reflection, self-awareness and empathy are products of the writing process for physicians, and using narrative medicine physicians-in-training learn to hone their abilities to listen to their patients, gain appreciation for the patient-physician relationship and are reminded that the patient is more than just his or her disease (Reisman, Hansen & Rastegar, 2006). Ultimately, medical students learn through literature what they are called on to do as physicians and what working in medicine will do to them (Charon et al., 1995).

As physician-writers sharing their literary work, the authors of the blogs are attempting to create meaning and develop an understanding of their experiences as medical residents and interns (Weisberg & Duffin, 1995), and, as such, open the window to observing advocacy from their point of view, a story that cannot be told by anyone else. For these reasons, studying stories authored by physicians-in-training will provide the depth of knowledge required to study how residents and interns are socialized to become health advocates.

Internet Research and Weblogs

Internet research is gaining in popularity for many reasons. It offers researchers expanded access to research participants, decreased cost and time, the removal of transcription biases, as well as simplified data organization (Lombardo & Gillett, 2006; Mann & Stewart, 2000; Walstrom, 2004). Comfort for research

participants is increased due to the lack of face-to-face contact, enabling them to provide data that is fecund with insights that people seldom discuss publicly (Walstrom, 2004), as well as a reduced need for the participant to feel the need to please the researcher (Lombardo & Gillett, 2006). Weblog (blog) analysis allows the authors, in this case residents and interns, to express themselves in unprofessional terms using everyday language (Lombardo & Gillett, 2006). It also allows them time to reflect on their stories, as any time limits would be self-imposed, and events could be recalled immediately after their occurrence, making any data attained more “live” and naturalistic (Lombardo & Gillett, 2006).

The narrative text of blogs is a valuable aspect of online research, as Markham notes, “just as the text cannot capture the nuance of the voice, the voice cannot capture the nuance of the text” (1998). Although the nuance of the voice cannot be captured, the linguistic characteristics of spoken word are often used in online narrative, such as “lol” and “hmmm”, which can aid the researcher in identifying the mood of the writer and the interpretation of meaning (Walstrom, 2004). Lombardo and Gillett note the broad range of information conveyed online through the use of text, images, sound and video that can make online research more bountiful than other methods (2006).

Method: The Present Study

Thematic Narrative Analysis of Weblogs.

The present study consists of a thematic narrative analysis of four biographical accounts published online as weblogs (blogs), authored by medical

residents or interns, with the internship year being the first year of a residency program (the term 'resident' will be used here on in to represent both interns and residents). The blogs, accessed between June- October 2011, are narrative descriptions of the experiences of the residents as they advance from medical school into medical practice. All blogs were written anonymously with the writers using pseudonyms, which will be used in this thesis to differentiate the authors. Due to the anonymity of the blogs and their public availability on the Internet, approval from the McMaster Research Ethics Board was not necessary for this study. Blogs were ideal as the sampling frame for this study, particularly because of the anonymity they offered. The residents were able to narrate their experiences without having to be concerned about repercussions. One other aspect of this method that made it superior to interviews is that the bloggers were not prompted to discuss issues the researcher felt were of importance, but had the freedom to express what they considered to be their genuine concerns, as well as their successes. The unit of analysis for this research is each story written by the residents, which at times could make up multiple blog entries as the authors regularly update readers on past events.

Residents were of interest for this study due to their completion of medical school (hence they should be aware of their role as a health advocate) and that they are entering a period of their professional socialization as doctors, for the first time interacting with patients in this capacity. In terms of medical practice, residency is a period when residents rotate through various medical specializations

and types of practice and, for the purposes of this study, it allows advocacy to be studied in various medical environments and cultures.

An Internet search using the Google search engine was performed using terms such as “medical resident blog”, “residency blog” and “med blog”. Blogs were purposively selected based on the criteria that they discussed the residents’ interactions with patients and their experiences in a clinical or hospital setting. Blogs that primarily focused on the personal lives of the residents were excluded. Four blogs were selected to be the cases making up the data corpus, with two authored by males and two by females. The authors consisted of three American residents and one Canadian (see *Table 1*). Fitting with the type of analysis employed (thematic narrative analysis- explanation to follow) the cases were selected for the purposes of developing a theoretical argument, and not meant to be statistically representative of all residents. The shortest blog consisted of 69 posts and the largest 271 posts. The earliest blog began in 2004. After the blogs were selected, posts that demonstrated elements that could impact the way residents negotiate their roles as health advocates, as well as instances where advocacy took place, were extracted to create the data set for analysis. Negative cases where advocacy did not occur, but possibly could have, were also examined in order to determine barriers. Thematic narrative analysis was the method of choice for this study.

Thematic narrative analysis describes the identification of common thematic elements across research participants, the events they report and the

action they take, much like other qualitative methods (Riessman, 2008).

Thematic narrative analysis is most often confused with grounded theory.

Riessman points out there are key differences between the methods (2008):

1. Thematic narrative analysis is often guided by prior theories and concepts-- grounded theory is not. In this study, prior theory will serve as a resource for the interpretation of the narrative. In particular, Arthur Frank's theory of the demoralization of medicine will be applied (see Chapter Five- Theoretical Framework) (Frank, 2004).
2. Thematic narrative analysis is case-centred, whereas grounded theory attempts to theorize across cases.
3. The greatest difference between thematic narrative analysis and grounded theory is evident in coding practices. Coding when using grounded theory has been described as "taking segments of data apart, naming them in concise terms and proposing an analytic handle to develop abstract ideas from interpreting each segment of data" (Riessman, 2008). In contrast, thematic narrative analysis strives to keep the 'story' intact for interpretive purposes, and to preserve sequence and substance of detail contained in long segments of narrative (Riessman, 2008). For this reason, all thematic coding for this study will be completed by hand, without the use of computer technology, in order to allow for a thorough examination of longer narratives, and in an effort to "live" with the data more fully (LeBesco, 2004).

When using thematic narrative analysis the researcher investigates one case at a time, isolating relevant events (Riessman, 2008). When this is complete, underlying assumptions in each account are discerned and coded (Riessman, 2008). To illuminate general patterns, particular stories are selected to demonstrate range and variation, and at this point, the cases are compared for their underlying assumptions (Riessman, 2008). Attention is paid to context, ranging from local to societal, with societal context receiving the most attention typically (Riessman, 2008). In this type of analysis the emphasis is on what is told by the author, and not how is it told or to whom (Riessman, 2008). The motive behind thematic narrative analysis is to “map the contours of the interpretive process” (Riessman, 2008).

Profiles of Medical Resident Bloggers.

Pseudonym Used for Blog	Location During Residency	Sex	Medical Specialty	Year of Residency	No. of Posts	Name of Blog
Dr. Couz	Canada	F	Emergency Medicine and Family Practice	Year 1- finish	196	Tales from the Emergency Room and Beyond
Nathan	U.S.A.	M	Cardiology	Year 1	82	A Jolly Company
Medical Resident (Idiopathic Medicine*)	U.S.A.	F	Emergency Medicine (Pediatric)	End of Year 1- End of Year 3	69	Idiopathic Medicine
Internal Medicine Doctor	U.S.A.	M	Internal Medicine	Year 1-finish	271	Tales From a Medical Madhouse

Table 1 – Profiles of medical resident bloggers.

*The researcher changed Medical Resident’s name to “Idiopathic Medicine” in order to eliminate confusion due to the name being generic in nature.

Advocacy as a Concept.

Medical literature uncovers the need to define advocacy in order to be able to create guidelines to provide protection for both patients and advocates, in this case being physicians (Schwartz, 2002; Verma, Flynn & Seguin, 2005). Six characteristics of a patient advocate as outlined by Schwartz (2002) include,

1. inform the patient and promote informed consent (Caplan, 1997; Willard, 1996),
2. empower the patient and protect autonomy (Caplan, 1997; Willard, 1996),
3. protect the rights and interests of patients where they cannot protect their own (Caplan, 1997; Willard, 1996),
4. ensure patients have fair access to available resources (Burke, 1997; Caplan, 1997; Hazzard, 1995),
5. support the patient no matter what the potential cost (Schwartz, 2002), and
6. represent the views/desires of the patient and not just his/her needs (Schwartz, 2002).

In a study of how patients develop concepts of trust, Mechanic and Meyer determined that patient advocacy is a common theme (2000). Participants in their study used phrases such as “advocates, argues for, defends, does everything in their power, in my best interests, fights for, doesn’t give up, never stops trying, on my side, sticks up for you, puts self on the line” and so on to describe physicians they trust (Mechanic & Meyer, 2000). According to Parsons, physicians are obligated to reinforce the patient’s motivation to recover from illness (1975), but

at times this also could constitute paternalism if the patient does not want to recover. At the micro level of the patient-physician relationship, advocacy can be complicated and physicians need to be prepared appropriately for this role (Schwartz, 2002; Verma, Flynn & Seguin, 2005).

Beyond the level of the patient-physician relationship, physicians can advocate for their patients in various ways within their community, or on a global scale (meso and macro level). Gruen, Russell and Brennan describe these physicians as “physician-citizens” and argue that there needs to be distinction between professional obligation and professional aspiration (2004). Promoting access to health care and addressing socioeconomic factors that directly affect the health of individuals (e.g. public policy about smoking) are considered professional obligations and need to be assessed according to evidence of illness causation and the feasibility of physician action (Gruen, Russell, & Brennan, 2004). Outside of this realm, where evidence of causation is weaker, lie professional aspirations (Gruen, Russell, & Brennan, 2004). The broader social determinants of health are included as professional aspirations, as the connections to health, although acknowledged, are less obvious (Gruen, Russell, & Brennan, 2004).

The definitions of advocacy provided by Schwartz (2002), as well as Gruen, Russell and Brennan (2004), will be used as a guideline for this study to identify instances where the residents demonstrate advocacy, and situations where they are not fulfilling their roles as health advocates. The CanMEDS definition of

the role of health advocate will also be utilized in order to provide a definition of advocacy, as it is understood in medical education. In addition, the concept of advocacy will be explored further in the discussion of the findings of this research to illuminate areas where understandings of this concept, as described in literature and in lay knowledge, are ambiguous.

Analytical Setbacks and Successes.

In terms of analytical setbacks, it is possible that issues with residency and medicine in general were over-reported in comparison to the everyday aspects of their careers that promote advocacy that do occur. It was noted that a few of the bloggers (Internal Medicine Doctor, Idiopathic Medicine) wrote less of their own experiences in medicine as their blogs progressed and began to write more about medical topics that were of interest to them, which could indicate they began to see the blog as an unsafe medium for airing their frustrations, they began to except that their situation wasn't going to change, or they began to cope with their circumstances more successfully as they continued their training. Also, the research completed relies on the fact residents are being truthful about their experiences. Lastly, the lack of blogging medical residents led to a smaller sample size than desired. Finding blogs that contained posts about the actual experience of residency was difficult, as most medical residents and interns preferred to write about their personal lives or strictly about medical topics. It is likely that there are not many resident bloggers due to the restricted amount of time they have available for extra-curricular activities.

The inability to ask the bloggers direct questions was a hindrance to this research as probing may have revealed clarification on how residents felt their professional socialization affected their negotiation of the role of health advocate specifically. On the other hand, the anonymity of the blogs, and the fact that they were not aware of this research, is also an analytical success because it allowed for more candid information from the bloggers. Residents were able to voice their opinions without fear of repercussions and without the restriction of having to use professional language. Additionally, with blogs being located online, and containing search engines, a database of posts was readily available making access to the research data expedient and uncomplicated, thus saving time and resources. The ability to copy and paste blog posts eliminated the need for transcription and reduced the likelihood of human error. Furthermore, the analysis for this study included posts that had been published online immediately prior to analysis, making the data set as current as possible. Overall, the use of blogs provided a depth of data that would not be accessible by any other method.

Summary

People construct their personal and cultural realities through narrative and storytelling, and, through narrative analysis, the researcher's role is to interpret the stories in order to analyze the underlying narrative that the storytellers may not be able to give voice to themselves. Personal experience and meaning can be systematically studied through narrative analysis, as well as the power of stories to create and re-forge identity. Physicians make indispensable authors because

they are privileged participants and witnesses in human experiences that are emotionally and physically intimate, that involve all the trials and tribulations of life and death. As physician-writers sharing their literary work, the authors of the blogs are attempting to create meaning and develop an understanding of their experiences as medical residents and interns. The advantages to online research include: expanded access to research participants, decreased cost and time, the removal of transcription biases, and simplified data organization. Online research also provides anonymity for participants, allowing them to make statements that they wouldn't otherwise want public, and decreasing any desire to please the interviewer. It also allows them time to reflect on their stories.

Thematic narrative analysis describes the identification of common thematic elements across research participants, the events they report and the action they take. It is often guided by prior theories and concepts, is case-centred and strives to keep the 'story' intact for interpretive purposes, while paying attention to context. Emphasis is on what is told by the author, and not how is it told or to whom.

For the purposes of this study, advocacy will be described as informing the patient and promoting informed consent, empowering the patient and protecting their autonomy, protecting the rights and interests of patients where they cannot protect their own, ensuring patients have fair access to available resources, supporting the patient no matter what the potential cost, and representing the views/desires of the patient and not just his/her needs (Schwartz, 2002). Gruen,

Russell and Brennan notion of “physician-citizen” will also be used to identify instances of advocacy beyond the patient-physician relationship (2004). In addition, the CanMEDS definition of the role of a health advocate will be employed, as it is used in medical education. The next chapter presents the substantive findings for this study and describes the impact of the culture of medicine on the medical residents’ ability to negotiate their roles as health advocates.

CHAPTER FOUR

Negotiating of the Role of Health Advocate

The literature review revealed that medical students typically embrace the value system of their school, and the professional culture, including beliefs regarding what it means to be a ‘good’ physician (Conrad, 1988; Coulehan & Williams, 2001; Keniston, 1967). A careful analysis of each resident’s story revealed four aspects of professional socialization in medicine, also fundamental to the culture of medicine, influencing the negotiation of the role of health advocate: 1) efficiency, 2) competence and competition, 3) support and the hierarchy of medicine, and 4) paternalism. This chapter outlines the experiences of the residents as they negotiate their roles as health advocates and make the transition from medical student to physician.

The Hidden Curriculum

As discussed in Chapter Two, the hidden curriculum of medical education is described as organizational and cultural influences that tacitly teach values and a sense of professional identity through the professional socialization process (Coulehan & Williams, 2001; Lempp & Seale, 2004). This study revealed four aspects of the hidden curriculum in medical training that influenced the residents’ ability to negotiate their roles as health advocates.

Efficiency.

With recent physician shortages and a focus on efficiency in hospitals and clinics, patient loads have increased, along with the responsibilities of physicians.

Academic hospitals are no exception, as residents are challenged with providing exceptional patient care while at the same time learning their profession and, for some, teaching interns and medical students that are below them in the medical hierarchy. Demonstrating the emphasis on efficiency, Nathan speaks of the difference between being a medical student and a resident:

As a medical student, I had charge over one, two, or at most four patients. These were acquired gradually, over a period of days, and I came to know them well. Now, on cardiology, I regularly admit six patients on a call night, and then I have to know them well enough to present the following morning... I realize that I cannot get information the way I am used to, cannot use the same organization. I must move faster, more thoroughly, more efficiently. (Nathan, July 8, 2007)

Idiopathic Medicine discusses the moral obligation traditionally felt by physicians to exceed expectations and put the needs of others above their own. She also discusses the valuing of efficiency over caregiver well-being and the pressure on residents to accept their circumstances without complaint:

Part of the inherent problem with physicians is that we have a difficult time accepting our own limitations – even though pilots and truck-drivers abide by strict duty-hour regulations, we are above that – we are physicians. Our duty is to surpass all expectations, to be the most noble and the most educated, to ignore the basic human needs of sleep and food, in order to serve our brethren. (Idiopathic Medicine, June 24, 2010)

This is the down and dirty, high-intensity, high-volume job where sleep is viewed as exceedingly unimportant, where the concept of caregiver well-being is brushed aside, and where anyone who dares to bring up these issues is viewed as weak rather than well-balanced. (Idiopathic Medicine, June 17, 2010)

Residents are socialized to accept their circumstances and allow themselves to become depersonalized, regardless of the negative impact it has on their own health or the health of their patients. This demonstrates the transition from substantive rationality (the most rational means to an end is determined by social values) toward formal rationality (the most rational means to an end is determined by rules, regulations, laws, and structures) (Ritzer & Walczak, 1988; Kalberg, 1980). Dr. Couz makes the following statement regarding sleep deprivation and the culture of medicine:

Of course medical residents are sleep deprived. It's practically in the job description. We know it's not healthy. We know it's not a sustainable lifestyle. But it's the way it has always been done. Stories of sleep deprivation are legendary among residents, who often share them as though they were badges of honour... 'Post-call' wasn't just a description of our work schedules, but a state of mind and an excuse for all sorts of mental dysfunction. It was part of the rite of passage. (Dr. Couz, December 29, 2006)

Often required to work shifts that are over thirty hours in length, residents regularly feel the effects of sleep deprivation. Dr. Couz provides the following description regarding the hours of work required by residents in the United States and Canada:

Residents in the US follow the 80-hour workweek, as legislated by law. The rules limit residents to an 80-hour workweek; prohibit any single stretch on duty of more than 24 hours, which must be followed by a full 24 hours off; and require at least 10 hours between shifts and at least one full day off a week. To most other professions, this is still a hellish schedule. To a Canadian resident, this is a cakewalk.

In Canada, the rules are less complicated-- 'in-house' call (meaning when you work overnight in the hospital, usually with little to no sleep) is limited to one every four days. So on this 'on-call' day, you start with your team (start time could be anywhere from 6am to 8am, depending on the rotation) and you work through the day and night. On your 'post-call' day you must be excused from your duties by noon. Ideally. These rules are haphazardly enforced. Particularly in surgical specialties, where the old-boys-club rules, leaving the hospital when you are post-call is often viewed as a sign of weakness. Many of the surgical Residents don't feel that they should leave, for fear of missing an interesting case. So they work a usual 12-14 hour day after putting in a full 24-hour shift. Or, in the case of orthopaedic surgery (the ultimate 'old-boys-club') they consider their call 'home call' (meaning they sleep at home and come in when needed) even though they end up spending the entire night in the OR more often than not. This allows them to be on call every three days, rather than every four days. In the province of Ontario, the Workplace and Contract Compliance Committee that is run by the resident's union is impotent in cracking down on abuses unless someone comes forward with concrete proof. And no one wants to be 'that guy'. (Dr. Couz, December 29, 2006)

In other occupations these types of work schedules would not be permitted, particularly in unionized environments, out of concern for the health and safety of the workers. In the case of physicians, the dangers are amplified as the health and safety of their patients is also at risk, yet they work hours that are well beyond the norm.

The stress of working in a high-pressure environment, which involves making decisions regarding people's lives, while exhausted, takes an emotional and physical toll on residents. Internal Medicine Doctor provides evidence of this as he describes a particularly frenetic week:

As I write this I am crying. Honestly. It has been a very rough week. The first day I was picking up the service and on call at the same time, had 2 patients on the floor crashing while I'm trying to admit eight more, figure out the patients I am suddenly managing and trying to teach two relatively new interns how to do anything. [I] left very late at night and presented my patients to the Chief of Medicine in the morning. Who made me look like shit in front of nearly everyone. The week went downhill from there, until today. But after this afternoon, **I am broken.** (Internal Medicine Doctor, October 1, 2004, emphasis is original)

Dr. Couz describes the physical symptoms she experiences while sleep deprived and remarks that she feels depersonalized. Expressing concerns for her patients, she writes:

By 4:30 am I was starting to feel physically ill from the effort it was taking to stay awake... I got two 15-minute naps before it was time to get up for good. It was brutal. This kind of post-call is the worst. You feel completely depersonalized. You're nauseous. You are unable to formulate coherent thoughts, let alone express them. At this point, I have to honestly say that I feel like I'm a danger to my patients. (Dr. Couz, November 26, 2005)

Similarly, Nathan tells of his inability to advocate for his patients by researching treatment options and the decline in his motivation, both being consequences of exhaustion:

... the flog is taking its toll. My motivation to read (or at least skim) an article or two on each of my patients before rounds has dropped off. Last night I fell asleep sitting up in my chair, in the process of typing a note. Where I was once understanding of being paged for even the dullest questions from nurses, I'm getting dangerously close to snapping out things like "that's exactly what I wrote in the orders, twice, and I just spent 30 whole seconds clarifying it in person." (Nathan, August 16, 2007)

This anecdote illustrates how exhaustion is affecting his ability to adequately care for his patients. The accuracy of his notes is at risk, and he is becoming unapproachable to other health care workers who require his assistance.

Demonstrating how dehumanizing it can be to work in an environment that requires maximum efficiency, Internal Medicine Doctor shares his idea of the “Perfect-Resident”:

I have a dream, nay, vision of a better world. In my better world Perfect-Residents exist. They are better Residents, maximally suited for today’s inpatient overload. Perfect-Residents admit eight to ten patients per night. They do this by disregarding all human urges... so that nothing may prevent them from achieving their ultimate goal.

Perfect-Residents travel attached to IV poles, ... Perfect-Residents run on hydrogen and emit only water as a waste product... Their gastric tubes are continually fed by a mix specially designed by our Pharmacy Department to include a potent form of caffeine and all the legal available amphetamines in the institution. Perfect-Residents are continuously conscious having overcome the need for sleep, powered by chemical energy... Thinking, as a general exercise, will be outsourced... of course, we’ve found that the Current-Resident thinking is skewed and easily affected by fatigue and other such *unimportant* factors. Not to mention that Intern thinking has been proven to be an exercise in futility... Get ready for the new improved prototype of graduate whose soul [sic] purpose in life will be to admit, obey and do as little thinking as possible. (Internal Medicine Doctor, January 18, 2005, emphasis original)

Nathan also addresses the inability to think due to exhaustion in the following post:

I came into medicine partly because it allowed me to treat people, to be around people, who are dealing with real questions, and to deal with them myself... I thought as a

medical student. As an Intern, I'm harried to the point that thought beyond "what do I need to do now?" is difficult. If I'm not moving, there's something wrong... All this action, all this doing, keeps me from thinking. (Nathan, July 17, 2009)

He expresses his yearning to practise the humanistic aspects of medicine, which are essential for some types of advocacy to take place. His inability to think beyond "what do I need to do now?" implies that there is no space for compassion or empathy, and that communication with patients does not extend beyond what is required for his tasks. As noted earlier, this environment could lead to pharmaceuticalization, as physicians seek ways to treat their patients more efficiently and attempt to attenuate as many problems as possible (Busfield, 2006). Idiopathic Medicine explains how losing the humanistic aspects of medicine has impacted herself and her fellow residents:

I am not sure what the solution is. With the demanding hours of this training, and the way residency – a living, breathing being – devours our lives, takes from us any ounces of energy which we may have remaining... I am not sure how we can open ourselves up to this, emotionally, and survive it. And so, at least for now, we do not. I watch my fellow residents. We walk around this hospital like zombies, more absent than present. I can only wonder how we will emerge from this – as alienated as we are now, or will we regain some sense of warped humanity after all of this is over... Only time will tell. (Idiopathic Medicine, February 2, 2011)

It is interesting to note that Idiopathic Medicine implies that even after residency she expects only a "warped" sense of humanity is to be regained.

In the following metaphor, Idiopathic Medicine reveals how medicine infiltrates all aspects of her life. She writes:

Maybe residency is a storm, wearing me down and taking its toll, day in, day out, hour after hour-- as I am flooded with a room full of suffering patients, and as I encounter moment upon moment of difficult intubations, suicide attempts, sexual assaults. The rain never stops, the flood never subsides, the doors never close-- and I never leave, through it all. The cruel irony is that even when I leave for 12 to 24 hours, I never really *leave*. My spirit remains there. This flood creeps in through the windows to invade my dreams, interrupt my sleep, and remind me that my patients are still-- always present, waiting, coming, dying. (Idiopathic Medicine, September 3, 2010, emphasis is original)

Residents spend so much time working that their personal lives are almost non-existent, and even though they may physically leave the hospital at the end of their shifts, their minds often remain with their work. This type of lifestyle is unhealthy and can generate a great deal of stress, as Idiopathic Medicine confirms by stating that her sleep is interrupted by her thoughts of work. If perpetuated, this could lead to burnout.

Competence and Competition.

The culture of medicine takes advantage of a resident's desire to succeed and, in addition to supporting dangerously long hours of work, the hidden curriculum coerces residents into believing that they need to be perfect, and if they aren't perfect, then they need to at least appear as though they are:

From an historical perspective, doctors have long been discouraged from admitting their mistakes. In doing so, they put themselves at risk for criticism and humiliation from their colleagues. The old-fashioned, paternalistic approach to medicine required that the physician maintain an image of professional, intelligent, and even faultless behavior. To admit openly to anything less than this would

be considered failure. (Idiopathic Medicine, August 25, 2010)

Evidence presented in the blogs suggests that residents are mindful of the need to appear “professional, intelligent and even faultless” (Idiopathic Medicine).

Nathan describes his concerns over making mistakes in front of his superior, and the impact it may have on his future:

Probably I will never be a success in my own eyes. But when I make stupid mistakes, like today in rounds, actually forgetting to write down half of a patient's chemistry panel and asking my resident for the numbers in the middle of my presentation, in front of the cardiology fellowship director, it is easy to sink farther in my own estimation than usual, even. Sigh. The only positive I can think of is the fact that I'm learning the hard way, which tends to make a more lasting impression. I just don't want to destroy my chances of success here before I even start. (Nathan, July 8, 2007).

The need to appear intelligent weighs on the minds of the residents as they are encouraged to preserve the mystique of science and, hence, the power of the medical profession (Busfield, 2006). Often feeling insecure and unsure of themselves, they question their ability to practise medicine:

These cases are complex and intriguing, but instead of feeling amazed one becomes amazingly overwhelmed as one's vocabulary instantly expands. It is truly incredible how many intelligent ways there are to write, “I don't know”. A few of my favourites: “unclear origin of source”, “questionable significance of finding”, “consider idiopathic origin”. Heck, I'd write “Dahhhh” and scratch my head if I didn't think more was expected of me. (Internal Medicine Doctor, January 26, 2005)

Perfection is difficult, if not impossible, for any human to attain, but particularly so in medicine with the high-volume of information that must be processed (and

when extremely sleep-deprived). In this post, it is clear that Internal Medicine Doctor is attempting to prove his competence despite his inconclusive findings in view of the fact that he feels more is expected of him. He is assuming a 'cloak of competence' in an effort to be assessed as successful by the legitimating audience of his senior staff (Haas & Shaffir, 1977; Hass & Shaffir, 1982). Internal Medicine Doctor describes the immensity of information residents are expected to retain:

Two weeks into the current rotation I find that the hardest thing about being a resident is keeping all these different patients and all their coexisting medical conditions straight in my head. As we round each morning through twenty to thirty patients for whom I am personally responsible, they all seem to blend together and become one big mega-patient. (Internal Medicine Doctor, October 16, 2004)

Like most professions, physicians gain experience in their field by learning from their mistakes, which unfortunately can be costly for their patients. Internal Medicine Doctor elucidates how this makes him question his work:

Whenever a patient dies I question myself as a physician. What was missed? Was I to blame? Was there something I did to provoke this? Could I have prevented this? Was there something I should have been doing differently? Were there any clues?... Unfortunately, experience in medicine is paid in the blood of others. How many will pay before my mind and senses work as one? God only knows. Until then, the clues will hide in scripted notes written by interns and residents, and consult notes. One day the hints will jump off the page and present themselves as clearly as the moon in the night sky. Until then, I will be the everlasting student. How many have you killed? Hindsight is so cruel to the physician. (Internal Medicine Doctor, August 30, 2005)

Understandably, when a patient dies residents feel a sense of failure and guilt. To expect perfection is unrealistic, but residents often feel that a 'good' physician is one who always has positive results (medically), as this is the sign of a competent doctor. The problem with the 'mystique of science' and the 'cloak of competence' is that it raises the expectations of physicians and their patients to the point where biomedicine is expected to cure all ailments. The reality is that in life the end result is always the same, and in biomedicine death is not typically seen as a success. This creates a gap between expectations and outcomes, which leads to self-doubt for physicians, disappointment for patients and their families, and disenchantment with medicine for both parties. This may also explain in part why patients are willingly taking on more responsibility for their health, as trust in medicine has diminished and health information has become more readily available.

Learning medical techniques and procedures is a sizable portion of residency training, as residents need to be proficient before working unsupervised. As noted by Conrad, social aspects of medicine are consequently lost, as residents are expected to learn too much information in too short a time and are not likely to be evaluated on their social skills (1988). Internal Medicine Doctor describes a situation when another intern's focus on completing a procedure puts a patient at risk. The intern asked Internal Medicine Doctor to supervise her while she completed the

procedure, and failed to mention that she had not received permission from her own resident to do it:

A bit of hospital politics: Since all residents have to perform a number of central line procedures to be certified, and since all have a three year residency, the general rule is, senior gets the procedure, unless resident has already done enough procedures. It's a dog war out there. To make a long story short: Intern scrubs in, intern preps area, intern breathes deeply and begins to hyperventilate, sticks in BIG ass needle, pokes around for a really annoyingly long time. It gets interesting: resident (her own) happens to walk by, storms into room yelling that he is the one supposed to do procedure, intern gets flustered and yells at her resident calling him "big baby", resident and intern continue to yell at each other (patient not under general anaesthesia and is now threatened by BIG ass needle in PISSED OFF intern's inexperienced hands), and me watching everything. Intern stops procedure and storms out of room, panic ensues (my own!), Resident storms out to continue yelling at intern, I do my best to finish procedure, I keep my name out of patient's chart to avoid impending law suit. (Internal Medicine Doctor, October 9, 2004, emphasis is original)

In this particular situation, no one is advocating for the patient, and the completion of the procedure is the focus of the residents and intern. Although this is the only specific incident reported by the bloggers where procedures were chosen over patient needs, overall the emphasis on the technical aspects of medicine was apparent in the blogs.

An important facet of a resident's training as a health advocate is learning to put patient needs over his or her own, as Nathan demonstrates:

Recently, I have started standing up for my ideas against those of my seniors. From my perspective as an intern, desperate for procedures and learning opportunities, it might have been a bad idea. Once we got her up to the floor, my senior told me to get consent and then put in a

central line. I was fairly excited about the prospect, because I'm getting close to having done enough not to need supervision for this procedure. But I'm trying to be an Internist, so I sat back and considered for a minute. Mrs. Wilkins didn't need a central line; she needed maybe a little fluid and the occasional lab... So instead I grabbed one of the techs... and he got a nice peripheral line on the first try. We gave Mrs. Wilkins her fluids, readjusted her insulin regimen, and sent her home two days later. It's not a particularly moving story, I know. But it stands out to me as one of the first times I went for something less exciting because I was thinking for myself, and for the patient, rather than for a check box in my training. It was a small step on my road from technician to physician. And even if I still need another central line or two, that step was the more important one. (Nathan, December 21, 2007)

Although Nathan made the correct choice this time, not all residents do, as Nathan states it was one of the first times that he considered the patients needs over completing the procedure. The necessity for learning medical procedures is a barrier to advocacy, when patient needs are overlooked in favour of the resident's training requirements. Although unnecessary procedures might leave the patient in no physical harm, the residents begin to view patients as procedures, and an opportunity to fulfill their learning requirements.

Lastly, a resident's motivation can be influenced when their own expectations regarding their career goals are not met. Internal Medicine Doctor explains his disappointment when he discovers his aspiration to complete a gastroenterology fellowship will not be realized:

After four years of college, one year of a Masters, four years of medical school and two years of residency, I am tired. This year, I competed for a gastroenterology (GI) fellowship. After many hours of work on applications, personal statements and waiting, I have gotten absolutely

no invitations for interviews. The time has come to accept the inevitable; GI is not in my future. Now, the more difficult question, what do I want to do with the rest of my life? I never really expected that it would come to this. Throughout medical school I assisted in a lot of research and worked in many different GI clinics. The thought of trying something else never really occurred to me. For a while I had an affair with Cardiology, but that affair has fizzled and I am left widowed, without a future and without motivation. (Internal Medicine Doctor, December 13, 2004)

The competitive nature of medicine drives residents to push themselves to their limits professionally, physically, mentally, and emotionally. They feel entitled as a result of the enormous sacrifices they have made for their career, but also bewildered when their best is not enough. Advocacy is impeded when residents compete to meet standards that are not achievable as it affects their motivation and their ability to put their patients needs over their own. The hidden curriculum contributes to the competitiveness by encouraging residents to choose learning over their own well-being, and that of their patients. Through demonstrations of competence (in technical skill and scientific knowledge) and the competitive nature of medicine, the development of interpersonal skills and social accountability are overshadowed in residency training, reflecting findings from the review of medical education literature in Chapter Two (Bloom, 1988; Coulehan & Williams, 2001; Faulkner & Layton McCurdy, 2000).

Support and the Hierarchy of Medicine.

Considering what is at stake when physicians make errors, it would be expected that physicians-in-training are given ample support in an effort to protect patients. In her initial explanation of what a resident is, Dr. Couz states she is a

junior doctor “that is closely supervised and has very little autonomy”. Not long after making this statement, it becomes evident that this is not the case. She writes,

Today I spent the entire day in a state of panic. Even after three weeks and four nights of call, I still feel like I’m in WAY over my head in general surgery. Today, a patient got sick... I was called when his O₂ sat dropped to below 90 on 50% oxygen. For the next two hours I tried everything I could think of. All my seniors were in the OR, and my staff didn’t seem nearly as concerned as I thought she should be. Finally after watching his stats fall... I called the staff and told her quite bluntly that I was not comfortable managing this patient on my own... In the end, he ended up intubated in the ICU. I don’t know what I would have done if he had crashed in front of me. I’ve never run a code, and I am petrified of my first time. Will I know what to do? (Dr. Couz, November 21, 2005, emphasis is original)

Nathan also experiences a lack of support from his Attending when he believes he may have made an error in the care of a patient:

A few days ago I wrote up the plan for a patient, presented it to my Attending, and enacted it. Now the patient is dying, intubated in the ICU, and though a relatively small change in my plan might not have made a difference, it also might have. He is 50 years old. Now despite the fact that it is my Attending's responsibility, it is also still my fault. And while my resident was pretty nice in the way he pointed out the mistakes, my Attending (perhaps to cover her own insecurities) has not been. I feel bad enough on my own, but her "teaching" of me now takes the tone of an owner-pet relationship. I want to remind her that "you signed off on the plan too, doc" but I value my future in this program. (Nathan, November 10, 2007)

This post illustrates how the residents are more open to social influence because they are at the bottom of the hierarchy of medicine (Wilkes & Raven, 2002). The

Attending's behaviour and refusal to accept responsibility for an error that occurred with one of her patients, along with Nathan's acceptance of this out of fear, illustrates the power of the hierarchy.

Internal Medicine Doctor and Idiopathic Medicine do not write about experiences where they felt unsupported, but Internal Medicine Doctor and Dr. Couz wrote about the paranoia of having people die during their shifts and, especially at the start of their residencies, deem a shift successful if all their patients have remained alive:

Fourth night call. We're maxed out on patients, or rather, we have no more beds. Currently, everyone is stable. In spite of this my paranoia keeps me awake. Like rafting in a river with a waterfall except you don't know where it is. Actually, it's more like swimming in water with a loose shark. I find myself looking through everyone's labs and checking on them constantly, afraid I may have missed something crucial, something that will hint the next coder. Having no room for more patients is comforting of sort as I always prefer the devil I know. (Internal Medicine Doctor, September 22, 2004)

When reading the blogs, you feel a sense of isolation, that the residents possess a great deal of autonomy and, consequently, responsibility, often only presenting their diagnoses and treatment plans during the daily rounds. Interactions with their superiors appear to be minimal, and intimidating at times, as the following post illustrates:

So today I presented my first CCU patient, and relearned a host of lessons I had thought were past... I was also very far behind in rounding today, and essentially I failed in every quantifiable area of accomplishment where my patient was concerned. Justly, I received some very stern correction for this...[My Attending said] that if next year I

saw a patient in the ER with severe, tearing chest pain radiating to the back with blood pressure different in each arm and I activated the catheterization lab, calling him in from a sound sleep at 2am, then "I will throw you off the top floor of the hospital. Which would be tragic. Because the patient would die." (Nathan, July 14, 2007)

By intimidating Nathan, his Attending is creating an environment that is not supportive of learning, and, as such, does not support advocacy. In particular, if moral courage is fortified through habituation (Kidder, 2005; Miller 2005; Clancy, 2003), it cannot be developed in an environment that supports conformity and submission. As occupants of the lower rungs of the hierarchy, residents are encouraged to make decisions based on the social norms intrinsic to the culture of medicine, rather than values, particularly the values of their patients. It is common in medical training programs to use intimidation and humiliation to chide residents. Dr. Couz provides an explanation of "shame-based learning":

It is the process by which anyone senior to you in the medical hierarchy (an Attending, a Senior Resident...) asks you a series of questions getting consecutively harder until you get one (or many) wrong. At this point you are likely mocked and the very basis of your medical qualification is called into question. At my medical school we ... called this process "shame-based learning", as it was often done in front of a group of your peers. (Dr. Couz, October 20, 2005).

In a subsequent post, Dr. Couz praises her Internal Medicine placement, which does not emphasize shame-based learning, stating "People are more interested in making sure you learn something than they are in publicly humiliating you for what you don't already know.... My team rocks... My Senior is very non-intimidating, reasonable and approachable" (Dr. Couz, May 12, 2006), clearly

indicating that she prefers a more supportive approach to learning. Other residents experienced being humiliated by their superiors, and sometimes experienced enduring consequences:

In my last post, I touched on how the [Chief of Medicine] embarrassed [me] in front of everyone and questioned [my] commitment to hard work and excellent patient care. I had trouble sleeping that night. Considering, I really took it kind of hard. It was really surprising how the [Chief of Medicine] got into [my] head. So bad, that during that evening [I] achieved total failure in bedroom with wife... Thus achieving failure in multiple aspects of life. Came to work the next day kind of cranky (you think?). (Internal Medicine Doctor, October 4, 2004)

He also writes:

At times I find my paternal instinct kicking in trying to protect my interns from attending's wrath. Attending has been kinda nonchalant about this whole rotation and he's barely teaching anything. (Internal Medicine Doctor, September 22, 2004)

Interestingly, in a post entitled, "Stronger" Nathan describes a situation where he publicly reprimands a fellow resident for his unsatisfactory work ethic, demonstrating the wide acceptance of shame-based learning by residents and their superiors:

I don't even remember all I said, but I do remember saying things like "this isn't about rules, about notes you think are silly, this isn't about work hours, or personality, it is about taking care of patients. And if you don't realize that, you don't belong here. Internship is supposed to be hell, but you have to make it that way. If the pressure doesn't come from within you won't succeed." I added some choice things about needing to write notes, to consider every patient carefully by system because if you don't learn to come up with plans on your own, you'll never be able to. You'll always be an intern, and never a real doctor. About

halfway through this harangue, I realized that the entire nursing staff of that ICU pod, about 20 some odd people, were listening, mostly while pretending not to. I noticed the nurse taking care of the patient in question nodding his head in agreement. I am a bit ashamed to say I enjoyed the audience almost as much as the fact that I finally had an opportunity to maybe, just maybe, work for positive change in this guy's life, and more importantly, in the lives of his patients. (Nathan, July 29, 2007)

Aside from being pleased about the audience, Nathan firmly believes that humiliating the resident was for his own benefit, and the benefit of his patients. He also affirms that residency (or internship) is supposed to be “hell”, further perpetuating the hidden curriculum, and proving his susceptibility to social influence by sustaining social norms (Wilkes & Raven, 2002).

As Dr. Couz progresses through her residency training lack of support surfaces recurrently, with one particular experience standing out above the rest for her. During a trauma rotation, Dr. Couz posted a letter that she had written to her Program Director regarding her placement,

This rotation is not meeting my educational objectives in any way. I am the junior Resident on the team, and my role does not extend past running the floor. Making this more difficult is the fact that no one at any point has explained to me how the hospital works, what exactly is expected of me or even things as simple as how to access x-rays. In fact, many of my duties are only identified as such the following day when they haven't been done and I am berated by various senior members of 'the team'. (Dr. Couz, August 5, 2007)

The letter has a positive result for Dr. Couz as the placement is put under review, and her rotation is cancelled. By taking this action, Dr. Couz successfully advocates for herself, her patients and residents, who could have been placed at

the same hospital in the future. In the early stages of her residency training Dr. Couz attempted to advocate for herself and other residents when the Chief Resident, in regard to the distribution of entitled vacation days over the Christmas holidays, did not honour her union contract. After involving the union lawyer, and being threatened with more hours of work by the Chief Resident, Dr. Couz met with the Program Director for general surgery, who, in addition to apologizing, “stuck up for the Chief, saying that his behaviour was very out of character for him” (Dr. Couz, December 27, 2005). Dr. Couz was content that the Program Director was aware the union had intended to take the issue to formal grievance, but it didn’t go that far because she was satisfied with just making her concerns known, and states, “So I looked good”. It is likely this attempt at advocating for her colleagues and herself had minimal impact, due to Dr. Couz’s concern for her own professional reputation with her superiors. This failed attempt at advocacy reveals the power of the hierarchy of medicine and little power that those on the bottom possess.

While Dr. Couz struggled with the hierarchy of medicine, others negotiated their way through with more of a “if you can’t beat them, join them” type of attitude, like Nathan. Internal Medicine Doctor was attuned to maintaining the hierarchy of medicine. He abides by what is expected of him in terms of the hierarchy and is conscious of being “too nice” to his students (Internal Medicine Doctor, September 15, 2004). Although he dislikes it, he is “slowly becoming the resident [he] hates”:

The cocky, arrogant, knowledgeable shit is back, but now I get to boss other people around. Maybe the power went to my head. Every time I even think about helping intern I am reminded of my last year and think “leave them alone, they need to go through this to learn”. Of course they don’t, just don’t tell me that. (Internal Medicine Doctor, October 8, 2004)

The following post indicates his acceptance of the hierarchy of medicine, and his belief that traumatic situations make the interns he supervises stronger. He tells the story of an inexperienced intern:

She is home now and she’s tired and her new life just smacked her in the face. I left her there on our post-call day after I saw all our patients. Helped her with a few notes and then I decided that my dues were already paid and that staying late on a post-call day is an intern’s job. I have no right to rob her of this experience... After arriving at home I found out that the patient from last night decompensated. I hear it was quick and chaotic. I also heard that my intern panicked. That she wasn’t ready for this and that the patient was rushed to the unit and later died... The news didn’t surprise me. It was a patient who was really sick and it was certainly a possibility that she would crash. Somehow though, I don’t think my intern realized what I meant. She’s wondering if this is really what she wants to do with her life now. Can she endure like this? Can she be a witness to such tragedy and be critical at critical situations. She is double-guessing everything she did today and likely herself. As I sat there... I thought of my tortured intern. She must be going through shock but it will eventually make her stronger... it’s misery now and it’s something she must experience. (Internal Medicine Doctor, July 24, 2005)

Internal Medicine Doctor is aware of the impact the experience will have on his intern, yet he provides her with no support, just as he was not given any when he was an intern. Additionally, the possibility that the patient’s health status would decrease did not prompt him to prepare the intern for what could happen.

Advocating for the patient does not take precedence over teaching his intern the harsh realities of medicine, and learning to cope without support.

At the start of his residency, Internal Medicine Doctor offers the following comical, but telling description of how the hierarchy of medicine works:

I think the best way to explain will be to list [the] primary goal of each, secondary goal (if applicable), friends and enemies. It is long; I am sorry for this, but essential for the upcoming month. Let us begin: [modified to table form for ease of reading]

Title	Primary Goal	Secondary Goal	Friends	Enemies
3 rd year medical students	To impress Attending and Resident with knowledge we were sure they never had	To cloud a simple clinical scenario by suggesting that the patient has as many extremely rare diseases as possible, to name a disease the Resident hasn't heard of and to send out for as many of the most expensive blood tests we have as the Resident allows.	The Sub-I, as he is closer to the Resident and gets the scoop on their performance thus far	Interestingly enough, they are each other's enemy as they are always being judged comparatively to each other
Sub-I (4 th year medical students)	Impress Attending, Sub-I's need recommendation letters for match so they too can be taken advantage of by residency programs and government	Discharge patients, less patients less work and try not to sound like Student by naming any rare disease	Intern and Resident, possibly third year but only if they agree to do his blood draws	Patients with extremely rare diseases (makes Sub-I extremely uncomfortable as he now has to sound like Student)
Interns	Discharge patients. Intern will do or say anything to achieve this goal as he/she is usually overworked and would love to have one less annoyance	Anything that ends in less patients (I cannot stress this enough)	Other Interns, amazing bonus point if able to really swing Resident to his "point of view" (often wrong!)	Patients!!!!

Residents	To impress Attending and Chief of Medicine while also keeping Intern happy, motivated and feeling that Resident is truly on his side	Constantly remember that Interns LIE! Again, they do anything to get patients out and resident must continually double check intern behind intern's back as INTERNS LIE!	The Giants and other Residents	Everyone on a certain level as Interns LIE, Sub-I wants information primarily for Student, Student wants to name rare disease and make Resident look bad. To counteract Student, Resident must immediately say "I don't know that but why don't you give us a presentation on this tomorrow morning"
Attendings	Come for 2 hours in morning, teach, leave as fast as possible, keep name out of chart so no one knows who to sue later	No secondary goal	All	No one
Chief of Medicine	Teach and run Medicine Department	Try to remain seemingly very humble, once in while give a lecture which makes every Resident in the room feel like he knows absolutely nothing/ give up his medical license and go back to medical school	N/A	N/A
"The Giants" (retired geniuses)	Ex-Chiefs of prestigious departments who don't want to stay home because their wives will drive them nuts. We all love them because they help us and they know way too much. They're great!			

Table 2- The hierarchy of medicine as described by Internal Medicine Doctor.

Although many of his comments are perhaps exaggerations they do speak to the pecking order of medicine. Credibility is difficult to achieve for those occupying the lower ranks, and the intimidation of those in the higher ranks is clear. Acting

as a health advocate could be challenging for anyone occupying the lower ranks of the hierarchy. As well, there is a clear division of labour, with each person having an ascribed set of tasks in relation to the patients. As Internal Medicine Doctor implies with his comment, “This will be my greatest chess match yet”, hospital politics greatly impact the way medicine is practised. Also notable is the lack of teaching responsibility and support ascribed to the Attendings and the Chief of Medicine, who appear to spend less time at the hospital and less time with patients, and presumably less time providing guidance for medical students, interns and residents.

In terms of professional socialization, residents are tacitly taught aspects of medical care through the encounters with their superiors leading by example. Situations requiring advocacy are sometimes ignored by virtue of following the status quo. For example, at the start of her residency Dr. Couz tells a story about assisting an exhausted surgeon through two surgeries, both of which did not go as anticipated and resulted in complications for the patient. She writes,

Although it would be difficult to determine how much of what happened was fluke and how much was surgeon error, I’ve already been told that there will likely be a lawsuit. Will it change the system? Doubtful. Doctors have always worked crazy hours, and been expected to perform perfectly with little to no sleep... sometimes to the detriment of their patients. (September 25, 2005).

Perhaps due to her social position as a new resident, or the non-reaction to the situation from other medical staff, Dr. Couz does not engage in any sort of advocacy to ensure that this situation does not reoccur. She is resigned to the fact that working while exhausted has always been expected of physicians, therefore it

is acceptable, regardless of the danger it poses to the patients. Senior medical staff tacitly teaches to residents when advocacy is appropriate through their own actions. Residents are not likely to advocate against something widely accepted by their superiors, and by not advocating in certain circumstances, senior medical staff are not supporting the residents in learning how to act as a health advocate.

It is evident in Dr. Couz's stories that the hierarchy of medicine has a substantial impact on a resident's decision-making ability, including their decisions to advocate. Feelings of intimidation and incompetence permeate throughout her blog, as well as frustration and powerlessness. At times her patients also reinforced the hierarchy of medicine. When Dr. Couz advocates for her patients, they do not always recognize her efforts:

To the patient who told me that the reason she was feeling better was because my Attending was such a good doctor and that she really respected and valued his medical skill. My Attending couldn't pick you out of a line-up. I am your doctor, for all intents and purposes. I am the one who visited you daily, managed your care, fought on your behalf for tests and spent time looking up information on alternative treatment options. He visits you for about 10 seconds every second day or so. Not that I'm looking for a medal here, but seriously! (Dr. Couz, June 28, 2006)

Patients who are dubious about the skill and aptitude of physicians-in-training contribute to resident's feelings of incompetence and support the hierarchy of medicine.

Idiopathic Medicine makes a strong argument when she states:

Our primary – and most important – job, as residents... is to recognize our limitations and to ascertain whether one of our patients needs a higher level of care... The common

line in emergency medicine is, “Be humble or be humbled.” We need to keep this in mind with every patient we see and have a low threshold to ask for assistance. (Idiopathic Medicine, August 30, 2010)

Dr. Couz also speaks of the need for health care workers to know their limits. She writes of other residents not wanting to admit when they are in a position that they are not equipped to handle, “Not everyone has the insight to know when they’re in over their head, or the guts to admit that they don’t know how to approach a particularly sticky problem.” (Dr. Couz, July 28, 2006). Dr. Couz makes a difficult decision regarding a position she wants to take, the deciding factor ultimately being the welfare of her patients,

Even though I CAN run out and start doing shifts in local community Emergency Departments, I don't actually think I should be. I'd feel more comfortable working in a student health centre, or in some kind of walk-in clinic. The money is tempting, as is the experience, but if something came in that I couldn't handle and the patient suffered from my lack of experience I'd never be able to put it behind me. (Dr. Couz, July 1, 2007, emphasis is original)

The ability to recognize when help is needed is important for patient advocacy. Fear and intimidation make senior medical staff unapproachable; aside from the affect it has on the self-confidence of residents. For Dr. Couz, there is a connection between support from her superiors and her confidence in her work,

A lot of people assume that if you’re a doctor you’re confident. Overconfident, in some ways. But sometimes, a little approval from someone whose opinion means a lot to you means the world. We spend so much of every day feeling completely incompetent and stupid that ‘confident’ does NOT describe my impression of my own intellectual abilities.” (Dr. Couz, November 21, 2005, emphasis is original).

A physician without confidence is not likely to advocate for their patients out of fear of making an error. Dr. Couz explains how she holds the opinion of her superiors in high regard, and encouragement and support from them has a substantial impact on how much credence she holds in her skill as a physician.

Each of the residents negotiated the hierarchy of medicine differently. Dr. Couz was challenged by it, as it fuelled her self-doubt. Internal Medicine Doctor didn't agree with it, but participated anyway because he enjoyed the power that came with it and worried that not participating would disrupt the natural order of his work environment. Nathan supported it throughout his residency and saw it as an opportunity for learning how to be a better doctor. Idiopathic Medicine did not mention it in her blog at all in terms of how it affects her training, but did discuss its importance to patient care and the necessity for physicians to be willing to seek assistance when required.

Paternalism.

Paternalism did not present itself as a major theme in the blogs, yet each blogger indicated that when it comes to health care, they typically advocate for biomedicine in comparison to alternative forms of treatment or non-treatment (the only exception being end-of-life issues). When treating a patient who requires lung resection surgery, but refuses to do so because she believes God told her he would heal her, Nathan tells how in medical school he resented the idea of a “strictly empirical physician” (October 5, 2007). Being a Christian himself, he was surprised at his reaction to the patient's decision:

But I realized today, standing next to [the patient's] bed, that I have become more like that person than I knew... I have come to believe in the power of medicine. I've seen medicine heal the sick and make the lame walk. If we haven't made the blind see yet, we're working on it. More effective than any lecture... was merely living this life. And standing by that bedside, my first reaction was anger, or at least irritation, that this woman held to a ridiculous conviction that is going to kill her. I was angry that this pleasantly deluded woman didn't share my near-religious conviction in the power of medicine. (Nathan, October 5, 2007)

This example illustrates how paternalism is in conflict with advocacy (Schwartz, 2002) as Nathan describes his patient as deluded for not agreeing with his treatment plan, implying that the medical treatment he was advocating for was the only action that could resolve the situation successfully, or as Zola elucidated, the “doctor-father” knows best (1975). Internal Medicine Doctor writes of a similar situation, and after trying to convince his patient to agree to medical treatment, records in her chart, “*non-compliant patient*” (January 7, 2005). He also admits, after working a few days in a medical clinic, “If a patient complains of something that I am unfamiliar with I am likely to think they are lying. I have no idea why” (Internal Medicine Doctor, December 4, 2004). These examples also show the detached ‘us versus them’ mentality that proliferates in medical education (Coulehan & Williams, 2001), which is brought about by the emphasis on competence and the belief that legitimate knowledge is contained within the boundaries biomedical science.

Despite being aware that paternalism in medicine is viewed as negative, Dr. Couz regularly made contradictory statements about a patient’s right to

choose their treatment. Her original stance is (in reference to the distribution of antibiotics),

I can understand the urge to keep your patients happy, but I also don't think patients should dictate their own treatment. It may sound paternalistic of me, but that's why we train for so damn many years... so that we have the knowledge and tools to make treatment decisions for them. Otherwise all drugs would be available over-the-counter. (Dr. Couz, February 12, 2006)

When discussing birthing options (e.g. caesarean section, vaginal birth, use of mid-wife or not), Dr. Couz wavers on her previous stance, stating, "if the pros and cons are laid out... in a non-biased way, why shouldn't they have the right to choose?" (May 5, 2006). When the topic changes to flu shots, her opinion changes again, "The problem with trying to push vaccinations in our society is that we live in a culture and time where the rights of the individual are prized above all else. The idea that something might be for the greater good of society is a foreign concept if it means sacrificing one's own personal rights." (November 8, 2006). She then moves on to mandatory flu shots for health care workers, "People don't like being forced to do things- and being told that they don't have a choice makes people's back come up." (November 8, 2006). Although Dr. Couz is considering the greater good of the population as a whole, she is paternalistic in this view. Near the end of her residency, she writes, "The evolution of medicine has been positive in many respects. We aren't paternalistic, and medical decisions are now made with the patient calling the shots. We listen." (April 30, 2008). Dr. Couz is demonstrating non-reflective professionalism (Coulehan &

Williams, 2001), as she consciously believes that she is being caring and empathic, but she is unaware that what she is advocating for is based on beliefs that do not coincide with the traditional values of medicine. Although her views on paternalism may waver, she makes the following statement in support of alternative therapies, and expresses her desire to learn more about complementary medicine:

As far as doctors go, I consider myself fairly knowledgeable when it comes to alternative therapies. I regularly recommend that my patients try chiropractic, massage therapy, acupuncture, or naturopathic medicine... Allopathic medicine is slow to accept, let alone endorse, many branches of 'alternative' or 'complementary' medicine... I suggested having a naturopath come in to speak to our group about some of the principles of naturopathic medicine and alternative healing-- it's something I've always wanted to learn more about and clearly it was an area of weakness for my colleagues as well. Instead my suggestion was met with uncomfortable silence. Instead it was decided by the group that we'll be having an MD give us a talk on alternative medicine. Um... right. Talk about defeating the purpose. The attitude that practitioners of alternative medicine have against physicians and the attitude that physicians have towards much of alternative medicine is only hurting the patient in the long run. A recent study showed that 63% of patients over the age of 50 were using some form of complementary or alternative medicine, and nearly 70% of these had not discussed it with their doctor... Traditional allopathic medicine has much to learn from the world of naturopathic and alternative therapies-- we should be keeping an open mind and ensuring that we have (at minimum) a basic knowledge of the therapies and techniques available. (Dr. Couz, February 4, 2007)

Unfortunately, Dr. Couz' attempt at expanding her knowledge of complementary medicine was not supported by her discussion group, and, as result did not

become part of her training. In a post entitled, “Things I Would Like to Tell My Patients”, Dr. Couz writes:

If you're convinced that all Western medicine is evil and that all doctors are just out to medicalize everything and exploit your health problems for profit, maybe you should be seeing some other kind of health practitioner. It's a waste of my time and yours if you're just going to...shoot down every suggestion I make with “I don't believe in taking medications/physiotherapy/lifestyle modifications”. What are you hoping I can do for you? (March 12, 2006).

Dr. Couz raises an interesting point- that she is trained in Western medicine and this is the type of treatment option patients should expect from her. It would be difficult for her to advocate for any type of treatment that is not within the boundaries of her training. As such, it becomes apparent that the promotion of advocacy in medicine could lead to an increase in medicalization and pharmaceuticalization, if the medical model is the only method by which physicians are trained to treat patients.

Lastly, Idiopathic Medicine describes paternalism as it relates to end-of-life care. She emphasizes the need to listen to patients and allow them to decide their treatment options for themselves:

Even if a patient is dying, we still need to be good physicians. And, at this stage, the nature of our job changes but the tactics remain the same – we should present our patients with all the options, answer all of their questions, and encourage them to decide for themselves how they would like to live and how they would like to die. We should listen to them, we should care for them, we should not abandon them at this stage, and our path to good medical care should not be thwarted by their or our own hope – as a physician once told me, plan for the worst, hope

for the best. That is the most we can do. (Idiopathic Medicine, August 9th, 2010)

In all of the blogs, end-of-life care was the only circumstance when the residents regularly advocated for minimal to no medical treatment as the most humane option for their patients.

Paternalism directly affects the way physicians advocate for their patients as residents are trained to treat patients solely by the medical model. As a result, there is more risk for medicalization and pharmaceuticalization. As demonstrated by the residents, moral neutrality is elusive in medicine, and definitions of the role of health advocate need to include further guidance as to the affect of morality on medical treatment. At a unique point in their career, when they are interacting with their own patients and have the responsibility of designing treatment plans for the first time, it is essential that residents are aware of paternalism and are educated on how to handle moral discrepancies, as well as the benefits of complimentary treatments, alternative treatments and the absence of medical treatments in order to better serve their patients.

Summary

The professional socialization of the residents was consistent with undergraduate medical education reported in the literature, despite the change in their roles from students to physicians. Influenced by the hidden curriculum, the residents struggled with learning humanistic values that have traditionally been inherent to doctoring (Anderson, 1992; Assor & Gordon, 1987; Crib & Bignold, 1999; Hafferty, 1998; Hafferty & Franks, 1994; Lempp & Seale, 2004; Marinker,

2001; Stern, 1998; Stevenson, Higgs, & Sugarman, 2001; Woloschuk, Harasym & Temple, 2004). Stern's claim that some feel medical education encourages individualism, efficiency, competitiveness and deception (ie. the 'cloak of competence') (1998) was also confirmed in these findings. The residents did demonstrate advocacy, but most often experienced situations where advocacy was limited due to a lack of time, the need to learn, an inability to express emotions, an inability to communicate, a fear of repercussions or paternalism. This chapter also discussed how the promotion of advocacy could lead to an increase in medicalization and pharmaceuticalization, as physicians are trained solely in biomedicine and learn to advocate for the medical model, despite the values held by their patients. Definitions of the role of health advocate need to address paternalism and be realistic about moral neutrality in medicine. Additionally, none of the residents wrote about acts of advocacy beyond the patient-physician relationship, which leaves marginalized groups inadequately served (Dharamsi et al., 2011). It should also be noted that the terms 'advocacy' and 'advocate' were not contained in any of the blog postings.

The following chapter discusses the resulting crisis in caring, compassion and communication experienced by the residents that leads to their disenchantment with the medical profession, and the demoralization of the role of health advocate. Disconcerted by their unmet moral expectations and the depersonalization of residency training, the residents contemplate the meaning of 'doctor' and their future in the profession.

CHAPTER FIVE

The Demoralization of the Role of Health Advocate

The previous chapter revealed that professional socialization in residency is consistent with undergraduate medical education, despite the fact that residents are interacting with patients as physicians for the first time. The culture of medicine, and the hidden curriculum of medical education, inhibited the residents in their roles of health advocates by emphasizing efficiency, as well as encouraging competition and the appearance of competence. The maintenance of the hierarchy of medicine led to a lack of support for residents in their new roles and increased their anxiety about becoming a doctor. In terms of treatment options, the residents favoured biomedicine and displayed paternalistic behaviour, with the exception of end-of-life care. The combination of these factors created a crisis in caring, compassion and communication for the residents and led to the demoralization of the role of health advocate, which will be explored in this chapter with the aid of Arthur Frank's theory on the demoralization of medicine.

Frank's Theory on the Demoralization of Medicine

The analysis for this study was guided by Arthur Frank's theory on the demoralization of medicine, extracted from his book *The Renewal of Generosity: Illness, Medicine, and How to Live* (2004). Frank uses a tunnel as a metaphor for the experience of being ill and for medical relationships, which was adapted from Richard Peschel and Enid Rhodes Peschel's book *When a Doctor Hates a Patient and Other Chapters in a Young Physicians Life* (1988). Speaking from personal

experience, he describes how when serious illness strikes it can be difficult to breathe, light is blinding and distorting, movement seems almost impossible, and ominously unknown shapes come out of the distance (Frank, 2004). For an ill person, who feels as though they are in this tunnel of illness, a physician can become a disembodied voice, who never enters the tunnel with the patient (Frank, 2004). A lack of communication leaves both the patient and the physician “unheard, unrecognized and unremembered”, leaving both patient and physician demoralized (Frank, 2004). Communication is central to the role of an advocate. Physicians cannot act as advocates for their patients if there is no patient-physician dialogue beyond medical history and the presenting illness. Frank recognizes that instances of re-moralization can occur in medical practice (2004). Returning to the metaphor of the tunnel, medicine is re-moralized when the physician enters the tunnel with the patient, and helps them to understand their illness experience (Frank, 2004). Unfortunately, modern healthcare reform is typically centred on economic efficiency, which generally doesn’t foster re-moralization (Frank, 2004) and patients are alone in their tunnel of illness, without an advocate. Although the main ideas in this analysis will be centred around this theory, additional supplementation will be provided from another work authored by Frank entitled *How Can They Act Like That? Clinicians and Patients as Characters in Each Other’s Stories* (2002a) in order to enhance our understanding of what is required in terms of care.

The Crisis in Caring, Compassion and Communication

The culture of medicine is a tremendous influence on a resident's ability to negotiate their roles as health advocates. At an important juncture in their training as physicians, residents are socialized to prioritize efficiency over their own well-being, appear competent and professional, view their patients as opportunities for learning technical skills, as well as maintain, and abide by, the medical hierarchy. While achieving success at these tasks, residents are expected to provide optimal care for their patients, despite the fact that their education is substantially, if not entirely, focused on biomedicine. These elements of residency training culminated in the four bloggers reporting a crisis in their ability to care for their patients, diminished capacity for compassion and impairment in their ability to communicate in ways that promote advocacy. Idiopathic Medicine explains:

There is an unspoken culture in medicine that it is cowardly to break down on the job. It is cowardly, in fact, to personalize the emotions of our patients enough so that it affects our performance. We are expected to rise "above this," if you will – to be objective, discerning physicians. And I have done exactly this, with raving reviews from my superiors. But it makes me concerned that there is something missing. Perhaps taking care of such sick patients should not be so easy. (Idiopathic Medicine, February 2, 2011)

Internal Medicine Doctor also wrote about feeling the need to hide his emotions:

Before I left I had to tell his wife that we need a biopsy to check if this *could be* cancer. I was lying because I know it is. We have to confirm it anyway. She cried. She has no one else in this world. She has no money, they don't have a real place to live, she barely gets by with him and now she will have to get by without him. I nearly broke down in

tears right in front of her and had to leave the room as fast as possible. I locked myself in the on call room and cried. I'm still crying. (Internal Medicine Doctor, December 21, 2004)

In the first example, Idiopathic Medicine is describing the type of care that is encouraged in medicine, care that does not go beyond the provision of treatment. Frank contends that issues of care in the sense of mutually caring relationships are usually negligible to bioethics (2002a). Physicians want to be active participants in their patients' stories, just as much as their patients want to be recognized by them, but are unable to do so because they have been socialized in a way that only permits emotional distance, under the guise of providing optimal care. Enmeshed in each other's stories (Frank, 2002a), the residents also recognize the need to make the patients part of their own story, and so they blog about their experiences as doctors.

Early in his internship, Nathan discusses the importance of seeing his patients as people, and describes how he appreciates the stories they tell:

The stories are often sad or bittersweet, but I like hearing them, and though I'll never know the details or even the endings, it definitely brightens my day knowing there is more to my patients than penicillin. ...humans are a tragic, noble, and foolish kind of creature, and seeing them "warts and all" does more each day to help me appreciate our little world and the kind of sense we all strive to make of it. (Nathan, September 15, 2007)

This post reflects Nathan's appreciation of the humanistic aspects of caring and his recognition that we all have different ways of "making sense" of the world. This realization is valuable as people have their own unique needs in terms of

health care. By listening to his patients, Nathan is able to provide care that is tailored to his patients' needs, as values and principles can be learned through the telling of stories (Miller, 2005).

The pressure to be efficient and the heavy workload impact on Nathan's ability to provide care and change the way he views his patients. In a post entitled *Don't Let Them Change You* Nathan writes:

I've changed, I know. I'm thinking maybe there is a finite amount of things we are able as humans to care about, and in the strain of this environment, having to deeply care about lab values, paperwork, physical exams, paperwork, research, paperwork, interpersonal dynamics, paperwork, the opinions of your superiors, and yes, paperwork, the pain of the patient gets bumped from the list, usually right after you bump your personal life from it as well. It becomes easy to see patients as intentionally causing you more work, even nice 80 old men with funny stories, because they are being admitted to your team for the third time this month...

Probably part of residency is learning to deal with this strain and busyness while maintaining some compassion. But I'm finding that the teaching we got in medical school on implying compassion with body language and listening was some of the most important of all. At the time I thought that would come naturally, since I cared about patients. Now I'm finding that much of medicine is acting. Some patients are easy to like. But no one who is solely human has ever loved all mankind equally. And with tiredness and frustration and a tangible link between whining and hours spent in the hospital, an increasing segment of the population becomes difficult to love. So yes, I've changed. Some of the compassion is acting. But the acting allows me to do my job, to be more dispassionate, to view a patient and their disease as I have to, to treat it... (Nathan, November 10, 2007)

This post is concerning for many reasons. Nathan describes how the "strain of this environment" changes his view of patients and causes him to prioritize their

pain below his other responsibilities. He hints toward a theme present in Internal Medicine Doctor's blog that patients are seen as the equivalent of more work, and less likeable ones are less deserving of compassion. This change is considerable for Nathan as he began his residency with an understanding that being a 'good' physician meant caring for and about patients, and he stated he enjoyed listening to their stories. It is disheartening that medical students are taught how to "imply compassion" instead of learning about feeling and displaying real compassion appropriately. Not being able to feel real compassion prevents physicians from entering the 'tunnel' with their patients, and recognizing their stories as important. It isn't until after Nathan has an experience with a husband who has just overheard a "code blue" being called for his wife that Nathan is gratefully reassured that he does still feel compassion:

As the intern year has gone on, compassion has been harder to feel, and later, even to fake. Patients mean work, and when your work is this draining and frustrating, the real people behind the mountains of paperwork become frustrating.

Walking out through the waiting room, I ran into the woman's husband. He was scared, worried, and completely in the dark. His first question was, "How is Susan?" His second was, "What does code blue mean?" Realizing his need, I started talking to him, answering what questions I could, both as a physician and as someone who genuinely cared.

And that was the shock. I realized, despite the bitterness, despite the pain, despite everything that over the last few months has brought so many undesirable characteristics to the fore in my personality, I did care. I'm not sure anyone who hasn't gone through a similar situation can fully understand this. The point of it was, I really did care, I do

care, and though I am saddened to know it took something so extreme to remind me of it, I am enheartened that I have been reminded. (Nathan, January 29, 2008)

When patients are depersonalized and only seen as work, opportunities for advocacy are minimized. As social beings, we are caught up in our own stories, and this includes physicians and patients (Frank, 2002a). Nathan demonstrates that the possibility of dialogue is initiated when he begins to appreciate the story of the husband, and offers assistance. By doing so, he is prioritizing the patient's story over his own, which is essential in clinical situations and for advocacy (Frank, 2002a). After this point, Nathan's blogging begins to decrease substantially. In one of his final posts as a resident he describes again how medicine has changed him. He writes about how medicine never really cures anyone and that, at best, all physicians can do is prolong what is inevitable-- death. He states, "I've changed. The show-cynicism of internship is now mostly heartfelt, as I start to see the same cases of self-harm, sometimes even the same patients, and I feel the helplessness than undergirds all of what we do" (Nathan, July 28, 2008). Once again, Nathan is failing to recognize that care is not always about the provision of treatment, and only sees success in terms of a medical cure, which is particularly detrimental in cases of repeated instances of self-harm.

Internal Medicine Doctor also wavered in his opinions about his patients. He addresses an article that discusses the loss of compassion felt by medical students and residents, as their focus shifts from patients to their own learning:

Is this universally true? Of course not. [The author] is right in that it happens to most medical students and residents.

It's a consequence of feeling overwhelmed with the body of knowledge one must master. It definitely happened to me as an Intern. I'd like to think that as a second year it's resolving and that I now see patients as human beings, friends even. (Internal Medicine Doctor, May 26, 2005)

It is reassuring that Internal Medicine Doctor is starting to see his patients as human beings, now that he is further in his training; however, in a post at the end of his residency he makes a contrary statement that implies some patients are worth more effort than others:

Saving a troubled father of two from a severe bout of congestive heart failure was rousing. Saving that same father from another bout and *yet another* simply because he refused to take medications can be downright depressing... Somewhere and sometimes I make a difference... But I've lost a large part of my former compassionate self. At times though, I do miss that young fourth year [medical student]. Would he disapprove of what he has become, a new breed of healer and warrior struggling with himself to survive?... So to all the fourth year students... like well-trained warriors, don't let your compassion run dry, but do learn with who it's worth fighting your battles. (Internal Medicine Doctor, January 3, 2006, emphasis is original)

Whilst Internal Medicine Doctor forges a deep connection with some of his patients, he is prone to restricting others based on their situations, for example, their reason for being under his care and how willing they are to help themselves. Interestingly, the result of this confused response to patients is a love-hate relationship with them, much like Nathan's statement about how some patients are "difficult to love" (November 10, 2007). By the end of his residency, Internal Medicine Doctor holds a dichotomous view of patients; for some patients he is capable of communicating and connecting with them on a level that fosters

advocacy, but has an aversion to other patients if he feels they have worsened their condition by either not following his orders, engaging in unhealthy behaviour or are at the hospital for what he deems as illegitimate reasons, particularly social admissions. According to Frank, patient-physician relationships are facilitated when they have an overlap in *habitus*, a term coined by sociologist Pierre Bourdieu meaning “embodied habits, tastes and dispositions” (Frank, 2002a). It is likely that Internal Medicine Doctor and his less-loved patients do not have similarities in their *habitus*’ and therefore he is unable to engage them with dialogue, or provide adequate care. When this occurs, his patients are left abandoned in their illness. It could also be argued that in addition to the “us versus them” mentality that provides the impetus for this behaviour (Coulehan & Williams, 2001), Internal Medicine Doctor is experiencing entitlement in that he feels he deserves compliant patients after all of the commitment and sacrifice he has made for his profession.

For two of the residents, events happened in their own lives that altered the way they view patients. Dr. Couz and Internal Medicine Doctor both told stories of their own personal experiences have changed the way they view their patients. For Dr. Couz, becoming a mother near the end of her residency caused her to become more emotionally connected to her patients, and for Internal Medicine Doctor it was his experience on the other side of medicine, as a family member of a patient when his wife gave birth to their first child, with a few complications:

One of my strengths in emergency medicine is my ability to have empathy without getting emotionally involved. I'm not made of stone or anything, but I've never had the breakdowns that my friends and colleagues have... Then I had the Bean [her child]. It was like flipping a switch. My ability to stay impartial and unaffected has been completely lost. (Dr. Couz, June 2, 2008)

There are times when I feel like my entire day is wasted updating one family after another about the current condition of my patient. I have other patients to care for, conferences, lectures, and tests to arrange. Not to mention the other odd situations that pop up here and there. So when I spend more than five minutes discussing 'the situation' I get antsy and, if sleep deprived, I get nasty... How many families must've left the hospital thinking that their loved one's doctor was a horrible person? How many families did I shrug off, avoid, or act rude to. Simply put, until now I was an asshole. They were worried sick and I shrugged them off as crazy and overbearing. (Internal Medicine Doctor, March 16, 2005)

Interestingly, these were the two residents who demonstrated the least compassion in their blogs. Internal Medicine Doctor often told stories of connecting with his patients, but he told an equal number of stories about doing unnecessary exams to patients he disliked.

Of all the resident bloggers, Dr. Couz is the only one who does not report a crisis in caring or compassion. Her blog gives the impression that she focuses more on medical procedures and techniques, than on connecting with her patients. She is also the author who wrote the most about exhaustion. On one occasion she tells the story of a woman who came in to the surgery with abdominal pain:

A few hours later, mired in the day-to-day floor scut, I had all but forgotten about her. Then I got a page from the radiology resident, sounding excited. She had a ruptured appendix. And it had ruptured, but good... So I found

myself in the OR... with the patient draped and me, the Chief Resident and the staff surgeon standing around her, someone handed me the scalpel and told me to cut... I removed the appendix. So standing there... holding this angry-looking appendix... I found it. That feeling. That “holy-crap-I-can’t-believe-they-let-me-do-this” feeling... I found my enthusiasm for medicine. Welcome back, I’ve missed you. (Dr. Couz, December 27, 2005)

Dr. Couz defines her professional success in terms of being proficient at medical procedures and making accurate diagnoses. She experiences anxiety over her own competence as a physician, and worries at length about having enough experience and the comprehensiveness of her medical knowledge. Opportunities for advocacy are likely limited for Dr. Couz as she is too enthralled by her own life story of being a medical resident. Other examples show that emotional detachment from patients seems to make dealing with negative results easier for Dr. Couz. An exemplar of this is the night of her first patients’ deaths (two in one night). Throughout the post, Dr. Couz implies that knowing the patient makes a difference:

I’ve had a patient or two die, but it was never while they were actually under my care. And only one of them was a patient that I’d actually had time to get to know beyond last name and chief complaint... [in reference to the second death] Although he wasn’t ‘my’ patient at the time of his death, he had been under my care the week before during one of his shorter admissions. I knew him... (Dr. Couz, June 17, 2006)

Other residents also indicated that knowing a patient more personally makes end-of-life situations more stressful for them. Unfortunately, recovery isn’t always attainable and this can leave a physician-in-training feeling as though he or she

has not met patient expectations or fulfilled their role as a healer. They fail to recognize care goes beyond medical cures, and patients still need a physician to enter the ‘tunnel’, even when the prognosis isn’t favourable. They need to be heard and recognized (Frank, 2004). Despite knowing that a cure is sometimes beyond biomedicine’s reach, Internal Medicine Doctor is distressed by his inability to help biomedically and avoids his dying patients. He copes by becoming more automated in his patient interactions, and detaches himself from what a fatal diagnosis really means for his patients:

In a world where doctors are supposed to be perfect and everything is supposed to be curable there are just dismal diseases that we have no answer for, at least not yet. After these last two weeks I find I am getting more comfortable with the word “cancer”. I am no longer affected by its consequences. Its true meaning as it relates to my patients lives and to their family’s life eludes me now. I have become automated, a sort of desensitized machine. At the same time, I have trouble falling asleep at night. I find that I try to avoid seeing my dying patients. Even consciously knowing what I am going through is really not helping me cope with it much. They are not necessarily my failures but they ask for help every day and every day I have to remind them just how helpless I am. There just is no cure, not for them. (Internal Medicine Doctor, October 14, 2004)

By avoiding his patients, Internal Medicine Doctor is limiting opportunities for dialogue and advocacy. Instead of communicating with the patients and their family and playing an active role in the illness experience, he is being unsupportive and forcing them to generate their own understanding of the situation. This example also illustrates Internal Medicine Doctor’s disenchantment with medicine, as he states that he feels helpless in view of the

fact that he cannot cure his dying patients. Internal Medicine Doctor could also be subscribing to the “enlightened paternalism of doctoring” as a form of social control (Hafferty & Light, 1995; Light, 1979; Waitzkin and Waterman, 1974). By avoiding his patients he is attempting to control their medical situation, which is in fact beyond his control, by encouraging incompetence, ignorance and helplessness in his patients. When physicians do not create dialogue with their patients they perpetuate power imbalances within the patient-physician relationship and limit their potential to advocate beyond biomedicine.

In situations that are less emotionally stressful for Internal Medicine Doctor, he is able to demonstrate the importance of dialogue in the patient-physician relationship. The following story is an example of advocacy being facilitated by dialogue:

Its moments like these that made me want to become a doctor in the first place... I'll set the stage. It's five in the afternoon... when the receptionist pages overhead, “Medical notification is HERE!”. Suddenly, I see a young girl; about 26 years old, being wheeled towards the back while Emergency technicians are trying to give her oxygen with a bag. She is not moving any air. I can't hear any breath sounds. No time to react. We establish a line and she is intubated almost immediately.

After the intubation a careful exam still reveals clear breath sounds, no wheezing, normal peak pressures on the ventilator. While before the intubation this was likely a case of horrible asthma, it doesn't seem to be the case now. A further probe into her past reveals this patient suffering of a condition called paradoxical vocal cord movement. A cause was not yet found but is probably psychiatric in nature.

She is extubated one hour later. Now she begins to wheeze heavily and we re-assess our initial impression...

Before my shift was about to end I went to check on her. Having looked to me like she was tiring I decided to attempt another blood gas. While I was obtaining the test I started asking her about her life.

“I have four kids,” she said.

“Four kids?” I answered, surprised. “If I had four kids I would be here getting intubated every night”. She laughed.

“Where’s your husband?”

“At home with the kids”

“How are things at home?”

“They’re great she answered” She was calming down. No more wheezing.

“Are you sure?” I continued.

And she nodded. We continued our conversation. I was trying to make as many jokes as I could, this was definitely working. Within two minutes even the non-rebreather was off, the legs were crossed and we were having a nice little chat. No more wheezing.

“What causes this[?]” I asked her.] She didn’t know. She’s been to therapy, is on medication and still she’s been intubated five times. We talked for a while, no wheezing, no intubation, no blood gas. Just words. She began to breath normally because *we were talking*.

I went home happy that night. And that’s why I became a doctor. (December 13, 2005, emphasis is original)

By talking to this patient, Internal Medicine Doctor has made her feel empowered and relaxed to the point that her ‘medical’ condition resolves. It is evident that he feels a great deal of satisfaction from this encounter, as he claims, “that’s why I became a doctor”, and he implies doctoring is more than just medicine. It should

be noted that in this case the outcome was a still medical success and Internal Medicine Doctor was able to control the situation, but none-the-less, the patient's condition dissipated as a result of Internal Medicine Doctor taking the time to hear her story. He shows admiration for his Attending when he writes, "I have been amazed by his ability to connect with patients. He speaks their vernacular instantaneously and seems to have dealt with each particular patient for years" (Internal Medicine Doctor, October 20, 2005). Idiopathic Medicine recognizes the value of communication skills in the provision of treatment when she states:

To be a good physician, you need to be a good teacher. There is an art to breaking down all the complexities of medical science into something that a third-grader can understand. There is also an art to modifying your explanation depending on the patient. A plumber has a very good understanding of pumps and water pressure – this can serve as a good analogy for the heart... Artists sometimes understand better if you draw a picture and talk them through the circulatory system, image by image... For patients who do not ask the right questions... it is imperative that we answer these questions for them anyway. Using analogies, images, and simple language does not come easily to all physicians – but one of our roles in this profession is to serve as a translator for our patients and to minimize medical jargon so that we can be on the same page with our patients and help them make informed decisions. (Idiopathic Medicine, July 6, 2010)

Although she is not discussing dialogue beyond treatment, this statement is of value because she is reinforcing the need for physicians to neutralize the power imbalance that is present in the patient-physician relationship by using language the patient can understand. By doing this, the physicians are entering the 'tunnel'

with their patients and helping them to gain understanding of their story through empowerment.

Idiopathic Medicine argues that residency training has changed its focus from medical history-taking and physical exams, both techniques that build the patient-physician relationship, to the use of technology for diagnosis:

Training during residency has changed over the last two decades, and the emphasis has shifted from performing a good history and physical examination to ordering and interpreting laboratory tests and imaging studies. We no longer take the time to listen to our patients... Laboratory tests and imaging studies, just like the physician's own hands, are an imperfect science. Although the perception is that patients benefit by getting a myriad of lab tests and imaging studies, they do not. These tests have as many limitations as the history and physical exam, and they only gain their significance when analyzed by a physician in the broader clinical picture... Rather than accepting the inherent limitations of tests, clinicians have begun to practice test-centered medicine rather than patient-centered medicine. This causes huge delays and expenses in patient care. It also places patient at risk for (1) being treated unnecessarily for incidental findings and (2) being exposed to unnecessary radiation. Furthermore, it alienates patients even further from their physicians – and this, perhaps, is the greatest cause of increased lawsuits and patient dissatisfaction, which starts the cycle of practising defensive medicine all over again. (June 29, 2010)

Medical technology has changed the patient-physician relationship, and gives residents a false sense of security that a more accurate diagnosis can be provided.

As Idiopathic Medicine states, this method is now preferred over listening to patients, and for this reason it acts as a barrier to dialogue and advocacy. Similar to arguments regarding pharmaceuticalization and physicians being deprofessionalized as gatekeepers to drugs (Abraham, 2010), the emphasis on

diagnostic technology over listening to patients also deprofessionalizes physicians by making them gatekeepers to diagnostic technology (Hafferty & Light, 1995; Haug 1988). As patients have become consumers of health care and are self-informed about treatment options and diagnostic technology from the Internet, adding to the proletarianization of the medical profession (Lupton, 2004; Weiss & Fitzpatrick, 2004), the role of the physician is minimized and dialogue suffers. Dr. Couz describes how lack of communication has become a barrier in health care:

Doctors often assume a level of medical knowledge in the general public that simply isn't there. And patients, for one reason or another, don't ask questions. When this is the situation, the patient will leave the encounter upset, and the doctor will have no idea that the patient wasn't satisfied with the result. (Dr. Couz, June 3, 2007)

History-taking and physical exams have added value as diagnostic tools in that they strengthen the patient-physician relationship and create opportunity for dialogue, which fosters advocacy. On the other hand, advocacy could also contribute to the deprofessionalization and proletarianization of the medical profession by decreasing the control of physicians (giving more power to patients) and demystifying scientific knowledge (increased dialogue leads to increased understanding). With increased credibility being given to lay, folk and practical ways of knowing (Gillett, Cain, & Pawluch, 2002), advocacy that incorporates the patient's voice and their ways of knowing devalues scientific knowledge and limits the social control of the medical profession.

Differences between medical specialties were also reported, with emergency medicine providing the least opportunities for building strong patient-physician relationships, understandably due to its nature. Idiopathic Medicine laments the opportunity to connect with her patients while working in emergency medicine:

The emergency department is a flurry. Placing too much emphasis on patient flow does not always mean providing the best care. I miss talking to my patients, listening to their stories, caring for them, and answering their questions. I can hardly estimate the number of patients whom I cared for today or remember them – 5 or 6 were flooding through the doors every hour. (Idiopathic Medicine, August 20, 2010)

It is important to note that in this quote she is also demonstrating her desire to provide care for her patients beyond the provision of treatment, and recognizing her role as a health advocate. The residents wrote about rivalries and disrespect among specialties, particularly toward emergency physicians:

Within the... walls... of this building are numerous warring tribes, calling themselves internists, surgeons, pediatricians, radiologists, and the like. Through the vicious coming of age ceremonies involved with these tribes, they come to identify all outsiders as unclean, beneath their attention, untouchable... What gets lost in the griping as the tribes head back to camp to prepare more war paint and weapons is the fact that... real people can be hurt in these conflicts... despite recognizing my growing attachment to my tribe, and my earnest defense of it in the call room, I'm trying to remember also that most of us have the patient in mind, most of the time. (Nathan, August 8, 2007)

The conflicts that develop between specialties negatively impact patient care as they foster competition and complicate the patient's illness experience; in other words, they make the 'tunnel' darker and more frightening than is necessary.

The crisis in caring for patients is brought about by the residents innate feelings of wanting to care for their patients (and be a part of their stories) and have compassion toward them, being restricted by their inability to provide this care due to the previously discussed aspects of the culture of medicine, particularly the emphasis on efficiency as it limits their time with patients, as

Idiopathic Medicine elucidates:

Surviving residency means learning to look away. Or, more precisely, learning to see through the very elements of life – and death – which used to stop us in our tracks. Writing has revealed to me how muddled – and how out of our control – this process is. I have learned to listen clinically – I have learned to listen to the words that will save me time later, which will clinch the diagnosis, so that I might have a minute to steal five minutes of sleep or a slice of sustenance. And, sadly, I have learned to discard all the other pieces of a patient's story. The details of their personal lives have become meaningless to me – even troublesome for my primary tasks, efficiency and depersonalization. (Idiopathic Medicine, February 2, 2011)

When residents do not listen to their patients' stories and recognize themselves as participants, patients are depersonalized, as are the residents. When this occurs, the role of health advocate is demoralized, as it is limited to advocacy in terms of provision of treatment. The impact on the patient being left alone in the 'tunnel' of illness has been identified, but what does this mean for the physician? Moral distress leads the residents to feel frustrated and powerless, similar to the

experiences of nurses when rules and praxis do not coincide (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Sundin-Huard & Fahy, 1999). The remaining analysis describes how the residents become disenchanted with medicine when their role as health advocate is not realized in a way that coincides with their morals, and for some, the reason why they became physicians. The following diagram (Diagram 2) depicts the process by which the role of health advocate is demoralized by the hidden curriculum.



Diagram 2- The demoralization of the role of health advocate- the culture of medicine creates a crisis in caring, compassion and communication for residents resulting in the demoralization of the role of health advocate.

“I Would Have Been Far Better Off had I Played a Doctor on TV”

The distress caused by the demoralization of the role of health advocate is substantiated in the blogs as the residents wrote about feeling frustrated with residency and, at times, contemplated their decision to pursue medicine as a career. Idiopathic Medicine describes her disenchantment with medicine in the first post of her blog, which she started at the end of her first year of residency:

I often wonder whether or not medicine is for me. It is a path I chose years ago, long before I knew what being a physician required. Many physicians regard it as a calling, rather than a profession. I am not sure how I feel. I know that before I got to medical school, I was driven by a burning desire to help people – building houses, donating

clothes, teaching children. Over the course of the last year, I have become increasingly tired of helping people. I have reached the point where I feel as though I have maxed out my energy and am ready to turn over the baton, so that someone else can help all of the people out there who need it. (Idiopathic Medicine, April 25, 2010)

Residents indicated that they had invested too much time and money into their education to abandon their careers:

If I could write off my loans, I would not be bound to this hardship...day in, day out of no sleep, of little respect, of being the low man on the totem pole. And to have achieved this after 4 years of post-college education and over \$200,000 of investment. Given the circumstances, I haven't quite been able to figure out how the hospital is so full – full of eager interns, of earnest residents. What are their reasons for being here? What are mine? It is when those reasons begin not to matter anymore...it is when you forget those reasons...that you have lost the idealism which brought you to this place of healing in the very beginning. It is the process of losing that idealism that has shaped my Intern year. (Nathan, June 17, 2010)

People ask me what I want to be when I grow up, now that I will be graduating in 18 months and interviewing for jobs in less than a year, and I look at them, perplexed... I always used to have an answer to this question. In high school, I wanted to go to college to be pre-med. In college, I wanted to be pre-med to go to medical school. In medical school, I wanted to go to residency. And somehow, after all these years of a nice, clean and cut path to success, I find my feet faltering at this next step. Part of me is hesitating, does not want to venture on anymore. (Idiopathic Medicine, September 2, 2011, emphasis is original)

Every day this coat feels heavier and heavier. On occasions, I want to rip it off my shoulders and leave, never turn back. Too much invested now... In many ways this coat feels like a ...A cage. I feel trapped in my white coat. (Internal Medicine Doctor, November 24, 2004)

The loss of idealism is evident and it is clear that their expectations of becoming a healer have not been met. For the residents, the sacrifice feels like it has been too much and they are not reaping the rewards that traditionally came with being a physician, to which they feel entitled (Coulehan & Williams, 2001). Non-monetary forms of compensation were important to the residents, in particular gratitude from patients. After working in a walk-in clinic for the first time, Dr. Couz explains how she felt more appreciated by her patients after taking the time to listen to them:

The second was the fact that I felt appreciated. I never thought that was all that important to me, but it made a big difference. I understand that emerg[ency medicine] is a pretty thankless job. You're seeing people at their worst, they're sick, their family members are worried and stressed, they're often angry at being made to wait for hours on end... I get that... But the patients were just so thankful to me afterwards. Maybe they expected the typical 'McMedicine' that walk-in clinics are famous for and were surprised that I took the time to sit and listen. But I was actually surprised by how much a simple 'thank you' meant to me. It made me feel a little narcissistic, but it was a stark contrast to the emergency department. (Dr. Couz, September 30, 2008)

This example illustrates the affect that a mutually caring relationship in medicine can have. Dr. Couz and her patients are both more satisfied with the experience due to the open dialogue that was achieved. This is an example of what Frank would call an instance of “remoralization” (Frank, 2004) as both the patients moral expectations of care and the doctor’s have been met.

The lack of financial compensation created a great deal of stress for residents, as Idiopathic Medicine reported that residents are among the poorest

people in United States, making an amount only a few dollars above minimum wage. Dr. Couz stated that if you considered how many hours she works, she is paid approximately \$10.00/hour for her labour (September 25, 2005). Internal Medicine Doctor explains the financial burden experienced by residents:

It seems that I would have been far better off had I played a doctor on TV... or maybe even learned to lip-sync and do a well-choreographed dance at the same time. As medical students we were berated by residents telling us how awful their lives were and to get out **now**. They all complained about how much they owe (nearly \$200,000 on the average) and how little they get paid, most importantly, how much they work. As medical students we pretty much dismissed these complaints, thinking they were just overworked and overstressed... After four years of college, a one-year masters, four years of medical school and three to six years of residency most physicians don't make a whole lot. We pay for overpriced malpractice insurance to protect ourselves from the people we've invested our whole lives to help and have now demonized us into monsters with a syringe. We have tremendous educational loans to pay back. We have very high expenses from clothing (they expect that we look like doctors, right?) to office expenditures and our compensation continues to dwindle. (Internal Medicine Doctor, November 10, 2004, emphasis is original)

Another interesting aspect of this quote is that Internal Medicine Doctor states that patients have “demonized” physicians “into monsters”. Perhaps these are patients with whom he has not been able to achieve care beyond treatment with, but it should also be noted that patients have a role to play in this relationship that involves respect for their physician and their experiences. As mentioned in the literature review, patients have changed as much as the medical profession and are altering the patient-physician relationship in their own ways by contributing to the

deprofessionalization and proletarianization of the medical profession (Abraham, 2010; Conrad, 2005; Lupton, 2004).

Despite the intense training they have endured, the residents were unsure of their skills as physicians at the end of their residency programs and allude to the fact that they feel more like actors than physicians:

It really doesn't take much to knock the wind out of my sails. No matter how the shift went, I can't shake the feeling of incompetence. I feel like a complete impostor, and feel like if people only knew how little I actually knew I'd have my medical licence pulled. (Dr. Couz, November 23, 2008)

I believe my whole life I've been cursed with a plague of insecurity. Once again this transition, I fear, will bring out the worst in me. Residency is over and I'm clueless and extremely apprehensive about what comes next. Raving about what extremely great qualities I offer on a cover letter feels like a big joke. (Internal Medicine Doctor, November 7, 2005)

The residents struggle to understand what it means to be a 'doctor' and as they have, become disenchanted with their profession. They try to come to terms with all they have sacrificed and find meaning in the work they have devoted so much of their time to, but they are left feeling unprepared, unconfident (in both their skills and their motivation to continue), undervalued, depersonalized and demoralized. Their training does not allow them to develop mutually respectful relationships with their patients, and, particularly when medical success is not likely, the stories of their patients remain unheard. As a result, they question the role of doctor, and their roles as health advocates are not fulfilled.

In the following post, Idiopathic Medicine – the resident who seemed to adapt most successfully during residency- explains the “skill and art” of medicine, and how a ‘good’ doctor does not presume to have all the answers:

I used to believe that residency was a mountain I needed to climb, and that as soon as I reached the summit, things would become clear. But residency is just a small part of a much larger journey – an uphill climb – continuing to learn, continuing to improve my skills, continuing to question myself. Becoming a doctor is a lifelong process. It requires constant questioning, self-reflection, and yes – even self-doubt. To become a good physician is to continue working and learning, day in, day out, year after year. Because no patient is ever black and white. Each one is gray, with subtleties to their stories that can trick you, trap you, mislead you. The skill and art lies in finessing your skills in interpreting each and every shade of gray, in considering each subtlety, each shadow of doubt that crosses your mind. It lies in continuing, no matter how many years of experience you have, to harbour that fine element of uncertainty, of imperceptible fear, that keeps you on your toes, that keeps you wondering. We doctors will never have all the answers. Thoroughness, experience, compassion, and most of all humility are the best we can offer our patients. (Idiopathic Medicine, April 24th, 2012)

When she states that thoroughness, experience, compassion and humility are the best a physician can offer a patient, she also describes qualities of a health advocate. Frank argues, “By seeing how the other is caught up in a story, people may be better able to understand the stories that they themselves are caught up in” (2002a). Listening to patients and becoming a part of their story (entering the ‘tunnel’), may help residents to become better health advocates as they will be able to identify the values held by their patients. If physicians are not taught the value of caring beyond provision of treatment, the role of health advocate will

remain demoralized. Remoralization is possible if the medical profession can ‘reprofessionalize’ itself to value care that is patient-centred and, with humility, accept that medicine is not always the best response to health care issues, in particular, issues that stem from social determinants of health. If this cannot be achieved due to organizational, institutional and cultural constraints there may be no role for advocacy in medicine beyond the provision of biomedical treatment. This research evokes additional questions: if physicians are not in an adequate position to advocate for their patients in ways that include all aspects and options of care, is anyone else better suited to adequately fulfill this role? If not, could this role be created external to, but inclusive of, medicine?

Summary

The previous chapter established the negative impact of the culture of medicine, and the hidden curriculum, on the residents’ ability to negotiate their roles as health advocates by limiting their care to provision of biomedical treatment, putting patients at risk for medicalization. The current chapter established the residents’ desire to provide care that is more humanistic, and how their inability to advocate for their patients beyond biomedicine, by listening to their stories, causes moral distress resulting in feelings of disenchantment with the medical profession. Additionally, the lack of communication between physician and patient leaves both parties unheard and depersonalized. These factors culminate in the demoralization of the role of health advocate. As indicated by Frank, this role could be remoralized if the medical profession were to refocus

medical education in ways that advance advocacy beyond biomedicine. In particular, residents and their patients need the opportunity to create dialogue in an effort to personalize health care through the recognition of values (as told through stories). Current organizational, institutional and cultural constraints restrict residents from developing advocacy skills, and, as such, the role of health advocate is called into question. Considering the recognition of medicalization and pharmaceuticalization in sociological literature, is there a place for advocacy in medicine, if physicians are only trained to advocate for biomedical interventions? At present, it is arguable that the boundaries between advocacy and paternalism have become blurred.

CHAPTER SIX

Conclusion

Summary

The hidden curriculum, as part of the culture of medicine, professionally socializes residents to prioritize their own stories as physicians-in-training, over their stories of their patients. This process leaves residents and their patients feeling depersonalized as relationships are built around provision of treatment and based on biomedically successful outcomes, resulting in a crisis in caring, compassion and communication. The role of health advocate is demoralized, as the medical profession disenchant residents by failing to meet their moral expectations of what it means to be a doctor. In this study, all the residents expressed a desire to care for their patients in ways that nurture advocacy, but were restricted in this effort by the culture of medicine. Regardless of whether or not advocacy skills are being taught in undergraduate medical programs, the professional socialization process in medicine not only did not support, but also worked against residents' efforts to develop advocacy skills. In comparison to Frank's utilization of the 'tunnel of illness', the residents were left to negotiate their roles as health advocates in a tunnel of learning isolation, where it was their own responsibility to learn how to put into practice caring beyond biomedical treatment, and how to be health advocates.

When medical schools begin to incorporate health advocacy competencies as a part of their curriculum, all aspects of care should be considered, not just

those pertaining to the provision of biomedical treatment. The medical profession needs to recognize that in order to determine the health needs of the patients, communities and populations they serve, they need to listen to the people in order to determine their values. If this can be accomplished, the role of health advocate will be re-moralized, but it is questionable as to whether or not the role of health advocate can ever be adequately fulfilled by the medical profession, as training is centred specifically on biomedicine. In this scenario, even at its best, advocacy could only be improved to provide the best possible biomedical care, but could not be inclusive of other health care options that may be more fitting for those that are ill. For this reason, advocacy could in fact work against itself, and would be better described as medicalization or paternalism. Definitions of advocacy and the role of health advocate in medicine require further clarification in order to illuminate the boundaries of advocacy and its potential risk if it is not implemented in a way that is responsive to patient values.

Theoretical and Substantive Contributions

In addition to the findings reported in this concluding chapter, theoretical and substantive conclusions can be drawn from this research. These conclusions are centered on the expansion of Frank's theory of the demoralization of medicine by establishing barriers to health advocacy in medicine, expanding notions of medicalization to include its' impact on health advocacy, and reflections at the macro-level that include the intersection of social determinants of health and health advocacy. Methodological contributions have also been generated.

Previous studies of professional socialization in medicine primarily focus on undergraduate medical education and do not take in account experiences in residency training, despite the fact that graduate training involves the practical application of medical knowledge and skills, including the care of patients. This period of training is of value to the study of professional socialization as residents further establish their own personal meanings of what a doctoring encompasses, according to their experiences. As stated by the RCPSC, health advocacy is one competency that physicians-in-training are expected to attain to fulfill their roles as physicians. Using Frank's theory to dissect notions of caring to generate a definition of advocacy that goes beyond the provision of biomedical treatment, this research illuminates discrepancies between the expectations of the role of health advocate and the realities of biomedicine by calling into question the ability of physicians to advocate for their patients in ways that are morally and ethically sufficient. By making the connection between professional socialization in medicine and the role of health advocate, as outlined by the RCPSC, this research was able to identify real-life instances of Frank's theory, and determine barriers to the re-moralization of medicine.

Ideas of medicalization are expanded within this study by demonstrating that medicalization reaches beyond diagnosis and biomedical treatment, and incorporates ways in which care is realized in biomedicine and how advocacy is executed. Advocating for patients based on their values goes against medical ideologies that focus on curing the ill through biomedical interventions and, as

such, leads to biomedical advocacy, not health advocacy. In order for health advocacy to be truly realized, it would need to recognize all determinants of health, including cultural norms and values that do not coincide with biomedicine.

Lastly, on a macro-level, this study revealed that the WHO's (and other health institutions) recent focus on improving the social determinants of health and increasing social responsibility in medicine will be difficult to achieve if advocacy is grounded in biomedicine and does not include dialogue with patients, communities and populations. Although some social determinants are more predictable (such as poverty, income, education, etc...), others may not be as obvious. Although biomedicine is an important aspect of improved health, input from other disciplines, such as those belonging to the social sciences, could reduce the lens of biomedicine and improve health advocacy by making it more inclusive.

Methodologically, this research further establishes blogs as viable data source for qualitative research. The blogs used for the study provided rich data and valuable insight into the thoughts, feelings and experiences of medical residents by offering a forum that is anonymous and easily accessible. It is unlikely that the data procured for this study would have been available through any other research method.

Directions for Future Research

As stated earlier, the concept of advocacy and the role of health advocate require further scrutiny and development in order to provide definitions that

adequately satisfy patients and the medical profession. Future research could include the study of physicians that have completed residency training to investigate whether or not more opportunities for advocacy arise as physicians gain experience and move up the medical hierarchy. Differences between specialties could also provide insight into the culture of medicine and its impact on advocacy. Additionally, given the sizable amount of medical information that residents must learn and their immense workload, a study to determine where advocacy training would fit into the medical curriculum, as well as various ways to support physicians-in-training in the development of their role as health advocates, would be worthwhile. Furthermore, connections between social responsibility and the social determinants of health require further examination, in particular the role of medicine in advocating to eliminate social problems in an effort to improve health. Lastly, further exploration into patient expectations in terms of advocacy might identify where gaps in advocacy exist, as well as the appropriateness of the role of health advocate for physicians.

References

- Abraham, J. (2010). Pharmaceuticalization of society in context: Theoretical, empirical and health dimension. *Sociology*, 44(4), 603-622.
- Anderson, D. (1992). The hidden curriculum. *American Journal of Roentgenology*, 159, 21-22.
- Annandale, E., Elston, M.A., & Prior, L. (2004). Medical work, medical knowledge and health care. Themes and perspectives. In E. Annandale, M.A. Elston & L. Prior (Eds.), *Medical work, medical knowledge and health care* (1-18). Malden, MA: Blackwell.
- Armstrong, D. (2004). The rise of surveillance medicine. In E. Annandale, M.A. Elston & L. Prior (Eds.), *Medical work, medical knowledge and health care* (135-145). Malden, MA: Blackwell.
- Association of Faculties of Medicine of Canada (2011). *Social Accountability Mandate*. Retrieved from <http://www.afmc.ca/about-social-accountability-mandate-e.php>
- Assor, A. & Gordon, D. (1987). The implicit learning theory of hidden curriculum research. *Journal of Curriculum Studies*, 19, 329-339.
- Beagan, B. (2001). “Even if I don’t know what I’m doing I can make it look like I know what I’m doing”: Becoming a doctor in the 1990s. *The Canadian Review of Sociology and Anthropology*, 38(3), 275-292.

- Beagan, B. (2003). Teaching social and cultural awareness to medical students: "It's all very nice to talk about it in theory, but ultimately it makes no difference". *Academic Medicine*, 78(6), 605-614.
- Becker, H., & Geer, B. (1958). The fate of idealism in medical school. *American Sociological Review*, 23(1), 50-56.
- Becker, H., Geer, B., Strauss, A., & Hughes, E. (1961). *Boys in white: Student culture in medical school*. Chicago: University of Chicago Press.
- Betz, M., & O'Connell, L. (1983). Changing doctor-patient relationships and the rise in concern for accountability. *Social Problems*, 31 (1), 84-95.
- Bledstein, B. (1976). *The culture of professionalism*. New York: W.W. Norton.
- Bloom, S. (1988). Structure and ideology in medical education: An analysis of resistance to change. *Journal of Health and Social Behaviour*, 29, 294-306.
- Brown, P. (1995). Naming and framing: The social construction of diagnosis and illness. *Journal of Health and Social Behaviour*, 35(extra issue), 34-52.
- Brown, P., & Zavestoski, S. (2004). Social movements in health: an introduction. *Sociology of Health & Illness*, 26 (6), pp. 679-694.
- Burke, M. (1997). Clinicoeconomics in geropsychiatry. *Psychiatric Clinics of North America*, 20, 219.
- Busfield, J. (2006). Pills, power, people: Sociological understandings of the pharmaceutical industry. *Sociology*, 40(2), 297-314.

- Caplan, A. (1997). The ethics of gatekeeping in rehabilitation medicine. *Journal of Head Trauma Rehabilitation, 12*, 29-36.
- Charon, R. (2000). Reading, writing, and doctoring: Literature and medicine. *The American Journal of Medical Sciences, 319*(5), 285-291.
- Charon, R. (2001). Narrative medicine: Form, function and Ethics. *Annals of Internal Medicine, 134*(1), 83-87.
- Charon, R., Trautmann Banks, J., Connelly, J.E., Hunsaker Hawkins, A., Montgomery Hunter, K., Hudson Jones, A., Montello, M., & Poirer, S. (1995). Literature and medicine: Contributions to clinical practice. *Annals of Internal Medicine, 122*, 599-606.
- Chirayath, H.T. (2006). Who serves the underserved? Predictors of physician care to medically indigent patients. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 10*(3), 259-282.
- Clancy, T.R. (2003). Courage and today's nurse leaders. *Nursing Administration Quarterly, 27*(2), 128-132.
- Conrad, P. (1979). Types of medical social control. *Sociology of Health and Illness, 1*, 1-11.
- Conrad, P. (1988). Learning to doctor: Reflections on recent accounts of the medical school years. *Journal of Health and Social Behaviour, 29*(4), 323-332.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209-32.

- Conrad P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behaviour*, 46, 3-14.
- Coulehan, J. & Williams, P.C. (2001). Vanquishing virtue: The impact of medical education. *Academic Medicine*, 76(6), 598-605.
- Coulehan, J., & Hunsaker Hawkins, A. (2003). Keeping faith: Ethics and the physician-writer. *Annals of Internal Medicine*, 139(4), 307-311.
- Cortazzi, M. (1993). *Narrative analysis*. London: Falmer.
- Cribb, A., & Bignold, S. (1999). Towards the reflexive medical school: The hidden curriculum and medical education research. *Studies in Higher Education*, 24, 195-209.
- Crossley, M. (2000). *Introducing narrative psychology*. Buckingham: Open University Press.
- Cruess, R., Cruess, S., & Johnston, S. (2000a). Professionalism and medicine's social contract. *The Journal of Bone and Joint Surgery*, 82, 1189-1194.
- Cruess, R., Cruess, S., & Johnston, S. (2000b). Professionalism: An ideal to be sustained. *Lancet*, 356, 156-159.
- Dharamsi, S., Ho, A., Spadafora, S., & Woollard, R. (2011). The physician as health advocate: Translating the quest for social responsibility into medical education and practice. *Academic Medicine*, 86(9), 1108-1113.
- Dr. Couz. (2005). Tales from the emergency room and beyond [weblog]. Retrieved from http://drcouz.blogspot.com/2005_08_01_archive.html
- Durkheim, E. (1933). *The division of labor in society*. New York: Macmillan.

- Erlen, J.A. (2001). Moral distress: A pervasive problem. *Orthopaedic Nursing, 20(2)*, 76-80.
- Faulkner, L., & Layton McCurdy, R. (2000). Teaching medical students social responsibility: The right thing to do. *Academic Medicine, 75(4)*, 346-350.
- Foucault, M. (1973). *The birth of the clinic*. New York: Vintage.
- Foucault, M. (1977). *Discipline and punish*. New York: Random.
- Frank, A.W. (2000). The standpoint of storyteller. *Qualitative Health Research, 10(3)*, 354-365.
- Frank, A.W. (2002a). "How can they act like that?" Clinicians and patients as characters in each other's stories. *The Hastings Centre Report, 32(6)*, 14-23.
- Frank, A.W. (2002b). Why study people's stories? The dialogical ethics of narrative analysis. *The International Journal of Qualitative Research, 1(1)*, 109-117.
- Frank, A.W. (2004). *The renewal of generosity: Illness, medicine and how to live*. Chicago: University of Chicago Press.
- Franzosi, R. (1998). Narrative analysis- Or why (and how) sociologists should be interested in narrative. *Annual Review of Sociology, 24*, 517-554.
- Gillett, J., Cain, R., & Pawluch, D. (2002). Moving beyond the biomedical: The use of physical activity to negotiate illness. *Sociology of Sport Journal, 19*, 370-384.

- Gruen, R., Pearson, S., & Brennan, T. (2004). Physician-citizens- Public roles and professional obligations. *Journal of the American Medical Association, 291*(1), 94-98.
- Gutierrez, K.M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing, 24*(5), 229-241.
- Hafferty, F. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine, 73*, 403-407.
- Hafferty, F., & Franks, R. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine, 69*, 861-871.
- Hafferty, F., & Light, D. (1995). Professional dynamics and the changing nature of medical work. *Journal of Health and Social Behaviour*, (extra issue), 132-153.
- Haas, J., & Shaffir, W. (1977). The professionalization of medical students: Developing competence and a cloak of competence. *Symbolic Interaction, 1*(1), 71-88.
- Haas, J., & Shaffir, W. (1982). Ritual evaluation of competence: The hidden curriculum of professionalization in an innovative medical school program. *Work and Occupations, 9*, 131-154.
- Haug, M. (1988). A reexamination of the hypothesis of physician deprofessionalization. *Milbank Quarterly, 66*(Suppl. 2), 28-56.
- Hazzard, W. (1995). Elder abuse- definitions and implications for medical education. *Academic Medicine, 70*, 979-81.

- Idiopathic Medicine/Medical Resident. (2010). A medical resident's journey [weblog]. Retrieved from <http://idiopathicmedicine.wordpress.com/2010/04/>
- Illich, I. (1976). *Medical Nemesis*. New York: Pantheon.
- Internal Medicine Doctor. (2004). Chronicles of a medical madhouse [weblog]. Retrieved from http://www.medicalmadhouse.blogspot.com/2004_09_01_archive.html
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Toronto: Prentice Hall.
- Kalberg, S. (1980). Max Weber's types of rationality: Cornerstones for the analysis of rationalization processes in history. *American Journal of Sociology*, 85, 1145-1179.
- Kälvemark, S., Höglund, A.T., Hansson, M.G., Westerholm, P., & Arnetz, B. (2004). *Social Science & Medicine*, 58, 1075-1084.
- Keniston, K. (1967). The medical student. *Yale Journal of Biology and Medicine*, 39, 346-358.
- Kermode, F. (1967). *The sense of an ending: Studies in the theory of fiction*. New York: Oxford University Press.
- Kidder, R.M. (2005). *Moral Courage*. New York: W. Morrow.
- Labov, W. (1972). *Language in the inner city*. Philadelphia: University of Pennsylvania Press.
- Lachman, V.D. (2007). Moral courage: A virtue in need of development? *MEDSURG Nursing*, 16(2), 131-133.

- LeBesco, K. (2004). Managing visibility, intimacy, and focus in online critical ethnography. In M.D. Johns, S.-L.S. Chen and G.J. hall (Eds.), *Online social research methods: Methods, issues and ethics* (63-79). New York: Peter Lang.
- Lempp, H. & Seale, C. (2004). The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *The British Medical Journal*, 329, 770-773.
- Light, D. (1989). Social control and the American health care system. In H.E. Freeman & S. Levine (Eds.), *Handbook of medical sociology* (456-474). New Jersey: Prentice-Hall.
- Lombardo, A.P., & Gillett, J. (2006). Online HIV research: Assessing three case study methodologies. In Liamputtong, P. (Ed.), *Health Research in Cyberspace: Methodological, practical and personal issues* (133-146). New York: Nova Science Publishers.
- Lupton, D. (1997). Foucault and the medicalisation critique. In A. Petersen & R. Bunton (Eds.), *Foucault, health and medicine* (pp. 94-110). London: Routledge.
- Lupton, D. (2004). Doctors on the medical profession. In E. Annandale, M.A. Elston & L. Prior (Eds.), *Medical work, medical knowledge and health care* (168-184). Malden, MA: Blackwell.
- Maniker, M. (2001). Myth, paradox and the hidden curriculum. *Medical Education*, 31, 293-298.

- Mann, C., & Stewart, F. (2000). *Internet communication and qualitative research. A handbook for researching online*. Thousand Oaks, CA: Sage.
- Markham, A. (1998). *Life online: Researching real experience in virtual space*. Walnut Creek, CA: Altamira Press.
- McAdams, D. (1993). *The stories we live by*. London: The Guilford Press.
- McLellan, M.F. (1997). Literature and medicine: Physician-writers. *The Lancet*, 349, 564-567.
- McLeod, J. (1997). *Narrative and psychotherapy*. London: Sage.
- Mechanic, D., & Meyer, S. (2000). Concepts of trust among patients with serious illness. *Social Science & Medicine*, 51, 657-668.
- Merton, R., Reader, G., & Kendall, P. (1957). *The student physician: Introductory studies in the sociology of medical education*. Cambridge, MA: Harvard University Press.
- Miller, R. (2005). Moral Courage: Definition and development. Retrieved from <http://www.ethics.org/resource/moral-courage-definition-and-development>
- Murray, M. (1999). The storied nature of health and illness. In M. Murray and K. Chamberlain (Eds.), *Qualitative Health Psychology* (47-63). London: Sage.
- Murray, M. (2003). Narrative psychology. In J. Smith (Ed.), *Qualitative Psychology* (111-131). London: Sage.
- Nathan. (2007). A jolly company [weblog]. Retrieved from http://jollycompany.blogspot.com/2007_07_01_archive.html

- Nye, R. (2003). The evolution of the concept of medicalization in the late twentieth century. *Journal of History of the Behavioral Sciences*, 39(2), 115-129.
- Parsons, T. (1975). The sick role and the role of the physician reconsidered. *Health and Society*, 53(3), 257-278.
- Peschel, R. & Rhodes Peschel, E. (1988). *When a doctor hates a patient: And other chapters in a young physician's life*. Berkeley, CA: University of California Press.
- Reisman, A.B., Hansen, H., & Rastegar, A. (2006). The craft of writing: A physician-writer's workshop for resident physicians. *Journal of General Internal Medicine*, 21, 1109-1101.
- Riessman, C.K. (2002). Analysing personal narratives. In J. Gubrium and J. Holstein (Eds.), *Handbook of Interview Research* (695-710). London: Sage.
- Riessman, C.K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications.
- Ritzer, G. & Walczak, D. (1988). Rationalization and the deprofessionalization of physicians. *Social Forces*, 67(1), 1-22.
- Rodney, P. (1988). Moral distress in critical care nursing. *Canadian Critical Care Nursing Journal*, 5, 9-11.

- Royal College of Physicians and Surgeons of Canada (2005). CanMEDS 2005 framework. Retrieved from <http://rcpsc.medical.org/canmeds/CanMEDS2005/index.php>
- Royal College of Physicians and Surgeons of Canada (2010). The CanMEDS physician competency framework: Better standards, better physicians, better care. Retrieved from <http://rcpsc.medical.org/canmeds/index.php>
- Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. *Journal of Nursing Scholarship*, 23(3), 161-166.
- Schwartz, L. (2002). Is there an advocate in the house? The role of health care professionals in patient advocacy. *Journal of Medical Ethics*, 28, 37-40.
- Sinding, C., Hudak, P., Wiernikowski, J., Aronson, J., Miller, P., Gould, J., & Fitzpatrick-Lewis, D. (2010). "I like to be an informed person, but..." negotiating responsibility for treatment decisions in cancer care. *Social Science & Medicine*, 71, 1094-1101.
- Smith, J.K., & Weaver, D.B. (2006). Capturing medical students' idealism. *Annals of Family Medicine*, 4(1), S32-S37.
- Sparkes, A.C. (2007). Narrative analysis: Exploring the what's and how's of personal stories. In I. Holloway (Ed.), *Qualitative Research in Health Care* (191-209). Berkshire: Open University Press.
- Stern, D. (1998). Practicing what we preach? An analysis of the curriculum of values in medical education. *The American Journal of Medicine*, 104, 569-575.

- Stephenson, A., Higgs, R., & Sugarman, J. (2001). Teaching professional development in medical schools. *The Lancet*, 357, 867-870.
- Sundin-Huard, D., & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorising the relationships. *International Journal of Nursing Practice*, 5, 8-13.
- Vergheze, A. (2001). The physician as storyteller. *Annals of Internal Medicine*, 135(11), 1012-1017.
- Verma, S., Flynn, L., & Seguin, R. (2005). Faculty's and residents' perceptions of teaching and evaluating the role of health advocate: A study at one Canadian university. *Academic Medicine*, 80(1), 103-108.
- Waitzkin, H. (2006). One and a half centuries of forgetting and rediscovering: Virchow's lasting contributions to social medicine. *Social Medicine*, 1(1), 5-10.
- Waitzkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001). Social medicine then and now: Lessons from Latin America. *American Journal of Public Health*, 91(10), 1592-1601.
- Waitzkin, H., Iriart, C., Shipp Buchanan, H., Mercado, F., Tregear, J., & Eldredge, J. (2008). The Latin American Social Medicine Database: a resource for epidemiology. *International Journal of Epidemiology*, 37(4), 724-728.
- Waitzkin, H., & Waterman, B. (1974). *The exploration of illness in a capitalistic society*. Indianapolis, IN: Bobbs-Merrill.

- Walstrom, M.K. (2004). Ethics and Engagement in Communication Scholarship: Analyzing public online support groups as research/participant-experiencer. In E. Buchanan (Ed.), *Readings in virtual research ethics: Issues and controversies* (174-202). Hershey, PA: Information Science Pub.
- Weisberg, M., & Duffin, J. (1995). Evoking the moral imagination: Using stories to teach ethics and professionalism to nursing, medical and law students. *The Journal of Medical Humanities*, 16(4), 247-263.
- Weiss, M., & Fitzpatrick, R. (2004). Challenges to medicine: The case of prescribing. In E. Annandale, M.A. Elston & L. Prior (Eds.), *Medical work, medical knowledge and health care* (208-237). Malden, MA: Blackwell.
- Wilkes, M., & Raven, B. (2002). Understanding social influence in medical education. *Academic Medicine*, 77(6), 481-488.
- Willard, C. (1996). The nurse's role as patient advocate- obligation or imposition. *Journal of Advanced Nursing*, 24, 60-66.
- William, S. (2001). Sociological imperialism and the profession of medicine revisited: Where are we now? *Sociology of Health and Illness*, 23(2), 135-158.
- Williams, G.H. (2000). Knowledgeable narratives. *Anthropology & Medicine*, 7(1), 135-140.

- Williams, S., & Calnan, M. (1996). The 'limits' of medicalization? Modern medicine and the lay populace in 'late' modernity. *Social Science and Medicine*, 42(12), 1609-1620.
- Woloschuk, W., Harasym, P., & Temple, W. (2004). Attitude change during medical school: A cohort study. *Medical Education*, 38, 522-534.
- World Health Organization (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- Zola, I. (1975). In the name of health and illness: On some socio-political consequences of medical influence. *Social Science & Medicine*, 9, 83-87.