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Learning About Healing In Family Medicine: Making Doctors In An American Medical Residency Program

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**LEARNING ABOUT HEALING IN FAMILY MEDICINE:
MAKING DOCTORS IN AN AMERICAN
MEDICAL RESIDENCY PROGRAM**

by

EDWARD J. ROHN

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2016

MAJOR: ANTHROPOLOGY

Approved By:

Advisor

Date

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DEDICATION

For Heather

*For no less a reason than her unswerving alliance, unending love, and indomitable spirit
as she walked this process with me – every step of the way.*

I love you always!

ACKNOWLEDGEMENTS

I would like to begin by extending my deepest thanks and appreciation to my doctoral committee. Your guidance, support, and friendship have made this dissertation what it is today. To my advisor and chair, Dr. Sherylyn Briller – there are simply no words that can fully express the honor you have bestowed upon me. Thank you for your dedication, mentorship, and continuous encouragement throughout this journey. I have learned more than I can ever articulate. Your example showed me how perseverance and dedication do lead to completion and success. To my committee members Dr. Mark Luborsky, Dr. Todd Meyers, and Dr. Seth Messinger, I cannot thank you enough for your support and feedback, your camaraderie and mentorship on this research, from its inception to this final manuscript. Perhaps, the hardest lesson learned is that critique and challenging feedback are the foundation of personal growth as a scholar. I would also like to thank Dr. Andrea Sankar for the opportunities and guidance she provided ahead of this project. She gave me my earliest opportunity to begin to work as a professional anthropologist. Through the combined efforts of these amazing scholars – individuals I consider friends in anthropology – I have come to see a new moment.

To my family, I will first offer an apology and a promise. This dedication marks the final passage of a long and harrowing journey. Moving beyond the doctoral program will mark a new chapter, a new level of work and dedication, and a new perspective on life that will never again be dominated by such an enormously emotional undertaking. The sacrifices my wife and daughter have made – coping with my stress, my lack of time, my crazy schedule – will all worth be it now that this dissertation is complete. You

have walked beside me through this entire process and I bring the best version of myself back from this journey to continue building and improving our lives together.

To my Mom and Dad, your lessons, instilled in me throughout my life, gave me the strength to complete this project. Your lessons of hard work, perseverance, right action, and faith in myself all paid off and led me here. Never cruel or cowardly; never give up, never surrender. To the rest of my family, it is now safe to ask me when I am finishing my dissertation, because here it is. It is done. I am excited to return from this odyssey and catch up with each and every one of you.

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CHAPTER 1

INTRODUCTION

Research problem

This study explores the making of healers in an American family medicine residency training program. The study of healing traditions around the world is an age-old conversation in anthropology, focusing attention on the cultural contexts in which healing occurs. In studying ethnomedical systems, anthropologists shed light on different ways of thinking about health practices cross-culturally, and on those who serve as healers (DelVecchio-Good 2013; Luhrmann 2013; Moerman 2012, 1979; Good and DelVecchio-Good; Hunt and Mattingly 1998; Vaughan 1994). Ethnomedical studies examine the interactions of patients and healers, and the many ways in which healers are trained and socially recognized (Womack 2009; Kleinman 1980; Levi-Strauss 1963; Evans-Pritchard 1937; Rivers 1924). “Making healers” involves a process of becoming; the apprentice takes on a new social role often through the guidance of someone already steeped in the relevant practices (Womack 2009; Levi-Strauss 1963). In this research, I look at how residency training in American biomedicine, a formal program of professional socialization, moves the newly-graduated doctor towards becoming a board-certified and autonomous family medicine physician.

As in other ethnomedical systems, this process of “becoming”, of making a particular kind of healer, involves a significant period of instruction. Experts, who are already acting in the relevant social capacity, assist the novice physician in becoming something new (DelVecchio-Good 1995; Mizrahi 1986; Gaines and Hahn 1985; Levi-Strauss 1963; Merton, et al. 1957). In the present case, more-senior physicians attempt

to impart the necessary techniques, values and knowledge to the novice in order to socialize and professionalize them into their new role. In turn, the newcomer negotiates how they will integrate their own past experiences with this new cultural information, and contest or accept what they are learning. Residents are expected to acquire key knowledge, master appropriate techniques, and internalize particular cultural values. I will make the case that American family medicine is a particularly interesting biomedical specialty for considering the process of how both physicians and healers are “made” and socially recognized in biomedicine.

As with any medical specialty, family medicine has a particular focus or “object” (Weisz 2006), informing the type of knowledge and values residents are taught. Family medicine eschews a narrow specialization on a particular organ system, disease process, or age or gender group, in favor of a “whole patient” approach. Family medicine aims to address patient concerns “holistically”, to explore and incorporate the patient’s broader sociocultural context. Patients are a locus of a group of relationships, circumstances, conditions – of which the individual disease is only a part (Martin, et al. 2004; Shahady 1993; Stephens 1982; Leaman, et al. 1977; McWhinney 1997; Gayle 1982; Good 1994; Kleinman 1980, 1988, 1997; Kleinman, et al. 1978). By engaging with family medicine’s “object”, physicians attempt to understand the patient’s entire illness experience and to incorporate a patient’s wishes, concerns, and personal understandings of sickness into the treatment process. Family medicine seeks longitudinal relationships with patients, taking a “cradle-to-the-grave” philosophy of patient care (Shahady 1993). Thus, family medicine attempts to not only treat the biological processes of disease and master the technical skills of diagnosis and

treatment, but to incorporate a broader sense of patients' social contexts and personal experiences. These attributes make this biomedical specialty a fascinating site for exploring rhetorical and practical notions of healing.

As a theoretical framework, practice theory (Bourdieu 1977, 1983, 1990, 2008; Mauss 1973; Mauss and Brewster 1979) allows me to explore the making of physicians in the context of family medicine. Practice theory has a long history of being used to study a variety of educational settings, including those in medical education (Bourdieu 2008; King 2000; Krischner and Lachicotte 2001). Specifically, I anthropologically consider how family medicine physicians are trained to become a particular sort of healer through this educational process. Practice theory offers a number of key constructs to analyze the relationship between the history of family medicine, medical practice, medical education and experiences within family medicine residency training.

Project goal and specific aims

The goal of this project is to identify and describe the training of physicians and making of "healers" in an American family medicine residency training program. Describing how residents and faculty are involved in this educational experience and interpret the process of "becoming" will illustrate how enculturation to family medicine unfolds. Further, the project investigates discourses and practices around healing in the making of family medicine doctors. For context, the project considers how family medicine developed historically and how this broader history influenced the goals and values of this residency program. The project uses practice theory to analyze the wide array of experiences, attitudes, values, techniques, and knowledge encountered in the fieldsite. This project has three specific aims. They are:

1. To identify and describe the educational processes in a residency training program towards professional socialization of residents into family medicine.
2. To describe how the particular habitus of the residency informed the ways in which residents came to embody of the role of family medicine physicians.
3. To identify and describe definitions of and meaning-making around healing through discourses, practices, and engagement with family medicine's values.

Background and significance

Anthropology of healing

Each healing system is bound by the values, techniques, and claims to knowledge – the culture – of the society in which the system is situated (Lock 1984; Kleinman 1980; Press 1980; Foster 1976). Thus, anthropologists have spent much time exploring the nature of healing practices and notions of therapeutic efficacy at work in particular contexts. However, it is also possible to examine anthropologically ideas about healing and healers in a broader cross-cultural and comparative manner as well.

Healing has been conceptualized by anthropologists in many different ways – as a symbolic negotiation between the practitioner and the patient (Levi-Strauss 1963; Janzen 1978; Davis-Floyd and St. John 1998); as a way for the sick person to construct meaning around their experiences (Mattingly 1998a, 1998b; Kleinman 1988), whether health is restored or not (Kleinman 1980); or as direct medical or surgical treatment of a disease state (Kleinman 1980; Good 2005). Regardless of these different ways of conceptualizing “healing”, one central tenet connects them: persons suffering from sickness seek assistance from socially-recognized person(s) whose role and skills give them a socially-proven ability to address and alleviate sickness. In other words, healing

is those actions taken by healers to address sickness, regardless of the etiological model of sickness at work within the cultural context. The context of healing practices therefore needs to be understood and described in order to understand both local definitions of healing and healers. Towards this end, I will begin by discussing some influential works that greatly influenced how medical anthropologists thought about and understood healing and healers over time.

George Foster's classic work on disease etiologies (1976) addresses what actions constitute healing and how different explanations of causation lead to different approaches to treatment. His broad distinction between "personalistic" and "naturalistic" causes of disease frames the responsibilities and actions of those treating sickness as well as those experiencing sickness. The "personalistic" category characterizes disease as the "active, purposeful intervention of an agent" (ibid: 775) – meaning that someone or some supernatural entity is responsible for one's current disease state. In contrast, the "naturalistic" model explains illness in systematic, impersonal terms: natural forces are responsible for an upset in the balance of the body, leading to disease.

This difference in causation leads socially-sanctioned specialists to take different healing actions in their approach to treating sickness. In personalistic systems, healing is more diagnostic and involves identifying the agent of disease. The patient in a naturalistic system usually, upon reflection, gleans the potential cause of illness for him- or herself, (e.g. eating the wrong foods,) and then approach the naturalistic healer for particular healing treatments (ibid: 779-80). Foster however immediately states that this distinction is problematic, that the taxonomy he proposes is almost certainly more complex. In Foster's scheme, biomedicine in general fits into the naturalistic category,

with its focus on disease agents and disease-treatment. Foster's concerns are relevant the specifics of any medical system may not conform to either one etiology or the other; the two etiologies are "rarely if ever exclusive" (ibid:776). From studying Foster's classic conceptual scheme, I learned early on the importance of understanding the etiological scheme within my fieldsite in order to grasp fully the context in which healing practices occur there.

Arthur Kleinman also had a major in influencing how medical anthropologists understood healing and healers over time. Kleinman, Eisenberg and Good (Kleinman, et al. 1978) put the following distinction between disease and illness forward in the seminal work. Disease was characterized as "the malfunctioning of biological and psychological processes" and illness as "the subjective psychosocial and cultural experience and meaning of a perceived state of sickness" (Kleinman 1980: 72). Together, the authors referred to these categories as "sickness". Kleinman (1980) defined healing through the inclusion of the patient's illness experience, as opposed to "curing" as indicative of the treatment and amelioration of disease symptoms and processes. Relief is brought to the symptomatic experiences of the persons seeking improvement of their health circumstances, without concern for patients' role beyond improved health. Curing, Kleinman claims, is not healing. This claim will be important to investigate in this study where I need to consider what both healing and curing are and look like in this fieldsite. As indicated, both Foster and Kleinman are interested in the way a society views the causes of sickness and how these views shape ideas about etiological explanations, diagnosis, and treatment. Since I am studying the making of

healers, I will need to consider how healing is recognized in the setting as well as how the efficacy of healers is determined by those involved in these processes.

In thinking about the contextual nature of healing, I also explored Glick's (1967) classic work that places the medical and healing practices of the Gimi of New Guinea into broader cross-cultural context. Glick argues that while the Gimi do not share Western notions of disease etiology and processes, their practices can similarly be examined for thinking about healing practices. The Gimi primarily focus on the cause of sickness – often a type of sorcery, poison, or demonic being. The diagnostic process is a community effort, involving friends and family; a distinct “healer” is not mentioned in Glick's accounts but this is still a good example to think with here. Healing is a collection of ways of “strengthening sick persons, increasing their powers of resistance, through the use of medicines” (44). These medicines are diverse, often not categorically related to particular sicknesses, but designed to bolster the individual to resist the causes of their disease state. “Curing rituals” are used to bring the community together, and healing becomes a social activity. Sickness has meaning for the community, and healing is a social activity designed to provide strength to the sufferer such that he or she may resist and overcome the causative agent of the disease.

In the Gimi medical system, one can still see that healing involves matching the social treatment process to the diagnosis, aiming to empower the sick person, rather than focusing on the treatment agent (drug, medicinal plant, or otherwise). Involving the community of friends, family, and loved ones leads ideally to restored health and wellbeing – the entire community bears witness to efficacious healing. In Glick's he questions the “entrenched ethnographic categories” (ibid: 36) that explain medical and

healing systems around the world. From reading this work, I learned to think more about the place of the community in how healing occurs in different ethnomedical systems around the world.

Furthering this cross-cultural examination of how healing occurs in different contexts, I also examined Good's (1977) classic work on illness and the healing process in Iran. His research focused on the medical "semantics" or language used in the social experience of sickness. Good argues that the culturally-specific ways that people talk about disease and illness are critical to understanding medical systems cross-culturally and how healing occurs within them. Further, he argues that understanding local etiologies, diagnoses, and treatments all require attention to language. By focusing on the "folk illness" of heart distress in Iran, he demonstrates how meanings of disease and illness are more than a simple relationship between symptoms and disease, but a complex landscape of symbols and experiences used to "make sense" of what a person and community is experiencing. Social stress is at the heart of discourse around treatment and healing and negotiating relief is a communal practice involving family and social networks (ibid).

For my purposes, I am most interested in how Good thinks about the meanings of patient-healer interactions and how healing practices are contextualized and understood. In one intriguing case, Good explains how a woman with heart distress has seen numerous "nerve doctors" without success. Finally, the last doctor asked her what was wrong and explored her concerns. The woman cried and explained her worries: about her fears of her husband's opium use, stress about her home life, and the loss of her father. The doctor prescribed tranquilizers for her, but the patient mentioned her

opportunity to talk about her problems, and her husband's promise never to smoke opium again, as the relieving agents. From this example, I take away that the doctor's tranquilizers were not as potent a healing agent, to the woman, as her voice being heard and the social conflicts in her life improving; restoring her equilibrium. The subtle linguistic difference between her prior doctors' conversing and the last one – the one who focused not on the disease but on the patient's illness experience and broader social concerns – achieved an efficacious healing effect. Re-reading this classic work in medical anthropology reminds me yet again to think about how these types of issues matter in the mission and delivery of family medicine care – and how to evaluate healing practices in this context.

Making healers in anthropology

From the earliest beginnings of medical anthropology, there has been a long tradition of studying healers and their training, as situated within the respective healing systems (e.g., Rivers 1924; Levi-Strauss 1963; Evans-Pritchard 1937). As seen above, each ethnomedical system will have a socially-recognized process of making healers. Further, what constitutes a healer will vary from setting to setting, and across time, just as healing practices do, and will depend on disease etiologies, the particular focus on disease versus illness experiences, and the type(s) of medical systems in place within a culture. In the case of the Gimi, for example, the healer is the community – many people come together to help diagnose and empower the patient to overcome his sickness. With Good's discussion of folk illnesses in Iran, doctors are seen as healers, though not every doctor: only those who are willing and able to engage in the language of "heart distress" and explore the patient's social concerns are efficacious. Kleinman (1980)

asserts how curing is not healing, and that biomedical practitioners may not, in fact, be capable of healing when defined as the product of attention to social and personal components of patients' illness experiences (Maretzki 1985).

It remains clear that healing practices are contextual, and healers must learn those practices in order to be socially-recognized as healers. Therefore, the making of healers will likewise be contextual. With these thoughts in mind, in this research project the “making” of healers is a socially-constituted process of becoming for family medicine residents. It is a social transformation towards a new, recognized professional role involving healing practices (Womack 2009; Moerman 2012, 1979). Drawing in the literature, I must think about how in this process of “becoming” each novice undergoes a process of joining, training, and professional socialization in order to be recognized as a healer. This process involves acquiring the knowledge, techniques, and values necessary to be recognized as a healer and perform in that socially-recognized capacity (Hafferty 2000, 1991; Dow 1986; Evans-Pritchard 1971). These experiences occur in the context of a specialized system within a larger culture – typically a healing tradition or medical system – one designed to build up a personal stake, a set of beliefs, and to elicit adherence to a particular school or tradition (Levi-Strauss 1963).

I will now explore three classic anthropological examples, each pointing to a particular set of patterns in the way of “becoming”. I will illustrate the common threads throughout these examples. The transformation to healer is a social one, involving the internalization and demonstration of certain “ways of acting, thinking, and feeling” (Durkheim 1994 [1895]: 86), often taking an extended period of time. Healers take on a culturally-particular way of healing, molded by the structure of societal expectations of

what is efficacious, as well as those of the patients being treated. Each actor undertakes socially-designated roles and meaning is made and discovered through their interactions. The making of a particular type of healer therefore involves the taking on of various cultural and social facts – techniques, knowledge, and values – particular to the context in which they exist. For a person to become a healer, some process must instill him or her with the proper symbolic tools and conceptualizations of illness and disease – to substitute “one identity for another” (Womack 2009: 220) – for others to recognize and accept their ability. The healer must believe they can heal, but also prove they can heal to others. While keeping these broader shared ideas in mind, I now delve into the examples.

W. H. R. Rivers was one of the first physicians to become an anthropologist and engage in ethnographic work (Good, et al. 2010). His chief contribution comes in the form of his seminal study, titled *Medicine, Magic and Religion* (1924) written following his work among Polynesian and Melanesian societies. Rivers proposed an idea, startling for the time, that has become crucial to ethnomedicine and cross-cultural studies of health and illness – namely, that indigenous medicine practices represents medical systems, and that medical systems are social institutions that can be studied as any social institution can be (Foster and Anderson 1978). His discussion of medicine in Melanesia reflects this notion – demonstrating how “superstition” and “rational” explanations cannot be clearly distinguished between (Rivers 1924; Good, et al. 2010).

Important to this discussion of the making of healers, medical services and medical providers are highly specialized in Rivers’ description of Melanesian healthcare. One healer might treat rheumatism, another fever, a third for epilepsy, and a fourth

insanity, although in each case the cure is intimately associated with religious beliefs and roles (Rivers 1924). The making of healers then, in Rivers' examples, is markedly specialized and bears religious connotations. The making of healers in Melanesian and Polynesian societies is tied into the making of ritual specialists, steeped in particular systems of religious and magical beliefs and practices.

Of importance, these practices require more-specialized healers to treat successfully. Rivers details how those who possess such skill usually acquired their healing art by initiation or instruction. In Melanesia, such knowledge has to be purchased. The instruction comes at a cost, and is not considered complete until money has passed from apprentice to master (ibid). Interestingly, the knowledge often includes the ability to both cause and cure disease, particularly for those conditions attributable to human agency. In reading this account, I am struck by something of a parallel where students often incur considerable debt before graduating from American medical schools and seeking employment in the form of residency training.

E. E. Evans-Pritchard makes a similar argument in the introduction to his seminal work, *Witchcraft, Oracles and Magic among the Azande* (1937). His work includes extensive explorations not only of the causation of misfortune and illness, but also the role of healers (referred to as "witch-doctors") and the place of witchcraft as medical system in broader Azande social organization. Witchcraft serves to explain how and why someone becomes sick, carrying equal explanatory weight within each cultural context (Good, et al 2010). In his detailed account of the training of a novice in the art of the witch-doctor, Evans-Pritchard describes the processes by which an apprentice healer acquires the skills necessary to practice the art of healing; acquiring the

necessary techniques, knowledge, and values to practice and be recognized as an efficacious healer.

In brief, the process involves a person expressing their desire to become a witch-doctor to a senior member of the profession and asking this senior member to act as a sponsor. From acceptance, the apprentice spends time with the sponsor and other practitioners, partaking in communal meals involving both food and medical plants. In River's example, magic and healing skills like the use of leeches and diagnosis through divination must be purchased: "the really significant part of initiation is the slow transference of knowledge about plants from teacher to pupil in exchange for a long string of fees" (1937: 213). In fact, it is believed that medicine must be paid for or risk the loss of potency. When the apprentice has mastered adequate healing skills, as recognized by his teacher and sponsor, the final section of his initiation as a full witch-doctor can begin. This social transformation involves a "ritual burial" (ibid: 242). This ceremony "imprints" the apprentice with his new social signifier. He is now a witch-doctor and takes a new name, which is used professionally when engaged in magical and healing practices (ibid: 250).

Further, Evans-Pritchard argues that historical context is critical to understanding the social structure of the present. He pushes for the prominence of social history to our understanding of anthropology, that "to leave out the historical dimension is to deprive ourselves of knowledge that is... necessary for an understanding of political organizations" (Evans-Pritchard 1971: 267). This focus on historical context informs our understanding of medical systems, to which Evans-Pritchard gave considerable focus, as well as opening the door to cross-cultural studies of social structures among a wide

range of societies (Moore 2000). Likewise, the social history of family medicine will inform my analysis and findings in this study.

Evans-Pritchard's work is important to the present study by providing a detailed description of making healers among the Azande and the context in which these practices occur. His work motivates me to adequately explore the history and context of family medicine as it influences the making of healers. Much of what Evans-Pritchard describes as healing among the Azande would not work in other contexts; likewise, I must consider if family medicine's approach is particularly useful for family medicine and may not be as applicable for other biomedical specialties. Further, I note interesting parallels between Rivers, Evans-Pritchard, and Western medical education in the expectation of monetary exchanges in medical training. Though residency is a reversal of this arrangement – in that the training program includes a living wage for the resident – I see that I must attend to the role of both monetary and other exchanges that go on during the process of making healers.

Finally, in "The Sorcerer and His Magic", Levi-Strauss (1963) recalls the autobiography of Quesalid, a member the Kwakiutl tribe of Native Americans. This foundational piece in medical anthropology explores the role of belief in healing and harm – what today might be called the "placebo effect". The essay is also a significant work in the making of healers. This story is perhaps the clearest indication that "becoming a healer" involves more than just learning new skills or acquiring new knowledge, but involves the acquiring of values and cultural notions of the role. Quesalid is doubtful of the efficacy of sorcery in healing sickness. He believes that magic healing among his people is fraudulent and manipulative, using sleight-of-hand to

convince patients that an efficacious healing is taking place. Healers employ simulated fainting and spies to gather information about patients such that the healer appears to know things he could not otherwise know. Quesalid takes it upon himself to attempt to become a sorcerer, but with explicit goal of debunking the practices; to refute the local realities and explanatory models of illness and healing.

Levi-Strauss's approach in recalling Quesalid's tale is molded by his own theoretical stance. He aims to break down the cultural and social phenomenon he is observing into its component parts, to understand each step and stage of the story in turn and as it relates to the other parts. In keeping with his structuralist approach, Levi-Strauss outlines how three central components help to build and reinforce the reality of illness causation models and healing in this context: the shaman, the sick person, and the public, or broader social group in which the former two are situated (ibid). Becoming a healer, in this case, involves learning not only the skills, but also the place of the shaman and the beliefs of the community. The shaman acts and manipulates appropriate symbols in accordance with cultural beliefs of those he is trying to heal. The sick person, through being an enculturated member of the Kwakiutl accepts and thinks with these particular symbols. In the symbolic context of their interactions, the shaman and the sick person both play their socially-constituted roles, each recognizing the efficacy and culturally-appropriate action of the others.

It is through some early successes in healing, the accumulation of experiences, and successfully meeting challenges from other practitioners that Quesalid eventually gains a personal stake in the healing practices he is learning. In fact, Quesalid's first patient was someone who dreamed of Quesalid and the healing of which he was

capable. After this dream, the family sought out Quesalid directly. Though inexperienced, Quesalid tries his best to help and has overwhelming success. As with Mauss' "prestigious imitation" (1973), wherein a learner behaves as if he or she already possesses the skills being taught, Quesalid acts as if he has the qualifications of the healer, until he, in fact, acquires them through imitation of his teacher. The unintended consequence is that Quesalid, rather than debunking the practices, becomes a believer in the efficacy of his tribe's sorcery. He acquires not only the proper knowledge and skills to practice his society's healing arts, but becomes symbolically recognized by the community as a healer, and eventually comes to internalize and believe it himself.

Levi-Strauss' work is important to the present study by demonstrating how healers are made not only through the accumulation of knowledge and techniques, but also through the taking-on of the values and beliefs – the culture – of the role within its context. Further, the social structures that allow for belief in these practices are as powerful among the Kwakiutl (they made a believer out of Quesalid) as they are among practitioners (and patients) in a biomedical context. In other words, Quesalid "fakes it" until he accidentally "makes it". The residents in family medicine may engage in a similar process, though one would presume their intention is not to debunk. The framing of Quesalid's story within their broader context of Kwakiutl society, and the power of the healing practices he learns, suggests again that the social history, structures, and particular cultural context are supportive and influential on the making of healers. Similarly, I will try to shed light on the underlying values and ideas of a particular type of healer, engaged in particular healing practices. I will study this topic within the particular

cultural context of family medicine, in order to understand the role and place of cultural values and underlying beliefs in the training of residents in family medicine.

In summary, I argue that the apprentice, be it in Azande society or an American biomedical setting, goes through a process of learning, joining, and professionalization in order to become – and come to be recognized as – a healer. They have an object of medical attention to understand and acquire. Each must graduate and become socially signified in their new role as healer. They exist within a present day setting that is constructed and informed by history. The making of healers is a process suspended in a complex web of meaning and events, both past and present. The process of making healers, while variable, shares a number of common elements. Key areas in studying the making of healers cross-culturally include the following: one, becoming a healer is a process wherein the initiate undergoes a prescribed process of socialization and two, the sociocultural context in which healing occurs shapes the act itself and the people involved – healer, patient, and community. The “making of healers” – regardless of context – is processual. It involves social actors engaged in the training process – as both master and student – with the result of making healers.

The specific steps of this process are important to consider in order to operationalize how the making of healers happens in practice. In *The Anthropology of Health and Healing*, Womack (2009) identifies and operationalizes a series of common elements of making healers cross-culturally. In other words, she explores the processual steps involved in becoming, the internalization and demonstration of certain “ways of acting, thinking, and feeling” (Durkheim 1994 [1895]:86). She specifically discusses what key steps must occur in the training of healers. To give an example,

Womack (2009) outlines five broad, cross-cultural stages through which an initiate becomes a shaman. These elements all appear but take varied forms in different contexts. First, shamans are often recognized as possessing an innate healing ability. Second, shamans often receive a “call from the spirits” – often a dream, “psychotic episode” or a personal illness that resists ordinary treatment. Third, they are recognized and diagnosed as a potential shaman by another shaman, someone who has already undergone the initiation. Fourth, the shaman-to-be undertakes an apprenticeship to a shaman. This is often a lengthy process, sometimes as long as twelve to fifteen years. Finally, the initiate “becomes a shaman”, having acquired the skills that allow him or her to heal others. There are parallels wherein both the shaman and the physician substitute “one identity for another” (ibid: 220), both are taken on as apprentices, and both must be recognized as a healer by the teachers, after a long process of education and initiation.

Each person falls into socially-designated roles through enculturation to their societal expectations of healers (in the case of patients) and the training that leads to becoming a healer (in the case of physicians). For a person to become a healer, some process must be used to instill in him or her proper symbolic tools and conceptualizations of illness and disease for others to recognize and accept their ability. The healer must prove they can heal. These skills must be demonstrated to the satisfaction of others in the community. As E. E. Evans-Pritchard wrote of the Azande, the magic “must prove efficacious” – the healing must work before the initiate can finally become the shaman.

This process of “becoming” involves more than just acquiring skills. To continue with an earlier example, despite Quesalid’s initial disbelief of the healing tradition, he comes to accept that of the healing practices of the Kwakiutl are valid and he becomes a shaman within his culture. Quesalid acquires not only the techniques and knowledge of the shaman, but learns to think and see the world of disease and illness according to the framework of the Kwakiutl. Quesalid is shaped by the context in which he learns his healing practices. He attempted to debunk the beliefs and sociocultural values he was exposed to, yet came to accept and internalize them. I will use Womack’s common elements in the socially-recognized process of making healers – as informed by the seminal works of Rivers, Evans-Pritchard, and Levi-Strauss – in analyzing what I ethnographically document in the residency training program. First, however, I must consider how these ideas relate to the literature on making healers for biomedicine.

Healing in biomedicine

In this section, I further contextualize the above discussions for biomedicine in analyzing healing and the role of healers in American society. Through this discussion, we will see that American biomedicine, is also an ethnomedical system, with particular cultural values and ideas about disease etiology, illness experiences, and treatment efficacy. Importantly, it is not a single monolith, but structured by virtue of particular contexts (Vaughn 1994).

Prior to the 1980s, the literature in medical anthropology often distinguished between Western and non-Western contexts of healing and put forward the idea that the differences between such contexts made cross-cultural comparison difficult (Foster 1976). Since then, medical anthropologists have increasingly studied Western medical

systems as also culturally-constituted and molded by social contexts (Emmerich 2013; Haffler, et al. 2011; Jaye, et al. 2006; Kleinman 1997; DelVecchio-Good 1985; Gaines and Hahn 1985; Maretzki 1985). In the earlier cross-cultural literature, emphasis was placed on how the healer essentially names and orders the illness, helps the patient find meaning in the experience, and treats the person, family, and social problems that constitute the illness. Healing in the context of biomedicine was sometimes defined as having a different structure and goals (Jaye, et al. 2006; Kleinman 1997; Gaines and Hahn 1985; Foster 1976).

The cultural meanings and values of the Western scientific tradition lean heavily on empiricism and science as its approach to identifying and addressing disease (Davis-Floyd and St. John 1998; Kleinman 1997, 1980; Hahn and Kleinman 1983; Kleinman, et al. 1978). Medical anthropologists clearly indicate how biomedicines are another form of ethnomedicine (Hahn and Kleinman 1983; Foster and Anderson 1978; van der Geest and Rienks 1998) which exists in a particular sociocultural context; simply one, like any other, with particular cultural features and behaviors that demarcate it from other traditions of health and healing. Robert Pool (1994), for example, argues that characterizations of African ethnomedical systems have too often focused on supernatural etiologies of disease and illness experiences, leaving out the possibility of the etiological systems of George Foster or the treatment of these systems of medical systems, as with Evans-Pritchard. He concludes that the label “medical system” is more widely applicable than Western researchers, with presuppositions of their own, are always willing to concede. This labeling suggests a breaking down of the artificial divide

between “ethnomedicine” as “other” and Western biomedical systems as somehow above; more logical and scientific.

On the other hand, Murray Last (2007) questions whether all healing traditions are truly “medical systems” – for example, biomedicine is generalized as being more “standardized”, with a recognized professional community of practitioners, constituting an institutional organization with a common body of theory used to diagnosis and treat illness (5). Others have pointed out the challenges of defining the parameters of a medical system (Press 1980; Foster 1976). Kleinman (1995, 1997) puts it another way – biomedicine is representative of an institutional and dominant professional social structure; one that treats disease in a way that is informed by a particular pervasive theory – in this case, “scientific” logic of disease causation and treatment. Further, the notion of only one biomedicine is problematic. With dozens of specialties and a multitude of contexts, biomedical systems are varied, even under the label of “Western” (Vaughan 1994).

It has been argued that a general theory of biomedical causation and treatment models, by virtue of their individual focus, tend not to incorporate the experiences of individuals and the role of the broader community in the same way as other healing traditions (Kleinman 1995, 1980; Kleinman, et al. 1977; Janzen 1978). George Foster (1976), immediately after outlining his model of disease causation cross-culturally admits that his model may not neatly categorize all healing traditions. He states that Western biomedicine is a particularly murky case that while at least ostensibly “naturalistic” involves a good deal of the “personalistic”. When compared to some other healing traditions cross-culturally, biomedical practices tend not to focus as explicitly on

the social contexts of patients' lived illness experiences. The general assumption in biomedical contexts is that, while social and psychological factors may contribute to disease, the biological body itself has somehow malfunctioned and is the primary locus for disease and therefore treatment; a material disease-driven focus (Kleinman 1997). The emphasis however is on individual actions and the patient's individual body as the locus of disease and illness experiences.

Megan Vaughan (1994) adds to this line of argument, showing through her synthesis of the social history of medical anthropology in various African contexts, that "healing" itself can become a problematic term. She argues that comparisons between African healing practices and scientific medicine can be misleading. She demonstrates how African healing systems are not homogenous, and argues by extension that Western biomedicine is not homogenous either. Consequently, she concludes that the context of healing is important in the character and features of healing practices.

Anthropologists Anwaar Mohyuddin and Mamonah Ambreen (2014) explore the shift from the use of traditional to allopathic medicine in a rural village in Pakistan. During the last three decades, economic developments in the region have led to increased awareness of and access to Western medical treatments and physicians. These changes have resulted in a shift in health related beliefs and practices among local residents. The dominant healing modality in this setting has been faith healing, Islamic rituals that form a particular way of looking at the world in which God can intervene in the health and wellness of the patient. Many medically-recognized ailments, such as heart disease, kidney problems, asthma and cancer, are conceptualized differently, as calling for personal faith in God to heal. Faith healers are consulted to

resolve social, medial, employment, and economic problems – the issues tied together and resulting in disease and illness. The healers provide guidance and encourage closeness to God as an avenue to resolve these issues.

Further, given the recent social and economic changes, a dual healthcare system has emerged, wherein villagers also consult allopathic physicians for treatment in conjunction with their faith healers. They utilize these modalities in a step-wise fashion, beginning with self-medication, then consulting Western-style doctors, then the faith healer, and then both faith healer and physician together. The medical system is seen as more of an economic transaction, as doctors are seen treating patients as clients, demanding money for treatment. Faith healers, by contrast, are seen as part of the community, and a system of reciprocity exists that supports both the healer and the community members. Further, patients have begun to experience permanent clientage to their doctors as treatments are often ongoing and leave side effects that require additional treatment.

When encountered together, the contrast between faith healers and physicians become stark. The technical approach to diagnosing and treating physical ailments, with attendant medications and side effects, while becoming a first resort, seems to leave the villagers wanting more. The faith healers engage with a broader array of the social organization of the setting – to include religion and spirituality, social and economic problems – situating themselves in a holistic way. This description leads me to think about how these ideas may be comparable to the ideals also expressed in family medicine. Further, the bias of Western-style allopathic healers is clear: as a product of

recent industrialization, these transactions are economic and focused on client-patron interactions, lacking the broader social and personal contexts of healing.

Another example of intriguing ways that dual healing systems are negotiated by patients is shown in the following example. Pharmacist John Rovers (2014) explores the case of a Malian healer he encountered on a medical mission. Again, we encounter differing medical systems and find intriguing ways in which these dual systems are negotiated by patients. I have summarized the case study here for brevity in order to focus on the relevance of this paper to the present study. Rovers interviewed this healer and through their lengthy discussion, a number of findings emerged. Specifically, the healer's understanding of the causes of health and disease is similar to the author's own conceptualization. For example, malaria is mutually understood as originating from a mosquito bite. However, differences in what the author considers symptoms are attributed to entirely separate diseases, related to malaria, by the healer. Further, beyond malaria, the author found many diseases attributed to supernatural forces rather than physical ones. The therapies chosen to treat disease, including malaria, included herbs and plants broadly similar to Western pharmaceuticals.

The relevance to the present study is in the conceptualization of disease and illness, as well as diagnosis and treatment, in a setting wherein Western and "traditional" medicine exist side-by-side. Rovers (2014) calls for awareness on the part of healthcare professionals visiting regions where non-Western medicine may be practiced; to observe, seek to understand, and negotiate the similarities and differences between parallel medical systems. I find it interesting that Rover did not discuss efficacy of these treatments. Regardless, patients in Western contexts may possess different

ideas of what healing is and what healers should do for them, be they biomedical or non-Western professionals. It will be intriguing to gauge whether differing conceptualizations of what a doctor “ought to” do for a patient impacts education of residents in family medicine.

The debate over the term “healing” leads to an important point made by Kleinman (1980) in discussing cross-cultural healing processes. Kleinman poses the same question I have wrestled with: what is healing? Kleinman argues that healing depends on social and cultural contexts. Healing traditions cross-culturally embody social actions in the production and distribution of knowledge and meaning-making in the pursuit of diagnosing and treating illness and disease (Hahn & Kleinman 1983). The same holds true for Western biomedicine. Healing appears and is experienced differently by patient, provider, and community; differs by socially-structured roles and culturally-constituted specifics of contextual experience. Healing, Kleinman writes, “is not so much a result of the healer’s efforts as a condition of experiencing a fit between socially legitimated forms of illness and care within the cultural context of the health care system” (ibid: 360). Kleinman postulates a “cultural construction of clinical reality” – that despite disease treatments, there are social and meaningful elements of illness experience that must be addressed in order for healing to occur.

Kleinman (1980) warns however, that biomedical practitioners may actually be incapable of healing – as he defines healing, it is not a routine part of the biomedical tradition as observed in other non-Western contexts. The modern professional physician is trained to focus “exclusive interest to the recognition and treatment of disease. He is taught to *cure*, not to *care*” (ibid: 363). Despite biomedicine’s possibilities for curing

disease and its strong focus on the biological, Kleinman (1980) asserts, biomedicine does not explicitly focus on the illness experience, the relationships with their patients, or between patients and their social contexts. When thinking about these ideas early on, Kleinman appears to agree with the ideas of Janzen (1978) who commented, “Western medicine focuses on the individual patient and leaves the social context of his illness in pathological chaos” (9). The critiques of these authors suggest that biomedicine’s focus on a disease-centric model of sickness tends to ignore the illness experiences of patients.

Further, according to early work by Kleinman, the professional Western physician measures and sees this disease-driven approach not as a form of failure, but healing as it ought to be (Kleinman, et al. 1978). This dual explanation of the differences between Western and non-Western healing traditions perhaps does not hold as much weight today as it did thirty years ago. In later writing, Kleinman (1995) expands his definition of healing to include Western biomedicine. While still suggesting biomedicine places a powerful emphasis on direct physical causal chains linking disease etiology and disease treatment, he does now suggest that biomedicine is a healing system, though a particular type, heavily focused on individual disease experience. He seems not to soften his position beyond this inclusion of Western biomedicine into a broader scheme of healing. His conclusion is that individual disease experience is the primary focus of a biomedical approach, but the moral, symbolic actions of other healing systems are absent. Kleinman (ibid) asserts: “the very idea of a moral purpose to the illness experience is a biomedical impossibility. That serious illness involves a quest for ultimate meaning is disavowed” (32).

This shift from “healing is not possible in biomedicine” to “biomedicine is a particular sort of healing system” is telling and useful for my own work in numerous ways. First, on the surface, this inclusiveness lends further weight to the argument that Western biomedicine is an ethnomedical system and can be approached as such, complete with particular cultural ideas about the roles of healers, patients, and medical practices. Second, I will assess the accuracy of his critique of biomedicine as it applies to family medicine residency training.

In exploring further how to identify healers in biomedicine, I turn next to the work of Davis-Floyd and St. John (1998). The authors suggest physicians have the capacity to transition from biomedical practitioners towards more cross-culturally recognizable “healers” over the course of their careers, characterizing the ongoing development and education of some physicians as a “transformative journey”. The title of their book is telling, “From Doctor to Healer”; the authors argue that the technocratic model of medicine, one taught in most medical schools and residency programs, inherently separates the practitioner from the patient, negating the social, interpersonal definition of healing; that a doctor is not necessarily a de facto healer.

The authors identify and outline three broad paradigms in American medicine’s approach – the technocratic, the humanistic, and the holistic. The former two are most useful for the present study and I will focus on these. The technocratic model focuses on “the body as a machine” (ibid: 21), a sense that “death is defeat” (42), using a process that diagnoses and treats patients from a position of authority, imparting knowledge to conquer disease (33). Parallels are clear with the critiques outlined above

regarding Western biomedicine in general. This paradigm is in keeping with a disease-focused, biologically-driven approach to sickness and treating disease.

The authors' ethnographic accounts follow numerous physicians who, after practicing autonomously for years, have begun to question some of the teachings and values into which they were professionalized. According to these authors, these physicians begin to segue into a new paradigm. This new paradigm is a humanistic model of medicine wherein the patient is in a relationship with the physician; there is a balance struck with the needs of the patient and the needs of physician. Death, for example, becomes an "acceptable outcome" (105) that can be gone through with the patient and their family, not a source of defeat. They document an openness to patient's illness experiences and other modalities of health and wellness, and willingness to discuss these with patients who bring them to the table. The central feature is shared decision-making and responsibility between the patient and provider (ibid). Davis-Floyd and St. John discuss a process by which doctors become dissatisfied with the technocratic and begin exploring other options. Interestingly enough, this transition to a new definition of "healer" mirrors a great deal of the cross-cultural descriptions of healers I have outlined above: attention to illness experiences and a sense of the broader socio-cultural contexts patients must navigate. Further, as I will discuss below, it mirrors family medicine's espoused views on patient care.

Other recent literature by physicians has further explored the healing concept in biomedicine. Oncologist Rebecca Johnson (2014) defines healing as set of behaviors that extend beyond the direct treatment of disease and disease symptoms. Johnson discusses the role of mental health screenings and particular therapeutic behaviors to

help prevent suicide in young adults with advanced cancer. The “healer” moniker is tied directly to these behaviors, including taking “time to listen”, remaining “open minded”, presenting information in an understandable way, discuss coping and quality of life with, and offering hope to patients. In her study, patients who identified their oncologists as displaying these behaviors often experienced positive mental health benefits, regardless of the status of their cancer and accompanying treatments.

The takeaway here, as relates to the present study, is a tacit division between “treatment” and “healing”, still seen in the medical literature. Johnson argues that medical behaviors like diagnosis and treatment are most often referred to as treatment – the chief behaviors of a doctor are to diagnosis and treat disease. “Healing” often entails something more, and yet something less definable and perhaps less “real” than these technical acts. I take from Johnson’s work the notion that healing entails behaviors that are social and interpersonal. In biomedicine, these behaviors often lend themselves to the arenas of “mental health” and perhaps fall outside the realm of “real” medicine – an issue I will continue to explore.

Another way that the literature in medicine has approaches healing is through self-reflective, autobiographical pieces wherein physicians themselves become the patient. In one particular case, Dr. Mario Melazzini (2014) struggles with finding meaning after being diagnosed with amyotrophic lateral sclerosis (ALS), a chronic, progressive disease that left him unable to work. Through his experiences, he found a new and deeper view of healing. Through his experiences, he delineates a three-pronged approach to healing: symptom management, allegiance with the patient, and a

mutual search for meaning. His experiences with his physicians led to the notion that healing is always possible even when a disease is incurable.

Healing refers to “the personal experience of the disease and occurs when the patient discovers and accepts the meaning of his/her suffering” (ibid: 152). This healing process, especially when death is a looming outcome, requires a close relationship between the physician and the patient until the very end: “The commitment to preserve the relation to the patient is the commitment to facilitate healing, which is to find the meaning of suffering and death” (ibid). I find it interesting to use this work to consider how finding mutual understanding and personal meaning in suffering is particularly acute when treatment options are limited or entirely absent. That a new notion of healing helps shift perspective on the illness experience, that “being” is more important than “acting” (ibid). He emphasizes that both patients and healthcare professionals need healing, and that physicians do themselves a disservice by not following terminal patients until the end of their lives; the process provides meaning and highlights the “unique value in the life journey” (ibid). Again, I am left with a vague sense of healing and the role of healers in terminal patients. In particular, I find it telling that once again, there is an assumption that healing emerges only when curing fails – that the technical, medical science of disease treatment takes priority and defines healing practices as ‘something else,’ a resort to turn to when science is not enough.

From the discussion above, one can see that healing has been characterized in a number of different ways in biomedicine over time. Physicians within in biomedicine have begun to recognize the role of patient’s contextual experiences and communication in the healing process (Hadjistavropoulos, et al. 2011; Street, et al.

2009; Ong, et al. 1995). Healing practices and how healing systems are defined in Western biomedicine both remain contested.

Making healers in biomedicine

Having traced the making of healers cross-culturally above, I postulate that the process of making of healing physicians may share numerous parallels. Some include being called to the profession through medical school or other earlier life experiences, being recognized as a potential healer through the residency hiring process, gaining and proving culturally-appropriate skills to treat disease. It is important to note who these residents are upon entering post-graduate training – they are doctors, albeit unlicensed doctors, who have often acquired a great deal of knowledge and practical training, but who now must transition into positions of autonomy in their journey towards licensure. Residents are neither fully-licensed physicians, nor are they new to medicine; they are truly in a liminal space – educated in medicine, yet in need of and ready for additional training to become professionally and socially recognized as healers.

Educating residents is a process in which newly-hired physicians transition towards ever-more intense expectations of autonomy and increased “assumption of responsibility” (Konner 1987: xiii). While the explicit-stated end goal and way of demonstrating competency is board-certification, a more implicit but equally important goal is that doctors and healers must both be made. In other words, it is often more formally acknowledged that particular milestones like graduation and board-certification will prepare and socially-recognize a resident towards becoming an autonomous physician. The formal milestones however only capture part of the picture in regards to the values and efficacy of the particular medical system, of Western biomedicine.

Less is known about the informal, day-to-day practices that mark individual residents as progressing towards a healer role in American biomedicine but some work has been done in this area. Before exploring the smaller literature on residency education in biomedicine, it should be noted that the work of medical anthropologists and others focused on the making of different types of healers in the Western biomedical tradition is considerable. For some relevant examples, see Cassell 1991; Csordas and Kleinman 1996; Davis-Floyd and St. John 1998; DeVecchio-Good 1995; Good 1994; Kleinman 1980; Konner 1987; Luhrmann 2000; Mattingly 1998a, 1998b; Messenger 2003; Sinclair 1997. In anthropology, the early education of medical students has been better-covered, much less often has focus been placed on specialty residency training. Notable exceptions include Luhrmann's work (2000) on psychiatric residents and DeVecchio-Good's work (1995) on obstetrics. However, both of these studies focus on how their respective specialties engage in the delivery of healthcare to their patients; less emphasis is placed on how these physicians *learn* to become healers.

In T. M. Luhrmann's (2000) work on psychiatric residents, she argues that medicine teaches its students "by having them act as if they are competent doctors from their first days on the job" (ibid: 26). From the moment they begin residency, biomedicine is the lens through which the healers-to-be are expected to see the world into which they are entering. As a result, the biomedical approach becomes "a way to cling to one's doctorly identity" (ibid: 99). Luhrmann spent years in the presence of psychiatric residents and the faculty physicians, shadowing and observing their activities, watching as they learned to treat psychiatric illness, and worked to make

sense of the process by which psychiatry formulates its “object of inquiry” and makes sense of their particular type of healing. I will largely mirror this approach in the present study. Lurhmann’s work on psychiatric residency powerfully suggested to me the importance of seeing the context of medicine being delivered in a particular specialty – that not all biomedicines will be the same.

Luhrmann shows how psychiatric residents are focused on a particular suite of diseases, a particular battery of techniques and treatments, concerned with the health of the brain and workings of the mind. Yet at the same time, they learn techniques and knowledge that connects biomedical practitioners more generally: how to communicate with patients, medical knowledge, the rigorous nature of residency work, and the hierarchy of learning as apprentices from masters. I will also be mindful of how family medicine is particular in and of itself, yet situated within a broader context of Western biomedicine.

In a similar vein, Messinger (2003, 2007) compares the struggles of residents and anthropologists in the process of “becoming”. Like Luhrmann earlier, Messinger explicitly focused on psychiatric residents. Messinger finds that psychiatric residents come to focus on their own experiences and the difficulties of working with patients and hospital system at large. Further, how psychiatric residents learn to see their patients closes off other ways of seeing. In becoming, if the process is harsh or less-than-ideal, the type of healer ones becomes at the end of training may be impacted in the now and later on as well. Similarly, exploring the impact of less-than-ideal learning conditions – be they negative treatment in the residency or stresses from outside the work place – on the socialization and professionalization of family medicine residents – into a

specialty that prides itself on close patient-physician relationships – could be enlightening.

As in Luhrmann’s work, Messinger also illustrates how anthropological insights into residency training are important and illuminating. They both contend that, anthropology allows for depth of understanding of particular educational processes, a comparison between the stated goals of residency education and the actual experiences of those participating in the educational context. Likewise, I chose to explore the differences between what is stated in the formal curriculum and the informal learning that occurred within my fieldsite.

DelVecchio-Good (1995) highlights some additional overarching aspects about residency training relevant to the present study. Her work with obstetrics sheds light on the acquisition of competence and the meaning competence takes on as a central symbol of the culture of American medicine. DelVecchio-Good outlines physicians’ understanding of competency as gained through residency, mostly related in narratives of individual physicians’ past experiences (ibid). Residency serves as a foundational experience for the acquisition of and meaning-making around competency, which serves to shape the role of a particular type of healer – in this case, obstetricians. This study however lends weight to the broader notion that residency is pivotal; a formative phase in physician training, where the healer-to-be comes into his or her role.

DelVecchio-Good sheds light on the particularities of obstetrics training. She focuses on the ways in which residents in obstetrics come to acquire and negotiate ideas of competency. Given the perceived higher-risk nature of obstetrics, residents appeared at times to engage in risk management. The residents actively avoided

certain patients or complex issues that may challenge their appearance of competency. When faced with a patient or set of circumstances that challenged their mastery of the techniques or knowledge of their specialty, some residents referred patients out to other specialists or found ways for other residents to take on their patient, such that the challenge could be avoided. I saw the need to be mindful of how family medicine residents grapple with issues of risk management and competence as well in my study.

DeVecchio-Good discusses ways in which obstetricians in her study found themselves on the defensive in their working relationships with other physicians. Intriguing enough, in one story, she recalls a family medicine practitioner who was in conflict with the obstetricians, because she would take on high risk deliveries. This family medicine practitioner was called into a dispute resolution meeting with some of the obstetricians. She was accused of challenging the boundaries of both specialties (ibid), despite the idea that family medicine physicians are trained to deliver babies. The obstetricians questioned the family physician's competency and sense of risk-management, common themes throughout DeVecchio-Good's work. In the end, the family medicine practitioner received fewer patient referrals for deliveries. The obstetricians had successfully cast doubt on the family medicine practitioner's competency and decision-making processes. Though family medicine was not her focus, DeVecchio-Good's anecdote made me again question the way family medicine sees itself, and others see the competency of these practitioners as well. DeVecchio Good's work helps guide me in investigating how competency is socially constructed, measured and assessed in my fieldsite.

A third study, Simon Sinclair's *Making Doctors* (1997), stands out for its particular use of practice theory and habitus in the training of medical students in a London teaching hospital in the early 1990s. As I will similarly do in Chapter 2, Sinclair describes the basic tenets of practice theory – habitus is culturally-constructed, acquired, and yet embodied in individual people. He takes up Bourdieu's concept of "dispositions" which organize thought and action – the habitus embodied, in a sense – and sets out to identify and describe the dispositions of those within his fieldsite. In particular, he points to the dispositions emerging from "experience" and "responsibility" as particularly telling in the professional education of physicians. He lends weight to the idea of "prestigious imitation" (Mauss 1973), spending time on dispositions of idealism, status, and knowledge as crucial to the medical training process. Sinclair's work has been useful in seeing habitus and practice theory applied to medical education in a British biomedical context. His theoretical approach and methods helped me to think more carefully about how to apply practice theory in my own study. In particular, he is careful to identify and describe the dispositions at work within the setting. He also makes a careful distinction between the basic medical knowledge and techniques that students learn and the more advanced skills they acquire over time. I outline my own use of practice theory further in Chapter 2.

As with any ethnomedical system, American biomedicine constructs "objects" to be studied and understood. Most relevant to the present study is that this process is learned – medical students through training and education come to acquire the necessary techniques and knowledge to understand health, illness, and even the human body in a particular way; one that supports and is supported by biomedicine's

underlying ideas about disease, illness, curing and healing. This process continues into the last years of medical school and come to fruition in residency by applying this gaze to real patients as physicians directly responsible for patient care, as opposed to the supervisory or classroom experiences of medical students. The present study assumes that the processes of seeing, speaking, and writing as physicians have already been begun in medical school, and focuses instead on the making of family medicine doctors and the activities of and meaning made around becoming a particular type of healer in the residency phase.

In *Becoming a Doctor* (1987) Konner, already a trained anthropologist, enters medical school. This ethnography is a rich description of the author's experiences of coming to think and act as a physician, while maintaining the perspective of the research anthropologist. Perhaps most relevant to the present study is this: Konner's experience reinforces the notion that biomedicine produces a particular sort of practitioner, with particular values and techniques, which can be documented and understood as culturally-constructed and contextual. For me, Konner provides valuable insight given my own experiences working in medical education for a number of years prior to beginning on this ethnographic study. Konner reminds us that physicians think and act in a particularly cultural way. Yet so do anthropologists (ibid). Lengthy exposure to a particular cultural setting leads to familiarity. Keeping this idea in mind, and maintaining a dialogue with other anthropologists, helped Konner clarify his thinking and avoid taking too much for granted as he became an "insider" in medicine. This perspective helped my own work, reminding me that I, like the residents, come to the

fieldsite with my own history and preconceived ideas about American society, biomedicine and medical education in this cultural context.

In sum, with Luhrmann, DelVecchio-Good, and Sinclair’s work in mind, as well as the work of recent physicians and others within biomedicine, the present study will contribute to the broader anthropological conversation around the process of “becoming” for healers in biomedicine. It will explore the processes around the making of healers, and the application of practice theory in understanding the socialization and professionalization of family medicine physicians. This study strives to contribute to the literature on the making of healers – both in anthropology and medical education – by deepening understanding of the processes that contribute to the novice coming to act as the specialist. Cultural reproduction is the foundation of the continuity of the social structures of medicine – and learning how these processes do or do not achieve that reproduction is an important part of understanding how these broader structures operate in medicine and society.

History of residency education

Historian and professor of medicine, Kenneth M. Ludmerer, explores the process of becoming physicians through a series of important books. These texts represent a particularly thorough, extended accounting of the history of residency education; a critical summary for the historical roots of the structure of my fieldsite. As such, I rely heavily upon his work. Beginning in *Learning to Heal* (1985) and continuing in *Time to Heal* (1999), Ludmerer explores the complex history of the modern medical school and teaching hospital in America. Most important to the present study is his third book, *Let Me Heal* (2015), in which Ludmerer focuses on American residency education, its

history and current impact on the health of the nation. He conceptualizes residency education at the “dominate formative influence” on physicians, wherein doctors “come of professional age”, acquiring knowledge and skills, form professional identities, and develop habits and behaviors that “last a professional lifetime” (ibid: ix).

Ludmerer begins by describing American medical education prior to the advent of residency programs. Graduate medical education did not exist in America for the eighteenth and most of the nineteenth century (ibid; Starr 1982). During this period, would-be doctors sought out opportunities for practical clinical experience. The learner found and became associated with a practicing physician who taught the student directly until deemed ready to enter practice on his own. Ludmerer illustrates how this approach was problematic. Mentors often did not keep up-to-date with recent medical developments. Further, apprentices often had no peers with whom to interact and enrich their learning. By 1867, the American Medical Association declared, “Private pupilage... is worse than useless. It is, in fact, a waste of time and money” (ibid: 3).

The limitations of the apprenticeship system was a major factor in the development of more rigorous medical school programs and the establishment of formal graduate medical training programs. Formal systems of hospital training grew rapidly in the 1880s and 1890s (ibid; Starr 1982). Competition for these positions – referred to as “house officer” or “residency” positions – was fierce given how few were available. As a result, early residents had few rights, were not allowed to marry, and were literal full-time residents of the hospital, hence the title. Clinical disciplines were developed “along genuine academic lines” and strove for a residency experience that “would represent true graduate education rather than mere vocational training” (ibid: 17). It was here that

the three classes of “house officer” were first established: interns, assistant residents, and chief residents – later to become first-, second-, and third-year residents.

By the 1920s, residency programs had been established across the nation in an attempt to meet demands for improved physician education. American residency programs established central educational principles, tied to the notion that medical education should mirror educational systems more generally. The mastery of medical knowledge was made central, bringing specialties like surgery from its infancy to a technologically sophisticated and trusted approach to treating many diseases. Further, it was felt that the “modern doctor needed to be a thinker, not a parrot” (ibid: 24), such that training focused on the scientific method, the acquisition and assimilation of new information, skepticism and critically thinking. To achieve this, house officers were given chief responsibility for the care of their patients. They typically were the first to evaluate the patient on admission, spoke with the patient on rounds, made all decisions in their care, wrote orders and progress notes, and were the first called should a problem arise. This “assumption of responsibility” (Konner 1987: xiii) remains a major theme in resident education today.

The passage of Medicare and Medicaid in 1965 was the next major change that influenced residency programs, leading to a “tsunami of clinical income” that allowed hospitals to begin rapidly increase the salaries of interns and residents (ibid: 167). A further consequence of the Medicare and Medicaid implementation was the growing burden of paperwork. Faculty attendings in particular had to document their involvement in all hospital charts, with precise rules for billing and a system of signatures and counter-signatures. Daily patient progress notes became a requirement. Given these

added pressures, residency programs were going to have to change in order to maintain their level of educational quality.

With the increased revenue and demand, programs greatly increased the number of full-time faculty members, growing from approximately 3,500 in 1951 to over 17,000 by 1966 (Strickland 1972). Accordingly, residency programs increased the size of their house staffs, with many leading teaching programs appointing more residents than minimally necessary in order to protect the needed time and energy for residents to effectively learn and reflect on their experiences. Demands on learners shifted with the increased number of patients overall and a decreased average length of hospital stays. Medical educators began to worry that this rapid turnover would no longer leave sufficient time for residents to reflect on what they were learning. Despite the increased demands on physicians, the atmosphere of most teaching hospitals reinforced the welfare of patients as the central mission: “the profession at large did not often forget that they existed to serve, and most patients continued to believe that doctors and the medical system were on their side” (Ludmerer 2015: 183).

These changes also had an impact on the personal lives of the residents. With the growing number of house officers, hospitals could no longer accommodate them all. Reluctantly, the hospitals began providing living allowances to reside outside the hospital, beginning with chiefs, then senior residents, and ultimately even interns. Increasingly, given this freedom, many house officers began to marry and start families. Many things remained the same for residents, however. The focus on inpatient medicine, the “thrills” of a steep learning curve, and heavy work hours were ubiquitous features. The first day of internship, making the transition from student to doctor,

remained perhaps the single most important day of a physician's life. Learning by doing helped interns to master the basic skills necessary to move towards greater competency and increased confidence. By the end of residency, most were seen as well prepared to enter practice (ibid).

The most conspicuous feature of the daily lives of all house officers was the hard work: "evenings, weekends, and holidays provided the house officers little respite from their duties, for sickness did not take a vacation" (ibid: 195). Further, house officers were viewed, by themselves and their supervisors, as invulnerable to fatigue and needing little sleep. Good doctors simply had "the right stuff" to continue on (ibid). This way of thinking had important and dangerous implications; residents were often changed by these experiences, moving from compassion to frustration. It would be some time still until changes were made to address resident burnout.

Program growth was even more significant between 1965 and 1990, with faculty numbers increasing to over 74,000 (ibid: 215). This growth led to a decline in the close, tightly knit communities of educators and learners. A growing perception during this period was that medical education had become impersonal, faculty members did not know each other, and residents shared less camaraderie with their mentors. The early residency directors and program chairs were seen as "personal" and connected to residents, but these trends too gave way to increased demands on managing larger and larger programs. As a result, residents began to feel unimportant to their faculty and their departments. Residents often no longer felt supported by their faculty and chairs. House officers in the 1970s began organizing and demanding better working conditions

and wages. By 1974, calls echoed across the nation for unionized collective bargaining (Starr 1982).

The time demands and strain of the work of residency meant this period of self-advocacy was short lived. It did however lead to the recognition of “burn out” as a serious threat to resident and patient wellbeing. The publication of Samuel Shem’s satire *The House of God* in 1978 depicted the challenges of residency training and shed light on the problems facing residents. Further, medical care in these years had become more effective, yet more difficult to master and often more dangerous for patients. Cancer treatments, new antibiotics, and cardiovascular drugs had potent side effects, potentially causing harm even when used correctly. Residents felt abandoned when perhaps they most needed guidance, to understand the limits of medicine and the strength of the tools at their disposal (Walt 1993).

By the 1980s, advances in medical technology and treatments meant many procedures that had once required a hospital stay moved to outpatient services. The insurance system also placed demands on shortening hospital stays, given the high per diem cost. As hospitalizations grew shorter or less frequent overall, those that were hospitalized were sicker as a result, requiring more-significant medical interventions. Further, given the high turnover of patients, another feature came to the fore: no single activity takes more time for a resident than an admission (Ludmerer 2015: 246); meaning as more patients came for shorter stays, admission intakes became a significant burden on resident work. As a result, education of residents took a back seat (ibid: 248). Scholarly patient care – where time was left to question and explore ideas

about patient experiences, treatment options, and learning – was replaced with this emphasis on patient discharge and turnover.

It took attention from the public sector and complaints about the diminishing quality of care to change circumstances for residents. The public began to take notice of the long, arduous hours worked by residents, though this was not framed as concern for resident wellbeing. Rather it was a growing worry that house officers might endanger patients. It took until the end of the 20th century to start making significant inroads. In 2003, the Accreditation Council for Graduate Medical Education (ACGME) enacted its first regulations strictly limiting the number of hours a resident is allowed to spend on duty. The stresses and concerns of working in medicine had been known within the profession since the Flexner Report (1910), but it took external forces – the voices of consumer advocates – to enact change (Beck 2004).

This public concern for work hours did not translate to concerns about educational quality of the residents. The concentration of work into fewer hours led to challenging choices in how that time was spent. The tension between commitment to patient-centered scholastic medicine and the rapid turnover of patients remained, and was intensified when work hours were limited. Ironically, residents were also now routinely violating those work hour restrictions, staying after their shift had ended to finish other tasks. In Charles Bosk's (2003) study, *Forgive and Remember*, residents often lied about their extra hours. Residents were in a difficult position, between obeying the rules or caring for the patients in the way they felt necessary. These residents were in an untenable situation, protesting a system designed to protect their patients by

staying longer to help those same patients. In essence, they were resisting “a system that did not let them heal” (Ludmerer 2015: 299).

A final major change to residency education came about in the 2000’s. A new “outcomes-based” model was introduced that emphasized the “functional capabilities of the end product” rather than the time spent in training (ibid: 305). This model focused on designing and meeting specific learning objectives, with the assumption that attainment of these objectives produced highly-desirable trained physicians (Beck 2004). In 2009, the ACGME expanded this model to include “milestones” of competency development, defined as “observable developmental steps that describe progression from a beginning to learner to the expected level of proficiency” (ACGME 2011). This model had a number of outcomes: “outstanding teachers” were needed for “transmitting the spirit and values, not just the content, of medicine” (Ludmerer 2015: 306) as these milestones often included less-tangible elements like professionalism and empathy. Safety and quality of care were also central to this model.

The new system attempted to balance the needs of residents (fewer work hours and attention to burnout) against the needs of patients (safety and thoroughness) and learning (setting and meeting expectations). This system highlighted the need for “slow medicine”, wherein residents could take the necessary time not only to do their due diligence with patients but the time to learn as well. Ludmerer concludes his history of residency by stating, “The key to success lay in remembering that good medical education could contribute to health care reform... The great opportunity for residency education was to improve the thinking and reasoning habits of ordinary practicing physicians in all specialties” (ibid: 333). He calls for a more careful approach to health

care that eliminates much of the excess in American medicine, and focuses on patient's immediate needs. This should include "the provision of enough time to provide 'slow medicine' to patients in need of it" (ibid).

Ludmerer's work speaks directly to what I sought to investigate in the present study. I am intrigued to see if the residency training at Suburban Family Medicine mirrors these current trends, what the place of this broader history is in the current state of residency education, and whether this program demonstrates any novel solutions for this underlying tension.

Residency as seen within medical education

In addition to historians and policy writers providing histories of residency education, medical educators have shared insights of their own, stemming from firsthand experiences in training residents. Medical education as a field has been aware of certain problems such as those raised above in the graduate and undergraduate training of physicians since the Flexner Report, published in 1910. In this landmark study, Dr. Abraham Flexner visited all 110 medical schools in operation at that time in the United States. His report changed the way medical school was structured, moved to identify medicine more-closely with the rigors of science, and helped formalize the educational process towards shared standards of professional knowledge and conduct (Flexner 1910; Cooke, et al. 2006).

Since the time of the Flexner Report, medical education has strived to refine and improve the making of doctors in medical schools and residency programs across the country. Of note here, Flexner's recommendations were couched in a particular educational philosophy that is often less emphasized than his specific

recommendations. Robert Ebert (1992) outlines this philosophy and its impact on the future of medical education. Flexner's central tenant, Ebert outlines, is that the professional education of physicians must be characterized by activity: "The student no longer merely watches, listens, memorizes; he *does*" (738). He believed lectures were of limited use and that one learned medicine by doing. Learners must have easy access to hospital wards; to have patients to whom the learning physician is wholly committed from admission to discharge. In this way, the student is held responsible and must learn a commitment to the patient through considerable exposure to illness and disease.

Flexner's report mirrored the trend towards an increased role of science and research in medicine. However, he emphasized that scientific knowledge was incomplete and could not serve as the sole guide to the practicing physician. He favored objective analysis as well as a deep commitment to the social components of health and healing. Scientific medicine has resulted in "physicians who are excellent technicians but lack a feeling of social responsibility" (Ebert 1992: 742). His position relates to what Ludmerer (2015) described as the use of residents as laborers rather than students. Flexner's philosophy had two main themes: that learning is best done in the inpatient services, hands-on with patients, and that education in medicine must be scientific, structured around a university setting, with faculty directly committed to teaching (ibid).

As Ebert (1992) points out, one of Flexner's central philosophical assertions regarding medical education was that learning occurs best on the inpatient service. An intriguing series of recent articles have returned attention to this idea. These articles revolve around a practice known as "bedside rounds," roughly defined as "the time-honored tradition of performing the activities of clinical care at the patient's bedside"

(Gonzalo, et al. 2010: 792) and taking that opportunity to teach students and residents in a direct, hands-on way. I will highlight some of the important recent articles that explore how bedside rounds are utilized in medical education, the rituals around bedside rounds, and the ebb and flow of their use in recent years. I attend to bedside rounds closely during my fieldwork and how they are enacted at Suburban Family Medicine to participate in this ongoing scholarly conversation.

An overarching theme across these recent studies is that bedside rounds are an important part of the education of medical student and residents, but are being less and less frequently performed. More in favor are “table rounds” where physicians discuss patients en masse away from the hospital wards. Gonzalo, et al (2013a, b) attempted to identify and describe the perceived value of bedside rounds among a sample of 34 bedside teachers across 10 medical institutions. They identified skill development through role-modeling, improved patient care through improved communication, and immediate feedback as the primary motivators for these rounds. They call for enhanced team-building as a way to continue developing these strengths. Finally, the study respondents agreed that bedside rounds improved care delivery through team building, joint clinical decision making, and immediate hands-on care (ibid).

Balmer and her colleagues (2010) came to similar conclusions about the importance of bedside rounds. First, bedside rounds are a pervasive and routine part of clinical education, but also involve a number of important assumptions and tensions around participants’ roles in the conversations and what “should” happen during them. The attending physicians are expected to teach clinical skills and role-model appropriate patient communication, and the learners are expected to observe the hands-on

examination of a patient, thereby acquiring knowledge about the patient. Shared knowledge, Balmer's study team contends, puts patients at less risk of miscommunication about treatment plans and diagnoses.

There is a central tension in Balmer's work relating to time management. Residents in the study were quick to point out that these "teaching" rounds are also "working" rounds. Residents felt that the intention of the faculty member was to teach, but more often, the resident was concerned about finishing all the work that was before them. Teaching was characterized, at times, as less important than the exegeses of patient care and management. Balmer's paper ends with a discussion of the ritualized nature of these rounds – a series of repeated, customary behaviors with the intent of teaching. The rounds are a "powerful communicative form" by which the participants make sense of their world, each participant playing their role, but can be seen as rigid – something that "should happen" in particular routine ways, but given the exegeses of inpatient work, may not always unfold as planned (Balmer, et al. 2010: 1113-1114).

Verghese, et al. (2011) mirrored many of the above findings with a similar focus on the ritual nature of bedside rounds. In their ethnographic study, Verghese and his team conceptualize health care itself as a ritual, with bedside rounds assisting in the patients' "transitions from sickness to health" (ibid: 550). These rituals often leads to learning and a sense of satisfaction in mastering new skills. The patient is approached at the bedside, questions are asked and answered by the team in a repetitious and routine way (as also seen in Gonzalo, et al. 2010), and those learners accumulating new knowledge and skills are able to watch and imitate their mentors. They assert that this "hands-on" experience is well-received by patients as well, in their study. The

rounds induce a “placebo effect” where “context, ritual, setting, and tone of voice of the examiner induce psychobiological events that produce measurable change in levels of neurotransmitters” (ibid: 552). In other words, “Patients have an expectation that their doctor will examine them in a skilled, respected, and ritualized fashion. If the expectation is fulfilled, it brings about a positive therapeutic effect” (ibid). The authors call for preserving the bedside examination to help patients, help students and residents to learn directly, and expedite the gathering of medical information.

Gonzalo, et al. (2009, 2010) reached similar conclusions through survey of student and resident attitudes towards bedside rounds. Gonzalo and his team designed and implemented an intervention to increase use of bedside rounds in a 556-bed hospital in Boston, between 2008 and 2009. Their intervention revealed the perceived importance of bedside rounds by a majority of attending physicians and house staff, but an ever-increasing tension with time management. Bedside rounds in this study often took between 95 and 98 minutes for all patients involved, with each patient session lasting 15 minutes. The study claims that a “patient care delivery system without the patient involved” has become increasingly common (ibid: 796) resulting in increases to the attendant problems of miscommunication and lack of patient-centered care. I will consider these findings in my exploration of healing and the teaching of healing practices in a family medicine residency education program.

Patients, the researchers found, greatly appreciated being directly involved in their own care, increasing confidence in their treatment and satisfaction with their hospital experiences. Residents and students however remained unconvinced, often more concerned with mounting number of additional tasks waiting for them while

engaging in this tradition of bedside rounds. Elder and his colleagues at Stanford's Program in Bedside Medicine have called for a "return to the bedside", calling for the involvement of "real patients" and focusing on the learning and demonstration of clinical skills (Elder, et al. 2013: 799-800). Bedside rounds provide an important opportunity to directly assess residents' practice and teach critical thinking skills in evaluating and sorting out evidence towards better diagnoses and treatments (ibid). Again, I will investigate whether these exegeses and issues emerge among bedside rounds in Suburban's Family Medicine inpatient service.

It remains unclear where exactly the patient is situated in these rounds. Gonzalo calls repeatedly (2009, 2010, 2013a, 2013b) for explanations to and engaging discussions with patients themselves; to involve them directly in bedside rounds. Verghese (2011) considers the patient the true locus of learning. From these recent studies, I see the need to continue to explore the use and usefulness of bedside rounds – its importance, values, and meaning will be assessed and described in Chapter 8.

I now move away from the topic of bedside rounds to professionalism, speaking to the organizational values of physicians in the performance of their duties. Dr. Flexner highlighted in his final report (1910) the overarching goal of "professionalization" of medicine through the careful training of the next generation of physicians. Professionals in training, he articulated, must master not only large bodies of knowledge and skills, but take on the values of the profession. Physicians and scholars are still working with Flexner's ideas around professionalism. The following definition of professionalization captures Flexner's ideals and suggests something about the social recognition of healers: "professionalism can be defined for all time as the means by which individual

doctors fulfill the medical profession's contract with society" (Cohen 2006). This definition is operationalized to include competence, honesty, respect, advance of scientific knowledge, improve care, and maintaining trust with patients (ibid). What exactly does this definition mean? As written, the definition is so broad as to cover almost everything a doctor learns in the course of becoming a physician. Other medical educators define professionalism differently: as a quality including various virtues like altruism, accountability, excellence, duty, and compassion (Cox 2006; Wear 1998), which are in turn challenging to define without demonstrating them in context.

Medical education literature presents an ongoing struggle in defining and therefore teaching professional ideals to students and residents (Stern and Papadakis 2006; Cohen 2006; Cooke, et al. 2006). As an anthropologist, I see that a definition of professionalism is often taken for granted, culturally-constructed and also somewhat culturally invisible. Something one recognizes when seen, but struggles to define. For these reasons, I will use practice theory to explore the role of professionalism and its attendant values for family medicine, including how it is defined and embodied, by identifying and describing the particular attitudes and beliefs that guide the process of educating residents.

Medical education is concerned with a long list of other topics as they relate to medical professionalization: communication practices between doctors that may result in medical errors, emically called "hand off" (Arora, et al. 2005; Solet, et al. 2005; Vidyarthi, et al. 2006), physician listening and communication with patients (Jagosh, et al. 2011, Ong, et al. 1995; Street, et al. 2009), and the potential role of ethnography in better understanding medical education (Atkinson & Pugsley 2005; Kellogg, et al. 2006;

Pope 2005; Goodson and Vassar 2011; Leung 2002). While these are all important issues to consider, more can be done to relate this ethnographic work to the making of healers specifically. My study seeks to make such a contribution in that area.

To illustrate how cultural aspects of biomedicine can be studied and made more visible, I point to Blumhagen's detailed analysis of universal symbol of biomedical professionalism – the doctor's white coat. Blumhagen (1979) describes the white coat as a symbol of healing, bringing Western "notions of purity to the often unsanitary conditions of disease". In the late 1880s, as medicine moved towards scientific approaches over "the discovery of magical new drugs", the white coat took on a symbolic meaning indicated a source of wellness and healing; situated in the relationship with a professional committed to working with patients for their health. The white coat further speaks to acquiring competence; physicians may be donning the white coat prior to possessing the skills, knowledge, and values that make them an autonomous physician (Wear 1998). Further, the white coat may provide a false sense of confidence and distance from patients; a sense of being better than one's patients (Branch 1998). Blumhagen's ideas about the complexities of the white coat's symbolism are relevant to explore in thinking about how family medicine residency education uses this coat and other symbols of medical professionalism in residency education.

An interesting aspect of professionalism is the use and possible "misuse" of humor in medicine. Humor can sometimes take on a cynical and derogatory tone that may have a negative impact on not only the educational process but also the professional development of physicians. In early ethnographic work touching on medical professionalism, Howard Becker (1993, 1961) referred to use of derogatory terms and

cynical humor by medical students regarding their patients, though often in a descriptive rather than critical way. Terry Mizrahi's (1986) important work on "getting rid" of patients further demonstrates how cynicism and negative attitudes, particularly towards patients who "self-abuse" (i.e. overuse of alcohol, tobacco, drugs, or over-eating) are evaluated as "less worthy" of medical care and derided by physicians. A more recent study that Wear reports on in several publications (Wear, et al. 2009, 2006) has focused on the use of humor among medical students to conceptualize their work with patients; numerous parallels with prior writings in medical education emerge. The study involved a number of focus groups and resulted in categories of humor use. I explore this topic here because I wish to see if the use of humor occurs in the making of healers in family medicine, and what impact it may have on the professional socialization of residents.

Wear's research was inspired by widespread anecdotal evidence that medical students become more cynical as learners progress through medical school. Collectively, the patients that the medical student sees in their third and fourth year begin to be grouped into informal categories. Those "good patients" – who listen to the students' and other doctors' recommendations, take care of themselves, are organized and to the point in their communication – are shown respect. Those who are not considered "good patients" – who seek additional, unwarranted (in the professionals' eyes) medications, eat too much, or abuse substances – become the target of derogatory comments. It is important to note, however, that these comments are kept private. To quote Becker (1961), himself quoting a physician in his study, "Some things have to be kept private... you think parents want to hear schoolteachers making fun of their kids?" (in Wear 2006: 454).

Medical students characterize humor as a coping mechanism for demanding work. To quote a student in Wear's study, "Life is hell anyway, but it's less hell if you're joking about it" (ibid: 459). Therefore, we see here that humor can become an outlet for frustration. Another motive for using humor involves distancing oneself from the sick and dying patients. Here, humor serves to create a barrier between the physician-in-training and the patient. Humor also provides relief, to manage what one respondent called the "if you don't laugh you're going to cry" phenomenon. The work of becoming a physician is challenging and humor offsets this to a degree. I am left wondering however, what the impact on patient care would be if cynical humor goes unchecked or not reflected upon. Specifically, what is the impact on the making of healers?

In a second study (Wear, et al. 2009), the research team utilized the same focus group protocol with groups of physicians, both residents and attending physicians. I was particularly intrigued by this given my focus on these two groups. Again, humor around obesity, self-abusive patients, and medication-seeking patients were noted. Added was a sense that this humor promoted camaraderie between physicians working in a continuously difficult set of working conditions. Intriguingly, given their different position of these physicians – now licensed and more-directly responsible for patient wellbeing – the doctors referenced the ill effects of humor more often. Widespread use of cynical and derogatory humor can "perpetuate a culture" (ibid: 37) of negative treatment towards patients.

It was the attending physicians who referenced inappropriate humor as a "teachable moment". Attending physicians referenced steering their residents and medical students towards empathy, pointing out the difficulties in the patients' lives that

may result in the material for their humor. Another asks his physician learners to imagine themselves in the patient's place; how it might feel to be the target of ridicule. Relationships matter, the authors contend, because it is in hearing the experiences of the patient, not "making fun", that the work of creating and maintaining an environment where healing can occur. Moving into my own research, I will attend to issues around the use of humor as it relates to the making of family medicine physicians and their journey towards becoming healers.

In my own work, I contend that professionalism and ways of demonstrating it represent an important step in the process of "becoming". I argue that the ways in which a particular setting defines professionalism and the ways in which new members take on and interpret these ideas, shed light upon the ways in which members "become" something new. Therefore, I explore the definition of "professionalism" in Suburban Family Medicine and how residents come to understand and take on those ideas of professionalism and relate these steps to the process of becoming family medicine physicians and healers.

Of all the topics touched upon by medical education, the concept of a "hidden curriculum" in training doctors is perhaps the most salient, receiving a great deal of attention in the medical education literature of the last fifty years. First described in the later 1960s, the hidden curriculum has been defined as the "tacit ways in which knowledge and behavior get constructed, outside the usual course materials and formally scheduled lessons" (Wear 1998: 734). The hidden curriculum is compared to the stated, formal curriculum and yet is also something beyond the informal, unscripted learning that may take place in an educational setting (Hafferty 1998) – it involves those

ideas that get passed on without conscious effort, the demonstrated behaviors and ideas that are coded into the profession of medicine. Further, it highlights the structural factors that influence the learning process (ibid). In medical training, the hidden curriculum is seen as a ubiquitous part of the socialization of doctors: “Only a fraction of the medical culture is to be found or can be conveyed within those curriculum-based hours formally allocated to instruction” (Hafferty and Franks 1994: 864).

The presence and impact of a hidden curriculum is not surprising in anthropology, wherein culture is often depicted as unconscious and difficult for reflect upon and identify the impact of one’s own culture. In American biomedicine, the hidden curriculum is a part of a medical culture – one that conveys the tacit values, ideas, and beliefs without being directly taught. The hidden curriculum serves to inculcate the new doctor with the broader biomedical and, specifically, family medicine ideas about what medicine is, what a physician and healer are, and how these ideas work in the real world with patients.

The importance of the hidden curriculum is that it is often taken for granted, structured by the broader social organization influencing medicine (e.g. insurance companies, tight schedules, prevailing attitudes about the work of medicine), and influences the socialization and professionalization of physicians in unexpected ways. It also may point to the less obvious ways in which new members in the residency program “become” family medicine physicians. The challenge is that learners encounter many ideas about the nature of medical work throughout their lives, and then into medical training, that may conflict with one another (Bennett, et al. 2004), and they are expected to learn and internalize the “right” ones towards becoming competent and

professional physicians, to become healers in American biomedicine and the family medicine specialty.

The hidden curriculum can seep even into the work of anthropologists studying medicine. For instance, Margaret Lock reflects on her time working in medical education: “One can maintain one’s integrity and walk the liminal line as an anthropologist ‘in’ medicine, but only if one steps outside regularly to refresh oneself with the anthropology ‘of’ medicine” (Lock 1982: 20). In other words, like the impact of the hidden curriculum on physicians, the anthropologist can become desensitized to the differences in their environment; they come to think and act as those socialized there. As we will see, I needed to think more deeply about my own positionality as I moved through the research setting and analysis; as a trained anthropological researcher and also as a social scientist, with a background in behavioral medicine involving working with medical residents. For more background and context, I now outline the critical components of family medicine, making of healers in family medicine, and some of the particularities of family medicine’s approach to educating residents.

History of family medicine as a specialty

Family medicine has its own particular path that serves to mark it as a distinct specialty within biomedicine. The history of family medicine provides a backdrop for its residency education, shedding light on the nature and identity of family medicine physicians. Often viewed as inferior and less capable by those in more prestigious specialties, family medicine practitioners characterize the specialty as something better, engaging in discourses that contest negative characterizations and emphasize the strengths of specialty. Armed with this rhetoric, family medicine residency programs are

shaped by these historical forces. Attending to this history helps to contextualize the process of making healers in family medicine as it unfolds in this dissertation.

The history of family medicine is situated within the broader history of medical specialization. As Western medical science developed in the late 18th and into the 19th century, it was perceived to be less possible to master all the information and techniques medicine had to offer. One way to trace the development of medical specialization through history is to outline the ways by which particular organs or regions of the body came to be the specialized purview of specific groups of doctors. George Weisz (2006), in his book *Divide and Conquer*, provides a detailed description of how medical specialization occurred in the context of medical research and development, public interest, and government oversight. Weisz outlines how the phenomenon of specialization results in a form of prestige defined by the specific skills honed in attempting to master a unique, particular role in medicine.

A “system of specialties” emerges, beginning in earnest in the early 19th century (Weisz 2006: xvii, xix, xxi). Like professions, specialties gradually evolve rules and models of behavior that regulate their activities – an organizational culture all their own, complete with specific techniques and capital. The specialty system was likewise defined by interactions between specialties, defense of their own “turf” outsiders, and the advances of medical science and technique particular to each specialty. These specialties eventually defined themselves, regulated their own members, and developed complex training programs, professional associations, and standards for socially-identifying, confirming, and verifying individual doctors as being of a particular specialty.

As a result of this process, individual medical specialties came to each have a particular “object” of inquiry that allowed the specialty to define its areas of treatment, its purpose and mission, and ultimately its claims to expertise (Good 2005; Thomasma 1984). Weisz, however, draws a distinction between organ- or system-specific medical specialties and what he refers to as “general practitioners”. He argues that some specialties focus on a particular organ system (nephrology, hepatology), disease processes (immunology, oncology), particular age groups (pediatrics, geriatrics), or particular procedures (obstetrics). General practitioners – primary care specialties like internal and family medicine – are focused on the long-term health and wellbeing of the patient, beyond age, episodic events, or particular organ systems (Stephens 1982, Weisz 2006).

Perhaps the moment that first marks the trend that would become family medicine was the renewed interest in a new “synthetic” medicine, one more sensitive to the total human being (ibid: xxviii). In the 1920s and 1930s, in response “the nearly total victory of reductionist medicine founded on specialization,” some within Western medicine began to recognize certain “painful trade-offs” were resulting from the increasingly narrow focus of specialization (ibid: xxx). Many in medicine came to feel that the generalist physician was to be championed as something worth preserving and made to flourish. Various proposals were put forward, both in America and abroad, attempting to revitalize general practice and gather specialists and generalists into collaborative groups within medical centers.

One effect was a reframing by many specialists to emphasize that their objects, the organs they focused upon, provided a window to the entire patient. They argued that

to be the best specialist required also being well-versed in general medicine (Ludmerer 2015). Concern over a trajectory that put less emphasis on patients and focused medical care too narrowly on particular organs can be seen as early as 1933. An editorial in the Journal of the American Medical Association (JAMA 1993) cited an overgrowth of specialization for this reason. Despite these significant concerns, the advances of science more generally marked the specialist as the elite within the broader medical community (Weisz 2006). This elite status, greater prestige, more interesting training, and greater financial opportunity resulted in the number of residencies dedicated to specialties increasing through the early and mid-20th century (Ludmerer 2015). The end result, rather than a revitalization of the generalist physician, was a marked increase in the number of specialists. Dividing the problem of human health into smaller, more manageable units allowed for tremendous advances in medical treatments, but concerns remained about what in the total human being was being missed through progressive specialization (Ludmerer 2015; Weisz 2006; JAMA 1993).

The result of this trend for general practitioners was telling, forming the seed of the professional status differences seen today. As late as the 1940s, residencies were for specialists, and general practitioners were only expected to complete a one-year internship before beginning autonomous practice. These two paths to practice resulted in a split in status and power. Those physicians who had completed the lengthier specialist residency came to look down upon generalists, viewing themselves as having more and better training; wielding medicine of a greater symbolic value given their lengthier, more rigorous education (AAFP 1980). Residency training was also closely

connected to hospital privileges, resulting in a pushing out of generalist physicians from inpatient medical settings (Ludmerer 2015; Weisz 2006; AAFP 1980).

As a result of these factors, generalist practitioners all over the United States saw themselves as threatened, and perceived a need to assert their role, importance, and legitimacy in the face of specialization. Further, with risks to privileges like hospital work, general practitioners began to organize and mobilize in their own interests. The American Academy of General Practice was organized in 1947 with the express goal of protecting their way of life and their way of practicing medicine (AAFP 1980). In 1971, this organization would be renamed the American Academy of Family Physicians. This mobilization of generalists drew the attention of the American Medical Association, who formed a committee to study the conditions of general practice. In 1948, the committee agreed that generalists needing something to help preserve their practice and raise them to a status similar to the specialists. The committee recommended protected privileges and a two-year training program, to help better legitimate the profession. However, nothing came directly of the report. It would still be many years before lasting change would come to status of the generalist physician (AAFP 1980).

One proposed solution was the creation of a board certification in general medicine. To be “boarded” in this way would place a stamp of legitimacy on general practice akin to that employed by the specialists in their respective fields (Ludmerer 2015). Many within general practice resisted this idea. They argued that board certification was the path to becoming a specialty, and they were actively resistant to specialty approaches to medicine (AAFP 1980; Arroyo 1986). Further, to become a specialty necessitated defining the field’s specific purpose and scope, a clear and

focused object of medicine inquiry. In defining themselves as such, many general practitioners felt boarding meant potentially losing part of what defined them; the very generalist approach that defined them. For example, many generalists performed obstetrics and surgical procedures, and concerns over turf meant the field might lose those privileges by becoming a specialty (Ludmerer 2015). The American College of Surgeons, for example, actively moved to protect their domain, and was moving to exclude surgery from the scope of practice of every other specialty. To open the possibility of boarding meant generalists would be engaging in negotiations that could cost them being able to provide many of the services they felt they should be able to offer their patients. However, other generalists argued that boarding would help protect privileges, chiefly the privilege to see their own patients in hospital. To avoid being squeezed out of inpatient medicine entirely, general medicine would need board certification and need to undertake the fight of defining their scope of practice.

In the 1950s and 1960s, numerous committees were formed by the American Academy of General Practice to explore the advantages and disadvantages of becoming a specialty. First was the 1957 committee, the Minimum Uniform Standards of Education for General Practice (MUSE). This committee worked to establish educational standards that would be requirements for membership in the Academy. The 1959 report ended with a clear call for board specialization, claiming “if board certification is the standard that so many in and out of the medical profession use as a form of competence” then boarding will help general practice to meet this standard, legitimating the profession in the eyes of the rest of medicine (AAFP 1980: 18).

At this point, the field began to make moves to neutralize or reverse unfavorable opinions surrounding generalist medicine. The MUSE report laid the foundation for this, suggesting a rebranding of the general physician as a “family physician,” and beginning to better define its object through advocating “care through relationships” with patients (Arroyo 1986: 172). This report was where family practice began the process of being defined as a specialty, but still faced a unique challenge. Delineating their role was difficult given a generalist approach. The specialty’s role and contribution was based on “a function instead of a body of knowledge”, on the whole patient rather than a single organ system or medical practice. To address this challenge, the call was made to place the family physician as the “first contact” with patients. This would “secure his position within the web of specialist care” (Arroyo 1986: 170), and allow for the formation of a coordinating function between diverse specialties for individual care and navigation through an increasingly complex healthcare system.

The Folsom Report, published in 1966, furthered the definition of family medicine as centered around patient relationships, and called more overtly for the establishment of a new specialty in family practice. Health was defined here as a “community affair” requiring a practiced, competent body of medical specialists to attend to broader social, personal, and cultural factors in healthcare (Folsom 1966a, 1966b). Folsom called for a “personal physician” to care for individuals, focused on “comprehensive, continuing and preventative care” with the necessary training, status, and privileges to accomplish this task (ibid). The Willard Report, also published in 1966, met the challenge of family practice head on, calling for a new kind of specialist in family medicine, educated to provide comprehensive personal health care, because this need was coming to be

viewed as critically important given the complexity of modern medicine. Helping patients navigate the landscape of American healthcare became the provenance of family practice physicians. Certification was therefore necessary to provide status to the field, especially to attract young physicians to the field (Willis 1996; AAFP 1980; Doohan, et al. 2014). Findings from the Millis Commission report on Graduate Medical Education, a third study produced in 1966, called for: “A physician who focuses not upon individual organs and systems but upon the whole man, who lives in a complex setting... knows that diagnosis or treatment of a part often overlooks major causative factors and therapeutic opportunities” (Millis 1966: 9).

Taken together, these reports documented the need for personal, primary care for individuals in a complex medical landscape. These reports also communicated other ideas about the problem of the shortage of general practitioners, and championed board certification as the means to higher status and solving the problem of what to do about general practice. The reports together serve as the foundation for family practice in the United States. However, the road to board certification and the creation of a new specialty in American medicine was not to be that straightforward. Other specialties resisted what they saw as infringement on their territory. This tension led representatives from five other specialties (internal medicine, pediatrics, surgery, obstetrics, and psychiatry) to join with members of the American Academy of General Practice towards drafting and legitimating the application to the AMA for family practice boarding.

I find it very telling of the threat family practice represented that in order to be allowed to join the halls of specialist medicine, these five representatives were viewed

as necessary gatekeepers. Further, this process sent a clear message to family practice that while board certification was possible, it would only happen through the graces of those already possessed of board specialty status. It was no accident that these five specialties represent practices that family practice considered part of their generalist approach. Many general practice physicians had been serving in roles similar to these specialties for many decades – delivering babies, treating children, performing minor surgeries, and treating patients' mental illness and emotional concerns.

The application for board certification and specialty status was approved the AMA Council on Medical Education. Official written notice was given on February 9, 1969 – the birthday of family medicine, officially becoming the twentieth specialty in American medicine (AAFP 1980). As a new specialty, family medicine brought with it a new type of physician, seen as a “medical revolutionary” (Arroyo 1980: 196); person-oriented rather than disease-oriented, poised to connect health care to patients in a more humanistic way (ibid; Arroyo 1980). The formation of the American Board of Family Practice in 1976 represents a significant milestone in the development of the specialty, providing more family practice specialists and acknowledging the role they were playing to date.

Many hopes were pinned on family medicine to solve certain problems in American healthcare, a role I believe it still attempts to play today. Primary care was often viewed as a form of medical delivery that would save money, right the wrongs of the health care system, and ultimately improve public health. A shortage of generalist physicians would be solved, in part, through the legitimizing process of becoming a specialty. First, beginning in 1969, state and federal governments provided funds to

support family practice training, including funding to hospitals to support inpatient training (Weisz 2006). As a result, by 1984, family medicine was the third largest residency program in the United States, after internal medicine and surgery (ibid).

The medical profession writ large however had different hopes for family medicine. There were public suspicions growing around healthcare in general, public calls for more comprehensive care, and concerns about the rising costs of health care. However, it has been postulated that the medical professions used family medicine to appease the public, with the hope that allowing the formation of a generalist specialty would protect the other specialists from external regulation or further encroachment on their expert domains and objects. The specialists did not welcome family medicine as a peer, but were able to see other uses for the specialty. Family medicine had essentially “taken the heat off” and preserved the status quo of high-status specialists and lower status general practitioners (Stephens 1989). With this as the case, it became clear that boarding did not solve the problem of family medicine’s status in the eyes of other specialist physicians. What boarding accomplished was the dissolving of the dual system of medical training; all physicians now were required to specialize, even if it meant specializing in what is essentially a generalist role.

What then was family medicine’s focus to be – its object? Characterizing family medicine as a specialized practice is a complex undertaking that continues into today. The problem that lingered through the first thirty years of family medicine was the lack of a clear-cut role. As mentioned earlier, family medicine physicians carried the status of the specialist without the central focus on disease or organ system. While other specialties have developed a specific focus, family medicine has eschewed a narrow

specialization in favor of a whole-patient approach. The success of family medicine therefore must be evaluated in terms of its ability to “treat the whole patient”. Further, family medicine goes beyond the management of patient health and wellbeing and situates the patient in a broader context, as a locus of a group of relationships, circumstances, conditions – of which the individual disease and disorder is only a part. This claim is complicated since the patient is the one who possesses a liver, a heart, a cancer, or any organ – so the intersection between family medicine and other specialties may be complicated.

There is no formal administrative structure in the early days of family medicine as a specialty, and no uniform standards for practice and learning in family practice. Residencies focused on various components of family practice in different ways – some offering inpatient medicine, others not; some focusing on obstetrics or surgery more than others do. The behavioral models of patient health have been with family medicine training from the beginning (Doohan, et al. 2014). We see the formal legitimating of “biopsychosocial” specialists who can integrate the whole person into care. Family physicians were then charged with providing acute care, managing chronic health problems, and managing preventative health recommendations, with an eye to broader social and personal patient concerns that could affect health.

Family medicine was also shaping its own identity during this time. Building on the narratives of the struggle for legitimization and equal status, a number of idiomatic tropes emerge in the early years of the specialty that remain in place today. For example, historian and sociologist Rosemary Stevens (2001) characterizes the family physician of the late 20th century as a mythic hero, couching their struggle for identity as

heroic. The claim was that the specialty's founding fathers made slow progress toward "infiltration and modification of venerable academic fortresses" (ibid: 237). With "purity of heart and minds", the early family medicine physicians dedicated themselves to their patient-centered care model. They called for efforts to continue reforms in American medicine, to champion their approach to care without fear, and show zeal and courage in the face of negative opinion (ibid: 238).

Dr. G. Gayle Stephens (1979, 1989) characterized family practice as "counter-culture," positioned as a foil to biomedicine's wide reliance of disease-centered reductionist models of health, possessing only a conditional faith in science. They continue to view patient suffering as more than physical, to prevent disease and provide care rather than only curing (ibid: 107). Family medicine's identity came to embrace the social, psychological, and behavioral factors in patient health, to help patients integrate care into their daily lives, and attend to relational knowledge – to be a good diagnostician through intimate patient knowledge (Berger and Mohr 1997). Further, the cradle to the grave philosophy of family medicine's object came to the fore during this period. This approach suggests that the doctor knows his patients over time, knows him or her before knowing the disease (McWhinney 1997). In this way, family medicine became a specialty in breadth, uniquely defined within the family context (AAFP 1980).

Stephens (1982) argues that patient management is "the quintessential skill of clinical practice and is the area of knowledge unique to family physicians" (8). Stephens explained that patient management is something beyond simply treating patients – beyond identifying illness and determining a course of treatment – patient management involves the decision of whether to treat at all, considerations of patients' state of

readiness for treatment, as well as addressing “clinical problems and conditions which require a therapeutic relationship with a physician” (Stephens 1982: 9). Put another way, the patient is a “series of one”, a unique case embodying particular life circumstances requiring knowledge of the patient as a person, knowing the person’s life experiences, and molding treatment – and the decision to treat at all – to include something more than an approach to diagnostics and therapeutics.

Further defining the role and place of family medicine in American healthcare, the Future of Family Medicine (FFM) Project was begun in 2002 with the goal of identifying the specialty’s core values and establishing finally a formal model for practice (Martin, et al. 2004). Recognizing the problems of previous decades were not solved medical costs continue to rise and the public distrust of medicine not entirely resolved (Gutierrez and Scheid 2002), the report lays out important features of the family medicine identity and goals for moving into the future. The FFM report established definitive definitions for family medicine’s core values.

First, was a commitment to “continuing, comprehensive, compassionate, and personal care within the context of family and community” (FFM 2002: S11). The family physician is concerned with the care of people of all ages, and to understand health and disease involve the mind, body, and spirit, including the context of the patients’ lives as members of the family and community (ibid: S12). To achieve top performance, the expectation was laid that family physicians must work in environments that promote their values. They must practice scientific, evidence-based, patient-centered care. They needed to be committed to fostering health for the whole person by humanizing medicine and providing high quality care. The FFM Report also called for integrative

teams of physicians working together to manage patient populations. Another goal was to integrate these values more directly into residency programs nationwide. Among these goals includes notions of lifelong learning, where physicians strive to always maintain their competency and knowledge of the field; to promote a growing workforce of skilled family physicians through rigorous, professional residency training; to forward a collaborative model where teams work together to meet these new goals; to reverse the trend of fragmentation in American healthcare systems.

These goals and values still remain widely open to interpretation and local definitions. What exactly does it mean to be patient-centered in family medicine? How does lifelong learning look in different contexts? How can one be both scientifically rigorous and yet critical of science, as was Stephens' (1989) assessment of family medicine's counter-culture status? Compared to other specialties, with clear cut objects of focus, family medicine's holism leaves a lot of room for noise and confusion, both within the specialty and perceptions of it from without. The core of family medicine's identity has never been very clear, and as a result, it retains an ambiguous and relatively low status within medicine (Weisz 2006: 253). The FFM Report acknowledged public confusion of family medicine's role and attempted to clarify that role. Today, family medicine still struggles for identity, conflicted over the same problems that were present at its inception (Stein 2006).

Given its broad focus providing patients a "basket of services" (Martin, et al. 2004; Doohan, et al. 2014), the field competes within a biomedical world of distinct specialties. Anthropologist Howard Stein (2006) argues that today the discourse around family medicine's object are not clearly reflected in the practice seen within the

discipline, that family medicine must “practice what they preach” (ibid: 455). The claim is that despite insistence on their own distinctiveness, family medicine has come to resemble more closely the world of biomedicine, focused on patient management, diagnosis and treatment of disease, and being gatekeepers for the other medical specialties. By pushing towards a future of scientifically rigorous, research-driven medicine, the focus on patients has slipped in favor of the prestige and need to focus on ever-changing scientific advancements in medicine.

Stein argues that three competing identities conflate the issue for family medicine as a specialty. First, philosophically and discursively, family medicine is an ethos – a world view with an integrative, holistic attitude towards life. Here family medicine is “both exemplar and champion of the biopsychosocial model” (ibid: 456). Family medicine also has from a long history of being defined by what it does and does not do. Market forces and personal preferences have shaped what services individual family medicine doctors offer; e.g. rates of minor surgeries, obstetrics, colonoscopy, etc. As a group, the range of practices and ideas of what a family doctor does change over time. The role of insurance companies mandating limited time for office visits has likewise threatened patient-centeredness. In terms of family medicine education, many residents never directly experience the longitudinal care their specialty holds as central, moving as they do from rotation to rotation, and graduating within three years, often never to see their patients again. It is perhaps only in getting into autonomous practice that the family medicine learner finally sees the value of long-term care firsthand.

There remains a call for reform in American healthcare, one family medicine physicians see themselves as uniquely suited to answer. Family medicine is couching

its identity on filling the need for leadership, for improving health outcomes, provide quality, safe care, and decreasing costs while improving patient satisfaction (Calman 2012). Characterized as a specialty for all ages, the American Academy of Family Practice characterizes family medicine as “specializing in the human family” and places the patient-physician relationship at “the heart of family medicine” (AAFP 1980). By the dawn of the 21st century, the American Board of Family Practice became the largest delegation to the American Medical Association (Gutierrez and Scheid 2002: 11). Today, recruitment for family medicine jobs is the highest among all specialties nationwide; three times higher than the next highest recruited specialty (National Residency Matching Program 2016). In the end, family medicine responds to a national need for improved healthcare, but itself remains mired in identity challenges, where each residency program defines for itself what family medicine is and how making family medicine doctors happens.

In terms of family medicine’s status within American medicine, Bloom (1989) talks about the tension between the reductionist approach to medicine and the holistic approach espoused by family medicine. The first emphasizes biomedical knowledge and technology while the latter focuses on caring as much as curing. This tension has been argued as a central cause for family medicine’s lower status within medicine (Brooks 2013). As an alternative approach, family medicine challenges the medical establishment and profession at large because its calls boundaries into question. However, the often ill-defined scope of family medicine’s object threatens the precision and control that the biomedical approach promises. Family medicine essentially deals with all the “untidy issues” that do not fit neatly into the dominant disease-based model

of biomedicine. According to its tenets, family medicine physicians want and require less control – over the disease process, the patient, and the specific limits of their practice than other physicians in American biomedicine.

Because of its role as a primary care specialty, many American patients see family medicine specialists to receive their basic care and then coordinate more-specialized care with other types of physicians (Gore 2011; Martin, et al. 2004; Gutierrez and Scheid 2002; McWhinney 1997). Even a decade ago, the Robert Graham Center report focused on the role of family practice in American society (cited in Guterrez and Scheid 2002), further suggests that family medicine physicians see more patients than any other primary care specialty, lending importance to a greater understanding of what family physicians do and how they learn to do it. Family medicine is known for placing special emphasis on the social nature of illness and the relationship between provider and patient (Martin, et al. 2004; Stephens 1982; McWhinney 1997). Further, family medicine literature cites “holism” as a central value, to treat patients as whole people (Rosenberg 2007; Shahady 1993). Family medicine physicians are expected to be adept at treating disease, yet also capable of bringing together the social circumstances of the patient’s illness with the diagnosis and treatment of disease through a patient-physician relationship (Gore 2011; Martin, et al. 2004; Gutierrez and Scheid 2002; McWhinney 1997; Gayle 1982).

This central difference is the basis of why family medicine doctors are sometimes seen as “peons putting Band-Aids on people” while the specialists are “doing the real job” (Arroyo 1986: 181). Family medicine challenges the dominant medical model through their object. If recent trends are true, the family medicine specialty is inundated

by the dominant model through new institutional structures of insurance and ever-evolving scientific medical discovery. In this sense, writ large, family medicine is distinct in its approach to patient care and outsider status as a specialty with generalist tendencies. Family medicine challenges the boundaries of medicine, about who has power in medical relationships, and what the role of personal and social circumstances are in effective care. They attempt to serve a vital role, but also struggle to define themselves. Moving forward, I will investigate how these notions of “what is family medicine?” are in play within Suburban’s family medicine residency program.

Making healers in family medicine

Family medicine is an interesting case to examine because it shares values with other biomedical specialties and yet has other ideas distinct from those other specialties. In a sense, family medicine residents are expected to balance several different approaches to healing. Nowadays, these include a technocratic, disease-centered model with demands for efficiency coming from swelling patient loads, accreditation and training requirements, and insurance companies versus the value placed on the humanistic model; the healing nature of social relationships within family medicine. As an “outlier” in these ways, the family medicine specialty can help us better examine some key assumptions of values of biomedicine as a whole as well as its own particular notions.

To study family medicine residency training therefore, I need to think about how it is structured by virtue of its position within larger social organizations. The professional setting is situated in a larger sociocultural universe – within the specialty of family medicine, American biomedicine, and healthcare in American society more generally.

These factors form an overarching social structure that bounds and shapes training processes. There are broader interconnected institutions that converge with the history and values of family medicine to mold the training process. Over time, insurance companies have narrowed the range of treatment options for and schedules of seeing patients (Bach and Kocher 2011; Bodenheimer 2008; Boulton and Wieland 2010; Boyd, et al. 2010; Cheah 1998; Gore 2011; Manning, et al. 1987; Nye 2003; Peikes, et al 2009). Medical research is constantly providing new information and options for professionals to learn, master, and make sense of, leading to ongoing expectations that physicians continue their medical education throughout their careers (Mann 2002; Mazmanian and Davis 2002). Patients are becoming more well-informed, increasingly bringing their own voice to medical decision making (Broom 2005; Charles, et al. 1999; McMullan 2006; Wald, et al. 2007).

Despite key changes in the American healthcare system and society over time, family medicine still holds as a central value the role of the doctor-patient relationship (Jagosh 2011; Martin, et al. 2004; Shahady 1993). As with any healing tradition, family medicine residency training occurs within specific social and historical structures that bound and shape it. The training process embodies a particular set of behaviors and ideals unique to a particular social setting: teaching residents, residents learning to treat patients, values of holism and attention to patients' illness experiences. I hope to demonstrate how family medicine residents come to acquire the techniques, knowledge, and importantly the values of family medicine through their three years of residency training. I explore the professional socialization of the initiation processes taking the initiate to a new place. I investigate whether and how they become something new.

Given what I have shown – that family medicine is a particular type of biomedicine – I began my study open to an exploration of what constitutes healing and the making of healers within my fieldsite. I knew going in that the process of “becoming” in family medicine would involve expectations that residents take on techniques, knowledge, and values distinct to the specialty. I postulated that the particularities of healing, healers and the making of family medicine doctors would emerge through my investigations.

To characterize the family medicine educational processes in particular, one must also look at the literature produced within the specialty and also the language used in discussing itself. In the opening chapter of *Essentials of Family Medicine*, physician Edward Shahady (1993) clearly outlines the principles of the specialty in their broadest sense; principles that remain in place today (Martin, et al. 2004). The object of family medicine is depicted as a keen focus on the therapeutic value of prevention medicine and the relationship that develops between patient and physician to facilitate that therapy. Since its inception, family medicine has defined itself as a medical specialty focused on the patient “not only from a biological perspective but also from a social and psychological one” (Shahady 1993: 4). The specialty is concerned not only with episodes of illness, but periods of wellbeing; on prevention as well as cure, with a “cradle to the grave” philosophy of health care delivery (Stephens 1982: 13).

In studying family medicine education, there is a need to understand how residents learn to manage the everyday – what the challenges are and how to address them, the lived experience of residency and how it influences their training and professionalization. This study will contribute to these discussions within family

medicine, medical education, and medical anthropology, while providing the sort of holistic point-of-view that family medicine claims for itself. In the field of family medicine residency training issues explored to date include challenges of foreign medical graduates (Woods, et al. 2009, Fiscella and Frankel 2000), burnout and wellbeing (Woodside, et al. 2008, Thomas 2004, Ratanawongsa, et al 2008), and balancing work and home life (Geurts, et al. 1999). Often taking what is labeled as an “ethnographic approach” (Atkinson 2005; Kellogg, et al. 2006; Lund 2002) these studies capture some of the full picture of family medicine residency training – the transmission of values, techniques, and knowledge that shape residents’ responses to work of becoming healers. There remains a need for more anthropological work to deepen our understanding of family medicine residency education generally and how it occurs in particular contexts. My study aims to contribute new knowledge in this area.

Study rationale

This ethnographic study is designed to collect a variety of perspectives and data on how educational experiences matter in the making of healers and the process of “becoming” in residency training. As an ethnographic investigation of a family medicine residency program, the study will be focused on the experiences of the processes of joining and acquiring the techniques, values, and knowledge of family medicine in order to fulfill a particular culturally-defined role in society. An anthropologically-informed approach to medical education, particularly residency training, sheds light on the lived experiences of residents, the history of the specialty as it impacts learning, the processes of socialization and professionalization, and the ways in which healing is understood and embodied in my fieldsite. This topic is of importance not only to the

anthropology of healers – in the making and fulfilling of certain key social roles – but also to American medicine – in understanding the place of patient management and the impact of family medicine’s approach in health and illness on the broader American healthcare landscape. Based on these important factors, I will investigate the particularly cultural ways in which healing occurs and healers are made in my fieldsite.

Studying these issues is especially timely as primary care specialties envision themselves becoming increasingly more important (Boyd, et al. 2010; Gore 2011; Safran, et al. 1998; Starfield 1998; Starfield, et al. 2005). We are approaching an era of population managed healthcare (Basu, et al. 2004; Gold, et al. 1996) – wherein a doctor manages entire patient populations at once, looking for patterns within. The role of the primary care physician, especially as an agent of coordinated care (Bodenheimer 2008; Boyd, et al. 2010), is central to the success of the American healthcare model. These physicians see their expertise as crucial to patients in navigating the system and delivering effective care (Bach and Kocher 2011; Martin, et al. 2004; Boulton and Wieland 2010; Peikes, et al 2009). Better understanding how physicians learn to embody their role will better inform our interfacing with the changing landscape of American medicine.

Description of study chapters

Chapter 1 contextualizes the research problem in wider conversations in anthropology and medical education. I outline the “making of healers” as a time-honored focus of anthropology, applying it to the biomedical arena by linking it to the training of family medicine physicians. I discuss relevant literature in medical anthropology, the history of medicine and medical education, to provide the important conceptual ideas that helped to structure the overall project. Chapter 2 explains how I will employ practice

theory overall and its specific elements in studying the “making of healers” in this residency training program. Chapter 3 provides a thick ethnographic description of the research setting, an overview of the educational process, specific key places within the setting, and types of activities that occur in residency training. I also outline the public image of the program and provide an overview of the educational process. Chapter 4 outlines the methodology and details the structure of the fourteen months spent conducting fieldwork. I outline the types of participants involved in the research. I situate the residency program in time and space, by detailing how residency training unfolds over three years in an “ideal” state. I also reflect on my own positionality.

Chapter 5 describes the formalized the orientation of new residents. This beginning sets the stage for the three training years to follow. Chapter 6 explores the exposure to and taking on by residents of key dispositions of the particular habitus, through the concept of “learning by doing”. Residents acquire more skills and knowledge, and begin to embody the broader disposition of a family medicine physician. Chapter 7 provides case studies designed to provide specific understanding of some key learning experiences encountered by residents and faculty. Residents are shown experiencing the kinds of dispositions and “learning by doing” as detailed in Chapter 6. Chapter 8 documents the kinds of demonstrative processes the residents are exposed to in the inpatient service, through the use of “bedside rounds”. This chapter continues the discussion from Chapter 7 by more-directly addressing local healing discourses and practices – has the healer finally been made? Chapter 9 concludes the dissertation by drawing formal conclusions, using the findings to engage directly with the literature on the making of healers, and outline directions for future research and inquiry.

CHAPTER 2

THEORY

Practice theory and its components

As a theoretical framework, practice theory offers a number of key concepts to explore the making of healers in family medicine residency training. These concepts allow me to draw together the social history of family medicine, tenets of medical education, and specific training episodes of training observed to make sense of the process by which healers are made in this family medicine residency training program. As indicated, the fieldsite is nested within a set of larger social structures – within the specialty of family medicine, the broader conversations of U.S. biomedicine, and the overall place of healthcare in American society.

Practice theory lends itself particularly well to studying the professional education and socialization of family medicine residents, there is a history of this conceptual approach being successfully applied in educational and medical settings (Sinclair 1997; Nash 1990; Kirschner & Lachicotte 2001; Brosnan 2010; Sullivan 2002). Seeds of practice theory can be traced back to the work of Emile Durkheim, who established the basic premises that would be incorporated into the theory. Social facts, Durkheim (1994 [1895]) argues – the currency of the social realm into which a person is socialized – are shared, explained, imitated, and learned. They are “ways of acting, thinking, and feeling, external to the individual” (ibid: 86) and designed to bound individual behavior into modes of behavior acceptable to the social order of the socializing group. Importantly, these social facts carry culturally-contextual and -constructed meaning; “behind every social fact there is a history, tradition, language and customs” (Mauss 1979). In thinking

about how to apply these ideas to the present case, I considered how I would look for these “social facts”. These facts include the techniques, values, and knowledge that residents are expected to acquire, as well as the social interactions residents and faculty have and the meaning made around the practices of medicine and learning healing. These facts emerge through both formal education and informal interactions and discussion – all within the historical and structural context of present-day family medicine.

Moving forward, Durkheim’s work was expounded upon by Marcel Mauss, and operationalized further by the work of Pierre Bourdieu. Mauss (2007 [1973]) argues, it is only within the particular social context that these social facts have meaning and are effective (55). The knowledge possessed by a group – be it a family, a team, or a vocation – exists not only as a shared set of techniques and values, steeped in the particular history of that social setting (social structures and cultural contexts) but serves to acculturate new members. Essential to this process is what Mauss calls “prestigious imitation” (54), wherein learning is through observation and repetition – and the prestige of the person educating lends weight and value to the lessons learned. In fact, this prestige helps inspire the learning in the first place, establishing expectations to take on certain techniques, knowledge, and values. The approach to education therefore must be traditional, rooted in the socially-recognized process of teaching, and come from a position of authority, Mauss reasons, in order to be effective. This transmission is impossible in the absence of tradition; the traditions themselves are in need of a particular traditional weight in order to be transmitted (56). Therefore, while the techniques of education are important, at the same time there are particular cultural

values imparted with the knowledge. In addition, to be considered are the actors themselves – in this case, the residents, who come to their own understandings and thereby, making their own meanings around their education and training. Following the ideas of Mauss (1973), the same holds true whether one investigates the socialization of children into a family, a swimmer learning to compete, or the recent medical school graduate joining a residency program.

In his survey of sociological perspectives on medical education, Emmerich (2013) outlines the ways in which Mauss and Bourdieu have contributed to our understanding of the making new physicians. He details how new members, with the assistance of existing members become socialized, enculturated and eventually incorporated into a professional setting (Emmerich 2013: 30). These processes involve the formal and informal transmission of contextually-appropriate knowledge, techniques, and values, as well as an assuming of increased responsibility. In this setting, I will explore how faculty mentors, senior residents and possibly others must hold the appropriate prestige to transmit knowledge and act as guides through the process of becoming healers that is the basis of resident training. Of further interest is how those involved attribute meaning to and make sense of this transmission and the attendant processes of enculturation, socialization, and professionalization. The goal of this project then is to observe and describe the making of healers in context, measurable through the taking-on and acting-out of culturally-constituted dispositions (Bourdieu 1977) and behaviors.

I will now outline the basic components of Bourdieu's theory of practice, defining terminology and discussing how these ideas have been applied by others and are

applied in the present study. “Habitus” is defined as a set of culturally-constituted attitudes, ideas, and beliefs, that “generate practice” (Nash 1990) are often taken for granted by those operating within the social setting. The concept of habitus can be used to explain how cultural experiences manifest themselves, structuring tastes, perceptions and aspirations. It is a learned set of “dispositions”, skills and ways of acting, acquired through the behaviors and experiences of everyday life (Bourdieu 1990). Habitus refers to “a system of embodied dispositions which generate practice in accordance with the structured principles of the social world” (Nash 1990: 433). Habitus is created around a particular culturally-important activity, such as resident education in the present case. Though often depicted as unconscious in nature, habitus is also discursive. Those engaging with one another within a particular habitus will discuss, reflect, and negotiate meaning around the behaviors, values, and dispositions therein. This discourse is one focus of the present study.

Habitus is also a product of history – it should be viewed as longitudinal and pervasive (Emmerich 2013). In this case, these ideas relate to the history of a particular medical specialty and its positionality in biomedicine as well as the larger American sociopolitical environment. Habitus represents a set of individual and collective practices, which themselves have a broader history. In the present case, the habitus of a family medicine residency program will stand as a set of behaviors, steeped in the knowledge, techniques, and values of the professional setting, to be passed from one set of doctors (faculty) to another (residents); understood and interpreted by the residents themselves and steeped within the historical context American biomedicine.

The traditions of a particular habitus suggest an overarching structure to the making of new social actors there. This is an important point to consider in thinking about the processual nature of family medicine residency training and how one learns about becoming a healer. “In every society, everyone knows and has to know and learn what he has to do in all conditions” (Mauss 1973). Individuals are not entirely structure-bound, however, but are deliberate actors in their own social learning. The learners and teachers possess a certain agency in making meaning and taking on of their intended roles. This tension between structure and agency is pervasive in the literature of applying practice theory to educational settings. While Bourdieu himself argued that habitus addresses this fundamental problem – do persons within a social structure hold agency over their decisions and actions (Sullivan 2002: 150) – others disagree (Nash 1990; King 2000). Notably, philosopher and sociologist Anthony King (2000) argues that habitus actually reinforces the notion of structure, that the “mode of operating” is pervasive and inescapable (422). Essentially, King critiques, habitus is treated as an objective “structuring structure” – the role of objective behavior molded by a Levi-Straussian form of structuralism. In other words, there is lacking a sense of subjective role of the social structure, meaning-making and agency. The present study was undertaken with this critique in mind, looking for ways in which *in situ* residents and faculty are actively determining their own understanding and meaning of the work they undertake. Are residents and faculty members able to interpret the habitus for themselves or does the social structure force a particular outcome and sense-making?

As indicated above, habitus is a theory of socialization. There are knowledge, techniques, and values that are passed through education – formal or otherwise – that

humans must learn as part of their society. The process leads to a particular type of “becoming”, pointing cultural actors towards the important techniques, knowledge, and values they must take on in order to successfully move through the educational process, to become that which the habitus is designed to make. Bourdieu refers to “forms of capital”, defined as resources possessed and exchanged by individuals, that lead to an emergent, collective habitus, within a given social setting (Bourdieu 1983). Through teaching the cultural norms of the particular habitus and conveying forms of capital new techniques, knowledge, and values are brought to the learners. The result is a dynamic creation of a particular occupational culture and the acculturation of new members. However, the concept of habitus and the particular culturally-important activities it signifies, must be operationalized in order to efficiently observe and describe within the present study. To operationalize the concept of habitus, three narrower concepts will now be outlined: field, capital, and disposition.

Broadly speaking, a “field” is the social setting and context in which persons interact for a particular reason. The professional setting acts as a field, structuring the transmission and acquisition of all forms of knowledge, as well as the ways in which members enact their habitus through dispositions. Both are relational and linked through the medium of capital. In the present case, the field is a residency program with its social landscape of interactions between educators and learners, structured by the broader social forces of the discipline of family medicine, the beliefs and values of Western biomedicine, and the needs and associated expectations of American society. These include the social and economic realities that shape the delivery of healthcare. The individuals in the field have and exchange forms of “capital” within a “field” that is

more than a physical setting, it is steeped in the historical and social structures that define a profession in context. Next I must consider ways of acquiring particular types of “capital”, whether this “taking on” occurs or not, and how these relate to the processes of making healers in my fieldsite.

Capital is the social “currency” that signifies the mastery of a particular cultural activity. These include numerous forms: cultural, social and symbolic capital. Social capital is defined as those resources based on connections and group memberships (Bourdieu 1977). Cultural capital involves information and knowledge accumulated through the educational process. Symbolic capital is the value or weight placed on social and cultural capital – perceived and recognized as legitimate, prioritized forms of prestige and status, culturally defined as “being worthy of being pursued and preserved” (ibid: 182). The practice of interacting leads to an exchange of capital in a particular field, making the world in which they interact, creating a set of norms and practices, a “natural order” (Erickson and Murphy 1998: 143). The accumulation of capital occurs through the transmission and assimilation of knowledge, techniques, and values. With capital, it is postulated, come changes in behavioral dispositions that more match the general definition of ‘correctness’ within the given field. Through prestigious imitation, the accumulation of capital, and other formal and informal experiences of education, residents’ behavior should come to more closely resemble that of their educators.

Finally, dispositions are, in Bourdieu’s words, “structured structures” (1977: 72) that work to mold practices, the external expression and behaviors as guided by one’s habitus. Dispositions are held and expressed by individuals; a person’s expression of the particular habitus. They are the momentary embodiment of the habitus, the

demonstration of accumulated history, personal distinctions, and amassed capital. Bourdieu theorized that humans acquire dispositions throughout their lives, but take on fundamental dispositions in early childhood, that guide and mold experiences through life. In the work environment, new dispositions can develop as an outcome of socialization and professionalization to an occupational habitus and set of cultural norms in the given setting. Dispositions, like habitus, are historical and culturally- and socially-contextual products (Sinclair 1997). Identifying and documenting dispositions will reveal a great deal about the habitus in which they occur; uncovering the structural and historical factors in their production sheds light on the source and the influence of the larger context on the smaller habitus of a particular group.

In summary, forms of capital are resources possessed and exchanged by individuals, fueling the behaviors that represent the dispositions that make up the particular habitus, all within a given field (Bourdieu 1983). Following the work of Mauss (1973) and Bourdieu (1977; 1983; 1990), identifying and describing a number of key features of this educational habitus are a central focus of this study. These include a number of factors: 1) the field where education and training take place (its features, characteristics, broader social structural contexts); 2) the capital that is exchanged, negotiated, and interpreted (values, techniques, and knowledge that are shared and learned and how value is given and contested); 3) the dispositions of those involved (the outward expression of internal values, ideas, and culture that influence and are influenced by processes of socialization and professionalization); and finally, 4) the creation of habitus (how these factors all work together to form a cultural universe in which training and education of family medicine residents take place).

Application of practice theory to the present study

The making of healers involves the accumulation of specific experiences and accompanying capital, through ongoing exposure to the field and habitus, and interactions with others within the field. It is a process of professional socialization wherein the normative behaviors and attitudes are embodied in the apprentice, as expected by the master. However, it is also a form of enculturation, wherein the apprentice comes to not only act, but to think and see the world in a particular cultural way. The residents acquire symbolic capital through taking on and demonstrating dispositions appropriately, a form of practical mastery (ibid). I examine the process of “becoming” healers in action in the fieldsite, through attention to the exchange of capital and taking on of dispositions within the field.

In “Reproduction in Education, Society and Culture”, Bourdieu and Passeron (1990) outline the role of teachers and schools in the reproduction of culture. The authority of teachers is the basis for claims to knowledge in the education system; it is an institution wherein the symbolic capital of the master leads them to be hierarchical above the apprentice and lend significance to the instructional lessons they are undertaking. Further, relationship between and among masters and apprentices engender complex social relations that influence learning on a daily basis. Again, returning to Emmerich’s (2013) analysis of the sociology of medical education, residency training is part of the “(re)production of medical habitus” (30), reinforcing the social structure and social order of medical practice through virtue of the authority of those faculty charged with educating the next generation of physicians. However, educational success, Bourdieu and Passeron assert, entail a range of cultural behaviors

– including dress, physical bearing, and ways of talking – that I contend may change through individual and group agency across groups of learners. Attending to these complexities can help uncover a range of forms of capital being exchanged.

Understanding the process of transmitting and receiving capital is not necessarily straightforward. Complexity of social agency and individual actors leads to the possibility of what Bourdieu refers as “the hysteresis effect” (Kirschner and Lachicotte 2001). Hysteresis is the word Bourdieu uses to describe the potential tensions that arise from conflicting dispositions (Emmerich 2013: 27). One can change the social order of things, but without becoming something new, behaviors of new members will not match the expectations of established ones. A person is not a blank slate upon which a new set of cultural ideas, values, and ways of being are overlaid. Residents come with a set of skills and values from medical school, and presuppositions about residency training. Hysteresis, in Bourdieu’s use of the term, means an effect that continues to linger although the cause has disappeared. Socially, people feel comfortable in the social world into which they have been socialized. When the social world, or field, changes people will continue to navigate and behave according to their normative patterns. In the case of newly-hired residents, expectations are introduced that differ from medical school expectations. Making the transition to these new expectations will be a departure and mark the stages of becoming something new.

Regardless of the outcome, hysteresis suggests something significant in the making of healers, one that may point to the agency of apprentices in the learning habitus. There may exist tensions between contradictory and conflicting ways of being, dispositions, and expectations. Residents possess their own ideas about what it means

to be a resident. Faculty members will certainly have expectations that may or may not conform to residents' presuppositions. I will explore the training of family medicine residents with an eye towards identify and describing these tensions as they learn to be healers in family medicine.

Finally, power is a critical component underlying the factors that make up practice theory. The exercise of power between and among the physicians in the making of new family medicine doctors will be explored. As a microcosm of society, residency education is taken to be a social system. The social system "is powerfully constraining" and yet "the system can be made and unmade through human action and interaction" (Ortner 1984: 159). Within the educational environments, power can be expected to be exercised towards both shaping the actions of residents, yet also shaping their response to expectations. Residents may contest the power being exercised over their actions to varying degrees and in varying ways. Attending to both hierarchical and lateral power relationships will help better describe how residents interact with family medicine attending physicians, other residents, patients and others they encounter during this training phase.

Science philosopher, Joseph Rouse (2007), explores notions of power in practice theory through investigations of social scientists as a body of social actors, who make decisions and meaning around the pursuit of specialized knowledge. Power, he says, "expresses how one action affects the situation in which other actions occur, so as to reconfigure what is at issue and at stake for the relevant actors" (Rouse 2007: 533). He contends that power exists in both discourse and practice, molding local idioms of what constitutes knowledge and appropriate behaviors in the pursuit of scientific findings.

Power helps define appropriate choices, discourse, and behavior. I will attend to this dynamic in investigating power relationships among the physicians in Suburban's residency training.

Randall Ford (2006) applied practice theory and the use of power to his study of organizational learning in hospital management. He focused on the political positions of some members of an organization to exercise power over those beneath them in the social hierarchy, yet also found considerable empowerment of those throughout the hierarchy by virtue of their social networks. The relationships helped cement power by mobilizing resources during crises and maintaining more open dialogues to address problems in the social environment. The openness of the interactions led to trust, which empowered joint decision-making and delegating authority.

I anticipate a number of key power dynamics to emerge in the field, appearing in both hierarchical and lateral patterns. The most obvious would be the power mentors exercise over their mentees. Established through seeking employment, the rigorous requirement for board certification prior to autonomous practice, and the expectations placed during training, residents will be formally positioned subordinately to their mentors. Who those mentors are (e.g., faculty, other residents, other social actors) and how is power manifested in the residency training merit further exploration. I will also be attentive of ways in which residents may contest the power of their faculty mentors.

Patterns between and among the resident physicians themselves also matter. Residents will be undergoing a process of professional socialization towards competency and autonomy. Increased sense of their own agency, coming with the

accumulated symbolic capital of residency training, may change power dynamics over the course of their three-year training cycle.

Finally, while not the central focus of this study, the power dynamics between the physicians and patients matter, given the respective expectations of patients and physicians in the treatment of disease. Where patients seek help from medical experts, and yet are experts in their own lived experiences, I anticipate contestations of power, reliance on authoritarian models of healthcare delivery, and resistance from patients to this model.

In summary, the making of healers will likely involve repetition of embodied behaviors, combined with ever-present expectations and threats of discipline, with appropriate displays of symbolic capital and the exercise of power. However, practice theory shows how social and personal history, resistance, and agency factor into learning. Residents are not passive learners; they make sense of the techniques, values, and knowledge to which they are exposed and contest and reinforce local forms of power. The residents will take on specific dispositions in the habitus, representing the embodied expression of the skills, values, and knowledge of family medicine physicians. Becoming family medicine doctors will certainly involve residents engaging with definitions of healing, taking on the expected dispositions, questioning the expectations being placed on them, and engaging with the power hierarchy in the social setting.

CHAPTER 3

STUDY SETTING

As described in Chapter 2, the field is the social context in which people enact the particular dispositions of a given group. In other words, the field includes the physical setting, but is also something more than that. The professional setting of residency acts to structure the educational experiences of residents. The description that follows will consequently detail the physical site selection but also consider the residency setting in broader terms. This chapter describes (1) the selection of a research site, (2) the metropolitan area, suburban city, and community where the hospital and residency program are located, and (3) descriptions of various key places, important in the educational process of residents. Finally, I will describe the nature of the educational processes of residency, setting the stage for the chapters to follow. The goal is to provide not only a description of the spatial setting but to include the social and education contexts and processes in which learning and training – the transmission of capital – took place. The intent is to provide the reader a sense of the fieldwork setting, ethnographer's background, and overall context for the study's findings. All identifying names have been changed to preserve the confidentiality of participants.

Site selection

In considering where to conduct my dissertation research, I sought to find a family medicine residency training program where I was not familiar with the specifics of the program or its day-to-day social order. Though having been previously employed as a behavioral scientist with a family medicine residency program in the same metropolitan region of the United States (Urban Hospital), it was clear that I needed to

find a new and separate residency program in order to preserve a sense of being an ethnographic outsider. This intentional process of choosing a different family medicine residency training program would allow for clearer insight through firsthand, new experiences, and also comparison with my prior employer Urban Hospital's family medicine residency program.

The broader metropolitan area has no shortage of medical centers, with as many as a dozen residency training programs in family medicine. In seeking a program for this study, I was interested in a program with numerous residents that would provide me with largely unfettered access to the spaces and people involved in training. Most family medicine residency programs employ between 20 and 30 residents at any given time, therefore a key selection criteria became which program would allow me good access.

I approached five different residency programs. Four of the program hesitated and ultimately declined to grant me access. I was told it would not work "at this time" or that the program could not "support a research project" – a statement I was not able to get full clarity on. One program was still in its infancy, and another was undergoing a major restructuring; both intriguing prospects for an anthropologist interesting in the structure of teaching and learning in residency. However, both politely declined. In reflecting back, I had to use cold calls to contact these residency programs, without knowing anyone affiliated with the program. This fact may explain the hesitancy I encountered. I needed an introduction, someone to vouch for me, in order to gain access.

How I came to work with Suburban Hospital's family medicine residency program is the result of an unlikely synchronicity. My daughter needed a school physical. I had

recently switched insurance providers and did not have a physician for her. I chose her new physician almost at random from the list approved by my insurance company. The doctor I chose happened to be a family medicine physician. More importantly, as I would later discover, she happened to be a graduate of Suburban Hospital's family medicine residency program. At my daughter's appointment, I cannot remember what inspired my uncharacteristic offering-up of my research interests, but this physician seemed excited about my ideas. To my surprise, my daughter's physician encouraged me to contact the program. She claimed the department was very open and inviting and remembered her time there as a resident fondly. This doctor offered that I should contact the program director via email and mention my daughter's new physician by her name. I sent the email and heard back from the program director, Dr. Hedges, within a couple of days. Dr. Hedges was intrigued by my desire to conduct my dissertation research in the department and put me in contact with one of her faculty members, Dr. Douglas, who also happened to have a background in anthropology; a second coincidence that proved invaluable.

Dr. Douglas, a family physician and faculty member at Suburban, with a background in anthropology, was serving in a role similar to my own prior work at Urban Hospital. For this reason, when we met, I began by touching on that common ground – our shared work in behavioral science – and the discussion then expanded into our shared interest in anthropology. I was able to display my own cultural and symbolic capital in being cognizant of the realities of residency life. I could also talk about the ways in which I envisioned an ethnographic research project successfully interfacing with residency work. By the end of this first meeting, I felt confident about this setting

being a viable fieldsite for my research. Over time, this faculty member became a useful informant during my fieldwork in the residency program. She often made herself available to me to answer questions and help clarify my understandings of the department's approach to resident education. She also understood the nature of anthropological research. I feel that without her endorsement I may not have gotten this project off the ground (at least not at this location).

Dr. Douglas and I met two more times resulting in my being invited to a faculty meeting. I was asked to give a brief presentation on my project and what it would mean to conduct ethnographic fieldwork in this setting. By now I had received the support of my first informant, as well as the program director via Dr. Douglas's endorsement. Through my presentation, I now also received the support of the broader faculty. Shortly thereafter I gave a similar presentation to the residents who also gave their consent, in general, to the project. At this point, the program was willing to host me; more specific consent was later also gained individual by individual, as directed by the policies of the IRB and the ethics of research.

I had concerns that early on my close identification with Dr. Douglas and Dr. Hedges would lead residents to distrust me, and I was wary against being "paired" with any faculty member too closely. I did not want to be perceived as coercive, using faculty to obtain resident buy-in. Due to this concern, I asked faculty not to be there during my presentation of my project to the residents. I strove to position myself as someone who understands and empathizes with family medicine and residency training in general, and also as a competent fieldworker who knows how to design and undertake a

research project. I also took care to explain how my project was designed not to interfere with the work of residency as much as possible.

What resulted from these meetings was a research partnership. I was given almost unlimited access to the site, including an identification badge with a magnetic sensor that would allow me access through otherwise locked doors throughout the hospital and medical center. In return, I assured them I would follow the ethics of research as laid out by anthropology and the IRB, and agreed to present my findings and insights about their educational processes to the research participants at some point in the future.

Community description

Suburban Hospital is located in a suburban city less than ten miles outside “Central City”, a large Midwestern urban metropolis. In the 2010 U.S. Census¹, Central City was ranked, by population, as one of the largest 20 cities within in the U.S. This population, estimated at approximately 700,000 has been on a steady decline, as a result of a declining economy. Recent years have seen Central City greatly affected by an unemployment crisis, an ongoing weak economy, national housing market collapse and resulting foreclosure crisis. Though efforts to revitalize the city are ongoing, the population remains low for its physical size. Central City covers nearly 140 square miles and is surrounded by an even larger metropolitan area with an estimated population of over four million people.

Metropolitan Central City is home to a large number of hospitals and medical centers, including specialized medical centers for women’s health, children, and cancer

¹ All demographic information provided, unless otherwise stated, is from the 2010 U.S. Census Report, <http://www.census.gov>.

treatment. Many of these centers serve as teaching hospitals with residency programs of their own. Suburban Hospital is located in Keystone, a suburb of Central City, covering approximately 26.3 square miles, with a population of over 71,000. Since 2000, there has been a 7.4% decline in local population, though this trend is beginning to reverse in recent years. Although Suburban Hospital employs a significant number of the city's residents, Keystone is also recognized as a business and manufacturing center with a large number of institutions of higher learning and technical training. Approximately half of its residents are employed in education, health, social services and manufacturing sections, with a median annual household income for a family of approximately \$50,000.

Keystone is a diverse ethnic community, experiencing change over the last ten years. According to the 2010 U.S. census, the number of non-Hispanic white residents is approximately 24% (~17,500) and has decreased significantly over time, while the number of African-American residents is approximately 70% (~50,000) in 2010 and continues to show increases in census estimates for 2011 to 2013. Other ethnicities represented in Keystone include Asian (1.7%; ~1200), Hispanic (1.3%; ~950), and those identifying as "Two or More Races" (2.4%; ~1750). It is worth noting that the ethnic composition of the residency program did not reflect the diversity of the local community. The physicians are predominantly non-Hispanic white, with a significant number of Asian residents and faculty members (including those from India and China). The number of African-American physicians in the Suburban Hospital family medicine department was lowest as a proportion of the whole program (2 of 14 faculty; 5 of 36 residents).

As has been written about extensively in medical anthropology, differences in ethnic background, socioeconomic differences between physicians and patients, and the variances in personal and professional experiences around health and illness, may all have profound effects on delivery of medical care and perceptions of therapeutic efficacy. These factors play into the larger field in which the habitus of residency training takes place and will be considered accordingly. That is why it was relevant to start out by documenting what were the demographics of this community and healthcare institution.

Description of educational settings

I will now describe the physical settings within Suburban Hospital itself where my data collection took place. These include places such as the medical office building, the hospital, and satellites. I will also describe some of the activities that typically take place in these settings.

Suburban Hospital is a 419 bed community teaching hospital, employing over 3400 staff members and 1500 physicians. The physician teams encompass the entire range of medical specialties, from behavioral health to oncology, emergency medicine to women's health. Suburban Hospital offers residency and fellowship training in 15 specialties. Suburban employs 160 residents across 19 residency specialty programs, including seven sub-specialty programs. The family medicine residency training program is a three-year program, employing 27 total residents, equally staged among the three years. There are 14 core faculty members, making for a high faculty/resident ratio. There are numerous other staff physicians and support staff that contribute to the work and education of the residents in the program.

Suburban Hospital displays their mission statement, vision, and values prominently around the field setting on plaques, posters, and screen savers. As a Catholic health ministry, the system is “committed to providing spiritually centered, holistic care which sustains and improves the health of individuals in the communities we serve, with special attention to the poor and vulnerable” (Suburban Hospital homepage: 2012). To what extent these factors play into the larger field and habitus is not entirely clear but will be considered accordingly later on.

Suburban Hospital’s main campus has two large buildings – the hospital and the medical office building. Most of the work done by residents and faculty members happens in these two buildings. The medical office building is an eight-story modern brick structure. Here are housed administrative offices and outpatient clinics for numerous specialties, as well as lecture halls and conference rooms. Of note for this study are the family medicine offices, the family medicine outpatient clinic, and the large meeting room used by for didactics and lectures in this specialty. These are some of the primary spaces in which my ethnographic fieldwork took place.

Administrative spaces

As a visual symbol, the core of the program is the family medicine administrative office suite. Here the department chair, program director, and residency coordinator have their offices, as well as other support staff and senior faculty members. The space itself is modern and compartmentalized. A magnetic identification badge is needed to unlock the door. The first office one comes to is that of the residency coordinator. A connected office in the back belongs to the program director, to whom the residency

coordinator directly reports². There are two conference rooms, one large one used by residents and faculty alike, and a smaller one typically reserved for more private meetings. There is a kitchen and dining area, used as a “break room”; most often I observed support staff eating lunch there.

In the large conference room, various types of meetings regularly occur³. Orientation month, the first month of training for new residents, which I will discuss in detail in the next chapter, heavily utilizes this conference room. The smaller conference room is used for more private meetings between smaller groups of faculty and residents.

Next to the large conference room is the residency coordinator and program director’s joint office. The residency coordinator’s office was often busy and over time I came to see that it serves as a central social, cultural, and even physical locus for the entire program. The role of the residency coordinator is to help faculty and residents in the day-to-day personal and bureaucratic requirements of residency training. Information regarding policy, employment issues (vacation requests, sick leave, meeting requirements), and upcoming social events flowed through the residency coordinator’s office. Importantly, communication from other departments and specialties also funnels through this office. If a resident is struggling with their performance in a surgery rotation, for example, the residency coordinator is likely among the first people in the family

² This arrangement suggests the residency coordinator serves a “gate-keeper” function.

³ Faculty members have their monthly meetings to discuss resident progress and other departmental issues. Clinic teams will use the room for team meetings to discuss issues around the day-to-day functions of the office. Staff members will conduct workshops to demonstrate minor surgical and other procedural techniques for residents. Visiting pharmaceutical representatives will use the conference room for presentations, usually accompanied by lunch.

medicine department to hear about it. In short, residents and faculty utilize this space as a hub to manage the requirements, requests and news of the training program.

Another key space for the residency training program within the same medical office building is a floor dedicated to lecture halls and large meeting rooms. In medical education, the activity that most often takes place in these rooms is called a “didactic lecture”. These lectures cover a vast range of topics, but typically involve a speaker who gives a focused presentation geared towards resident education. At this location, one half day a week is used for didactics and other informational meetings. These mornings are usually booked solid with four to six lectures or meetings, scheduled back-to-back. The chief residents also used this venue once a month for a resident forum where information is disseminated, opinions sought, and new policy communicated from the program’s faculty and administrators to the residents. Though there is a lot going on in these meetings, it was clear that the residents also used their time in these spaces to socialize and connect, and catch up with one another on a personal level.

The lecture space itself involves two rooms. The first is a large room with a series of tables in the middle set up in a rectangular formation. Interestingly, presenters sometimes chose to lecture from inside this box-like arrangement. A large screen used for projecting lecture material is on one end of the room. All told, this room can comfortably accommodate thirty or more people for a lecture, though there were seldom that many in attendance. The second room is immediately next to this one and is considerably smaller, providing a more private meeting space for fewer people. This room holds one long table in the middle with chairs on both sides. This room was most often used for smaller meetings of outpatient clinic teams, interns for their support

group, or one-on-one meetings between residents and faculty members. I also used the room many times for conducting interviews. In summary, the medical office building is used for administrative functions, for residents to check in with the residency coordinator, faculty, and program director, for lectures and didactics on various medical topics, and hands-on workshops in procedures. There are team meetings for clinic performance improvement and career planning, as well as behavioral medicine and resident wellness. In addition, informal activities like lunches and celebrations for birthdays and other events take place here. Central to the discussion in Chapter 5, the first week of orientation takes place entirely within these offices.

Hospital spaces

The Hospital is a seven-story modern brick building. It is connected to the medical office building via permanent hallways on the first floor and basement. The floors of the hospital are divided by major specialty, though family medicine's role and usage is a little different than most. Patients are typically admitted to the hospital and assigned to the specialty floor most able to care for their needs. Family medicine does not maintain a floor or wing to itself but rather their patients are scattered throughout the hospital in the various general medicine wards across numerous floors. Thus residents in family medicine must move around the hospital seeing patients and often working at computers in the large nurses stations on each floor.

Most inpatient rounding teams make use of a "call room" where they can meet, work, and sleep during long shifts. Typically, these rooms include a computer or two, a small television, a small refrigerator, a conference table and a couch for relaxing and sleeping, when time permits. After the first three months of my fieldwork, the family

medicine call room was closed for renovations. This began a semi-nomadic life for the family medicine team. For six months, the team used the librarian's lounge in the hospital library for their call room. On months where the inpatient team was large – for example, during orientation month, when new interns are paired with experienced former interns – the room was often cramped and meetings could not happen there. In this case, other conference rooms around the hospital had to be utilized. More than once I noticed a savvy chief resident pull out a list of available rooms and the schedule of when these rooms were occupied by other groups in search of a meeting place. Shortly before the end of my fieldwork, the renovations on the call room were complete.

As indicated, the family medicine inpatient service at Suburban Hospital is dispersed throughout numbers floors of the hospital. The 15 to 20 patients under the care of family medicine may be spread out across four or five floors of the hospital, requiring frequent visits to different halls and levels. The language use around these terms to indicate where family medicine personnel are working at any given time is somewhat intriguing. Physicians are “on the floor” when they're working the inpatient service: “Where is Dr. Douglas?” – “Oh, she's on the floor this week.” Likewise, they question each other, “how many patients do we have on the floor?”. Being “on the floor” simply means working in (healthcare providers) or being admitted to (patients) the hospital. Finally, the inpatient service is considered “the floor”, when in practice family medicine is spread across numerous floors in the hospital.

Clinical spaces

The residency program also utilizes a number of other clinic and satellite spaces where residents and faculty see patients. Each month, regardless of the rotation a

resident is on, they are each expected to spend at least one half-day a week seeing patients in the Suburban Family Medicine clinical settings. Each faculty member is expected to maintain his or her own clinical practice as well. Approximately two-thirds of the residents and faculty maintain their clinical practices at the clinic at the main campus, with the other one-third seeing patients at a second clinic off site. I will describe each of these in turn.

Across the hall from the Family Medicine Administrative Offices is the first of two family medicine clinics. The waiting room is large with room to seat twenty or more patients. The clinic consists of three long hallways, forming a “C” shaped corridor. There is a locked door at each end, which requires an identification badge to open. There are four offices, assigned for faculty use; two or three faculty members share each office. These offices are used as a “home base” for faculty members while seeing patients or attending to other work. The rooms between each set of corner offices are used for seeing patients. On the interior of the circle are the nurses’ stations, appointment desk, and a pair of rooms used as resident offices and for precepting, a process where residents and faculty mentors discuss patients and reach diagnosis and treatment decisions. These two rooms used by the residents were shaped like galleys with a long table on each wall, divided into named stations for each resident. There was space for laptop computers that the residents checked out and used during their clinic sessions.

Suburban Hospital is part of a large network of hospitals and clinics spread across the Metropolitan Area. Approximately twenty-five miles from the Suburban Hospital main campus, is the second of two clinics utilized by residents and faculty for seeing patients on an outpatient basis. This clinic is situated in an almost rural town

surrounded by farm land. It is located in a downtown space consisting of a few blocks of buildings around a main intersection. The clinic itself is housed within a large office-style building. The waiting room is spacious and modern. Gaining access to this clinic space required I inform the front desk personnel of who I was and why I was there. I was then told to enter and given directions to the residents' call room. By contrast with the main campus, no pass was needed to unlock the door; it was always unlocked.

The clinic space was similarly laid out to the other clinic, based on a large square with patient rooms located around the outer ring. Faculty also had a similar office sharing arrangement. Here the residents' call room was large and square, with a ring of table space around the outside and a large island in the center. Tables were again divided for resident use, with similar amenities to the main campus version. The entire western wall was a large window, with a view of the street, giving the entire space an open, illuminated feel – versus the closed, almost cramped space at the other clinic. This room was likewise used for precepting and for residents to work on patient reports and needs.

On numerous occasions, many residents asserted how different these two clinics are, how the experiences of working at each are worlds apart. Anecdotally, there was discussion of a range of patient and staffing issues. On the patient side for example, demographic differences of the patients at each clinic were frequently discussed. On the staffing side, there was a more fluid and less predictable month to month scheduling of residents was at the rural clinic. Having fewer residents and faculty assigned at the rural space and a different kind of physical environment there also seemed to contribute to these varying perceptions of the residents about working in these different clinics.

It is vital to consider what spaces are used for the key “precepting” educational activity. “Precepting” is a requirement of medical education where physicians are treating patients in a clinic without themselves being board-certified. They require oversight from a board-certified physician, in this case a faculty member, whose job it is to oversee the care being given, check the soundness of the medical plan the resident is designing for the patient, and teach the resident “in the moment” with real patient situations. Typically, at least one (often more) faculty member is assigned to “precept” at any time of the day when residents are seeing patients in clinic. While precepting, these faculty members occupy the residents’ group office in each clinic – as opposed to working in their private office – providing easy and ongoing contact between residents and preceptors.

The clinic space where “precepting” occurs is formally used to see patients. However, less formally, a great deal of paperwork and “catching up” is done in the offices, as well as a lot of socialization and professional discussion. Residents have individual stations, which serve as miniature offices, often decorated with family photos and friendly notes from their fellow residents. This backdrop serves as the setting for the learning that takes place – the group working environments encouraging a particular style of interaction and education, as will be made clear in the chapters that follow. However, it also serves the locus of professional socialization as concerns the clinical practice of family medicine physicians.

Faculty members and physician assistants maintain their own practices here alongside the residents. Both resident and faculty physicians have a caseload of patients assigned to them. Typically, patients have a primary care physician (PCP) as

assigned by their insurance provider. The faculty and residents form mixed teams to coordinator care when a patient's primary care doctor is not in the office. Teams consist of senior faculty, junior faculty, and residents at various stages of their training; as well as medical assistants and nursing staff. This creates, in effect, practice groups within the larger program that can share patient load and cover patient needs when someone is away from work, by providing a smaller group of medical professionals to better connect with patients and meet their needs. The goal is to provide answers to questions, follow-up information, and prescription refills to patients when they call, rather than having to wait for the single physician to get back to them.

Public image of the program

To characterize this family medicine residency program, I examined both how the program viewed itself and how it was viewed by other external sources. I describe the public face and status of the program as compared to other residency programs nationally and statewide, addressing the demographics of the program and its residents.

Significant public information was available about Suburban Family Medicine, both from its own website, the National Resident Matching Program (NRMP: 2016) website, and consumer reports (Residency Navigator: 2016) created and maintained by U.S. News and World Report. Combined with my own observational data, these sources provide insight into the demographics, rankings, and board certification rates of graduates. Cultural statements of the program's identity were obtained from program and hospital websites to help further describe and characterize the program.

Founded in 1976, Suburban's family medicine residency program was established within seven years of the official recognition of family medicine as a

specialty (Suburban Family Medicine website). Suburban Family Medicine has consistently matched and filled all available intern positions over the last five years (NMRP Program Results 2016); most family medicine residency programs in the state have performed similarly. Further, in 2015, family medicine residencies statewide had the second highest number of residents among all residency programs with 139 filled positions. Internal medicine was highest among all specialties with 323 residents statewide (NMRP Main Residency Match Rates by State: 2016).

Comparing family medicine residencies across the state, Suburban ranks second in terms of the percentage of residents subspecializing in medical practices that are part of family medicine (e.g. sports medicine, obstetrics) (Residency Navigator: 2016). It ranked sixth in terms of size statewide, with 27 residents total. The largest programs contained up to 39 residents, with some of the smallest containing only 18 residents. This spread places Suburban as a mid-sized program as compared to the other family medicine residency programs in the state (Residency Navigator: 2016). Suburban did not rank in the top ten in terms of successful board certification, with a first-time pass rate of 83%. The top program in the state had a pass rate of 96% (Residency Navigator 2016). This percentage means that in any given year, one or two third-year residents will not pass the board exams on their first attempt (out of 9). This was not seen as problematic in the fieldsite, as residents are permitted additional chances to take the board certification exam and none failed to pass on the second attempt.

The Residency Navigator website (residency.doximity.com), developed and supported by U.S. News and World Report, provides a search engine for residency programs by specialty nationwide, by region, and by state. This consumer reports

website developed a rubric to measure reputation by surveying over 38,000 U.S. physicians and mining reports of employment and career paths of over 700,000 U.S. residency program graduates. "Reputation" was defined as "statistically weighted to produce reputation values that represent the opinions of all survey-eligible participants". Of the available information on this service, limited to the top ten residency programs in each specialty and state, Suburban Family Medicine did not rank in the top ten.

Interestingly, Urban Hospital's family medicine residency program, where I was previously employed, ranked eighth overall. This difference in reputation suggests a comparison between the scores of Suburban and Urban Hospitals, and the way physicians at Urban characterized Suburban during my time working with Urban Family Medicine. Each year, the residency match is a lengthy process of interviewing candidates, ranking them by preference, with candidates ranking their top program choices, and relying on the National Resident Matching Program to assign residents to programs. The choices of a program and a candidate certainly do not always match. While working at Urban Hospital, we found that top choices for candidates, as selected by the residency program, often selected other residency programs as their top choices. As a result, Urban's top choices did not come to Urban Family Medicine for training. It was commonplace in my three years of helping hire residents to have none of the top ten candidates chose to come to Urban's program (Residency Program Director, personal communication: 2008). Match placement information is publicly available, and I found that often the top ranked candidates from Urban's list accepted positions at Suburban's program. The department and program leadership at Urban Hospital would comment that Suburban would steal all the best candidates (ibid). This led to

discussions about the quality of Suburban's program and suggestions that may explain the issue.

Despite Urban's program actually being higher ranked in reputation, Suburban was characterized by physicians at Urban as a "better program," though without clear evidence to explain why. An additional issue is suggested by the pseudonyms chosen for each program. Urban medicine was a key feature of the interview process at Urban Hospital; assessing candidates desire to work with urban populations. A service to the urban, lower income neighborhoods was part of the social justice mission of Urban Family Medicine. Suburban Family Medicine is situated in the suburbs. Perhaps concerns over living environment, particulars of the patient population, or personal desire to work in less urban areas steered residents away from Urban Hospital. Regardless, the Urban program "lost" many of its "best candidates" to Suburban, filling their ranks with candidates considered less desirable – either because of academic performance or a sense of "fitting in well" with the program – than those higher on the list (ibid). The reputation of Suburban Family Medicine as reflected in personal communications does not fully conform to the reputation as seen on the consumer website.

In exploring the public face of Suburban Family Medicine, I first turned to where perspective applicants are likely to turn – the department's website. In exploring Suburban's larger website, I found Family Medicine to have three different web pages outlining their program. Two of these were internal to Suburban: an information page outlining the program within the larger hospital site and a residency program-specific page for potential applicants. The third site was located through a web search, was

hosted outside the hospital's larger webpage, and served as an information page for current department physicians as well as potential applicants.

In general, the three websites contained similar material. All outlined how Suburban Family Medicine is a "strong academic program" for training family medicine physicians, with dual accreditation for both DO and MD physicians. Pay scales, a curriculum outline, and a link to the application page were included. These webpages did not clearly define what a "strong academic program" might look like. The third informational site was designed to provide some more specific information for applicants as well as announcements for current residents and faculty members. Some more personal information about those in the program and departmental news was listed there. Upcoming physicians' birthdays were noted, as well as announcements for upcoming exams or public events. There were biographies of current residents and faculty members, with statements about their interests and focus in family medicine. Finally, were biographies of former residents with stories about their current career status and life following residency.

Beyond the basic information that all three sites provided, showing a small glimpse of the nature of family medicine residency at Suburban, the third site puts forward an image of successful and happy residents and faculty. Everyone was smiling in pictures and stories of life-after-residency were universally success stories. The narrative and underlying suggestion is that this is a good program that successfully trains its residents, who then go on to successful careers. No mention was made of the problems, challenges, or failures of residents in their career paths, even though I came to learn more about some of these topics later on.

Three different statements, explaining Suburban Family Medicine’s approach to residency education, were identified through exploration of the program’s public web presence. If a culturally-significant activity, like residency training, defines itself in part by what it says about itself, then the fact that three different statements exist for one program may suggest a lack of clarity in their identity, similar to the concerns expressed in the broader history of family medicine as a specialty. In closer reading, these statements are similar, but there are some interesting differences.

On the general Suburban Hospital website, Family Medicine’s residency mission statement read:

Our mission is to create an excellent educational experience in a nurturing environment while providing quality comprehensive care for all of our patients. Highlights of the program include inpatient and outpatient patient-centered care, family centered maternity care, sports medicine, care of the poor, care of the elderly, international medicine (Suburban Hospital general website 2016).

This statement conforms to the values and focus of family medicine, firmly displaying its object. The statement highlights a range of activities seen in the history of family medicine. However, there are numerous words that are not defined, like “excellent”, “nurturing,” “patient-centered,” “quality,” and “comprehensive”. I later came to find that the operationalization of these terms was important in the learning experiences of residents.

On the program-specific internal website, the mission statement read:

Our mission is to foster compassionate, exceptional family physicians, through a nurturing environment, who are ready to serve the world. Highlights of the program include inpatient and outpatient-centered care, family centered maternity care, sports medicine, care of the poor, care of the elderly, international medicine (Suburban Family Medicine Residency Program internal website 2016).

This statement moves the focus from providing an educational experience to fostering new family physicians as well. The idea of being “ready to serve the world” is now highlighted here.

Finally, the external website’s mission state read:

Our philosophy: As a family physician education program we are dedicated to quality teaching and modeling in serving the health needs of the total individual - body, mind, and spirit. We do this with respect for the core values of Suburban Hospital: Service of the Poor, Reverence, Integrity, Wisdom, Creativity, and Dedication (Suburban Family Medicine external website 2016).

This statement is quite different from the other two. Intriguingly, it references “teaching and “modeling” but does not articulate much about how this is done. Importantly, we see reference to the “total individual,” harkening to the history of family medicine as a specialty focused on a whole patient approach to medical care. Finally are the core values of Suburban Hospital, these appear to relate to the hospital’s spiritual roots and faith tradition, yet these are also fully not contextualized or explained in detail.

What I found most telling came in a search of the websites of other specialties within the Suburban system. No other residency, either within the general Suburban website or on each specialty’s internal page, put forward a mission or vision statement. These areas include internal medicine, general surgery, obstetrics, podiatric surgery, orthopedic surgery, and transitional year programs; none posted a mission statement of any kind. What does this suggest? A single specialty in Suburban hospital felt the need put forward three separate mission statements, while no other specialty felt the need for even one. This fact suggests that, in keeping with the history of the specialty, the identity of family medicine still may be open and unclear to their colleagues in other specialties, to potential applicants, to the public, and perhaps even to themselves. The

multiple statements suggest that family medicine in this context operates with the sense of needing to explain themselves and defend their object, status, and privilege to be specialist physicians.

Educational overview

I will now provide a broad overview of the educational processes in medical school and family medicine residency training. This overview is designed to provide the necessary context for the data chapters that follow. The information in this overview comes from a combination of my own prior work at Urban Hospital, discussions with the program director, Dr. Hedges, and numerous interviews with residents, particularly interns who had most recently experienced the earliest parts of residency training.

While the road to becoming a physician is long and complex, I have chosen to begin this discussion where medical students first encounter the “work of being doctors” – the third and fourth years of medical school. The first two years of medical school are entirely classroom based, setting the stage for a series of “rotations” to follow during the third and fourth years. I then continue into a discussion of choosing and applying for residency programs. This material sets the stage and contextualizes a sense of where new residents are at when they begin this specialized training.

Applying for residency programs

The third and fourth years of medical school are spent doing month-long rotations in various specialties across a number of different hospitals. Oftentimes, medical students will travel considerable distances to participate in these unpaid apprenticeships. Exposure to many different specialties of medicine as well as working in different locations often helps with deciding on a direction for residency. The second

advantage of rotating heavily during one's third and fourth year is exploring the different programs to which a student may apply. Since medical students rotate with teams of residents and faculty, the student has the opportunity to get to know the program, some of the people who work there, and begin to demonstrate their capital as a potential candidate. Faculty in charge of hiring new residents will often remember that they have worked with this applicant in the past. According to the faculty of Suburban Family Medicine, these medical student experiences factor into the hiring of residents. The residents themselves admit that they focus their energy on applying to the programs where they had the best work experiences, perhaps having put their best face forward.

Applying for residency programs is, in some senses, analogous to applying for graduate school. Medical students look for the work environment, supervising physicians, type of medicine, and overall philosophy that synchs with their own goals and dreams. Residents told me that they base these ideas on word-of-mouth and internet research, but especially the personal experiences from student rotations. The number of programs a student applies to varies depending on their overall goals, interests, and desired specialties and region to live in, as well as their medical school exam results and academic record. A balance is often struck between cost incurred in traveling to interviews, the need to move, the effort it takes to apply and interview, and the likelihood of getting hired. It is considered risky to apply to not enough residency programs, and yet expensive and time consuming to apply to too many. Like graduate school, the goal is to find the program that will best prepare the new physician for their future career, with the best reputation, and to provide the best opportunities for employment in the particular specialty. Securing interviews with residency programs is

an important step, being granted interviews with a student's preferred programs is desired, and preparing for "The Match" is the end goal.

Programs evaluate applicants based on the merits, skills, service, and early exam scores. The United States Medical Licensing Examination (USMLE) is divided into three parts, or "Steps". Steps One and Two are taken during medical school: Step One at the end of the second year and Step Two during the fourth year of medical school. Step Three is taken during residency, typically during the intern year. The scores from Step One and Step Two are an important part of evaluating an applicant, though this is far from the only measure. The personal statement each applicant writes is taken into consideration too. From my prior work at Urban Hospital, as well as comments from Dr. Hedges, I know that this personal statement is evaluated from the point of view of a commitment to the specialty. In other words, by this point, the applicant needs to convey a clear sense of wanting to become a family medicine physician – to show a commitment to and at least a preliminary understanding of family medicine's "object". This first wave of decision-making is geared towards inviting applicants and is usually conducted by a subset of the faculty in a given program.

A committee is tapped to evaluate applications and decide on candidates to interview. With the right exam scores, personal statement showing a sincere interest in and commitment to family medicine, a record of excellence and service to medicine and the community, and perhaps a prior history with the residency program (during medical student rotations), a candidate is then invited for a face-to-face, day-long interview process. Candidates are selected for interviewing and then scheduled to visit the program, usually in groups of four to six applicants. During this visit, they tour the

hospital, meet with residents, and are interviewed by a committee of faculty members. Each faculty member has a period of time to meet with the applicant, one-on-one, to discuss their commitment to family medicine, their goals and personal interests, and to display why they would make a good addition to the program. The goal here is to peer into a potential future, to form an educated opinion of whether the applicant will not only perform well, but gel with the broader philosophy of the program. A final note about exam scores; sometimes, a promising candidate with a connection to the department, or a strong personal statement, may be invited to an interview despite less-than-ideal USMLE scores. This opportunity allows applicants who perhaps do not test well to provide another impression of their capabilities and skills during an interview process. The interview process can stretch out over a four month period – typically from November to February – and in the Suburban Family Medicine department, interviews occurred twice a week. Over 100 applicants were interviewed over the course of this period to fill only nine positions in the next intern year. It is worth noting that applicants often interview with many programs in the hopes of securing a position.

The final decision-making process comes in the form of “The Match” which occurs in March. Programs create a ranked list of applicants from those they are willing to hire, ranging from first choice to last choice. Applicants likewise rank the programs they most desire in order of preference. These lists are submitted to the National Resident Matching Program (NRMP), a non-profit corporation whose sole purpose is to produce unified date of appointment for residents across the country. The NRMP runs the Match pairing as closely as possible residents’ first choices with the programs that ranked them highly. Couples entering residency programs at the same time can be

labeled a “couples match” which adjusts some of the algorithms to minimize the chances that married residents will have to live far apart during their training. They may not match at the same program, health system or hospital, but every attempt is made to match them at institutions within easy driving distance of one another. I did not encounter anyone who, through a failure in the couples match, ended up living apart from his or her spouse. Anecdotally, a great deal of work is done by the residency programs and new potential hires to make couples matches work.

Match Day is typically the third Friday in March and is met with considerable excitement and anxiety by all parties involved. The program director, Dr. Hedges, compared the hiring of residents to a three-year marriage or limited period of parenthood – whoever is hired is not only making a three-year commitment, but also the program is likewise committing to their development for those three years. It can prove challenging on both ends. The NRMP generates and publishes a list of which applicants have been paired with which programs. According to Dr. Hedges, Suburban Family Medicine often matches all of the applicants highest on their match list. This success in attracting their highly desired residents marks them as a sought-after program. By comparison, when I worked at Urban Hospital, they seldom matched more than one of their top ten choices, and often filled their ranks from those in the midrange of their rank list.

Once the Match period has passed, some residents may find themselves without a hospital, having failed to match anywhere. Likewise, some programs find they have slots left open following the Match. These vacancies result in a period called the “Scramble” as applicants without a program call departments with openings and try to

find a place for themselves. Presumably, this is a tense time for all parties involved – the applicants possibly did not interview well or had poor exam scores, and the programs with openings may be considered less-than top choices. In the vast majority of cases, the Scramble fills the lingering vacancies in programs across the country, and from most accounts, most residents find a place for themselves, albeit not necessarily where they would have like to go. I do not recall any resident at Suburban coming to the program through the Scramble, having matched all of their available positions from their top-ranked candidates. I do however recall residents at Urban Hospital being hired through the Scramble. In cases where the resident fared well, and adjusted to residency life, no further mention of their hiring is mentioned. However, in one instance, a resident who struggled to learn and perform up to expectations was discussed in faculty meetings as a “Scramble hire”, as if that somehow explained and legitimated the problems she was having. Though it did not emerge as an issue at Suburban Hospital during my time there, it would be an interesting phenomenon to look at more broadly in the field moving forward.

Bringing on new hires

In the following weeks, the chosen applicants – from both the Match and the Scramble – are contacted and the hiring process begins. New residents must be licensed to practice medicine in the state in which they will be working, a process that can take up to 60 days. The process involves background checks, evaluating results of USMLE testing and medical school performance, and ultimately serves as documentation of the authority to practice in a particular locality. A critical initial step for a new hire then is to obtain licensure within the window between Match Day (third

Friday of March) and the beginning of residency training (from the last week of June to August 1). The newly-hired resident works closely with program leadership to gather the necessary documentation and submit their license application. In the case of Suburban Hospital, training begins at the end of June, so the pressure is on to navigate the licensure process quickly and efficiently.

In terms of scheduling, residency, like the third and fourth year of medical school, is divided into a series of month-long “rotations”⁴. Through interviewing, I discovered the program director often prepares the schedule up to a year in advance, with the new hires fitting into the existing draft once they are identified and hired. Residencies are subject to considerable oversight and accreditation requirements. The Accreditation Council for Graduate Medical Education (ACGME) sets policies and requirements for programs nationwide⁵. A survey of the common program requirements as set by the ACGME indicates what elements are required to be present in any residency, regardless of specialty. For family medicine, these include clinical and inpatient experiences, rotations within their own specialty, and exposure to other specialties like obstetrics, surgery, and emergency medicine to provide a clear understanding of the place of family medicine in the organization of medical services with the broader healthcare system. In other words, residents gain knowledge of what other specialties do for patients, providing knowledge of what care patients receive in other specialty clinics and inpatient services.

⁴ Preparing the rotation schedule for the new team (as well as finalizing the monthly schedules for the soon-to-be second- and third-year residents) is challenging, as each rotation requires a number of residents to function properly (particularly the Family Medicine in-patient rotation) and each resident is required to participate and pass certain non-Family Medicine rotations.

⁵ All information about residency requirements, unless otherwise stated, is from the official website of the ACGME <https://www.acgme.org/acgmeweb/>

Each specialty has their own additional program requirements. Family medicine's program requirements mention having an orientation as a mandatory initial training step. Orientation is a good example to illustrate how family medicine training programs must meet certain requirements and yet have latitude in designing the specifics of these educational rotations. First-year residents are seen as needing an orientation period to "introduce the comprehensive approach to health care and to promote resident identity as a family physician" (Dr. Turner, personal communication, 2012). Despite having this common requirement, no further details are offered as to what orientation must entail or how it will be measured as having been successful. Perhaps intentionally, this leaves programs considerable autonomy in the design and implementation of an orientation program, varying from the formal to the informal, brief to lengthy, general to in-depth. What programs like Suburban Family Medicine choose to do during orientation sheds light on their overarching philosophy in resident education; this topic is discussed further in Chapter 5.

To illustrate how a program puts its own stamp on a common requirement, let us briefly consider how Suburban Family Medicine has designed their orientation process. The first rotation new interns participate in is an official "orientation month," an exhaustive series of activities and lectures designed to prepare the intern for the work ahead, as well as evaluate their skills to create a learning plan, and to leave room for group bonds to form. From anecdotal reports, other ethnographic accounts and my own experiences in another hospital setting, I know Suburban's orientation program is quite unique in being one month long. For interns at Suburban Hospital Family Medicine, the first academic year is divided into 13 four-week blocks instead of rotations

corresponding with the calendar months (as the second- and third-year residents experience). This lengthy orientation allows the department opportunity to identify performance, educational, and personal issues and target learning activities to address residents' strengths and weaknesses.

Educational process

I will now outline the family medicine residency educational process at Suburban Hospital. Residents are physicians, yet not licensed or certified to practice without supervision. They are expected, in a sense, to “fake it” as they “make it” – they are granted the symbolic capital (through being interviewed, matched, hired, and oriented) to operate as physicians, but limited in that the faculty must supervise residents until they are deemed to have the skills necessary in order to work autonomously. This tension – between being a doctor and being a student – is central to the learning process in residency as will be detailed in later chapters.

Following orientation, interns launch into a complicated schedule of monthly rotations through a range of medical specialties, combined with weekly commitments in the family medicine department. Interns and more senior residents operated on a slightly different schedule. Intern year is divided into 13 blocks consisting of four weeks each. Second and third year residents retain the more traditional monthly block schedule of 12 rotations for each year. This intern year shift, particular to Suburban Hospital Family Medicine, was explicitly done to free up a four-week block for orientation without compromising the requirements for rotations through a standard year. Once the system of rotations gets underway, each year unfolds in a fairly regular way. Each month, residents spend their time working for a particular “service” under the

auspices of a particular medical specialty. No two residents' schedules are exactly alike – some months a resident may be the only Family Medicine on the Emergency Medicine rotation, for example. This system is designed to expose the residents to the breadth and depth of medicine, preparing them to practice autonomously through the acquisitions of skills, techniques, and knowledge.

Of central importance is the time spent on the family medicine inpatient service, during which teams typically comprised of three interns, one second-year, and one third-year resident – all from Family Medicine – work together under the supervision of the attending physicians (faculty members that take one week shifts on the service). For example, during their first year, interns spend three to four months (depending on scheduling) rotating in Family Medicine. Second- and third-year residents spend one to two months on the Family Medicine inpatient service. It is here, in particular, that the values and habitus of Family Medicine is transmitted, interpreted and received by residents, commensurate to their level of experience – a discussion that will be elaborated upon in the data chapters to follow.

Clinical work is ongoing in the residency program as well. Residents spend one or more half days a week in clinic, seeing patients and building their own patient load. This process involves precepting with faculty. Precepting – the working together between faculty and resident, as apprentice and master introduced earlier – is critical and will be expounded upon subsequently.

Didactic lectures form the third broad component of residency education, beginning after orientation month. Residents are expected to attend weekly lectures on a myriad of topics, from common diseases and their treatment, to health behavior

counseling (like smoke cessation or weight loss), to gynecological and other specialized lectures, to interpersonal communication and brief counseling skills. These lectures are in a format in which the resident physician is again the student. Yet they also provide a clear break from the fast-paced life of rotations and a chance to sit back and simply take in new information. Given the more passive nature of this educational activity, some residents choose to not focus on the lectures and instead use the time to catch up on other work (writing patient notes or checking lab results, for example). Didactic lectures as a learning activity will be described in greater detail in Chapter 6.

These three broad learning activities – rotations, clinical work, and didactics – form the backbone through which residents learn, accumulate the necessary cultural and symbolic capital to be recognized as family medicine physicians, and eventually move towards graduation. The new intern may not yet possess the skills or confidence to immediately perform all of the assigned tasks. The intern behaves as a physician, yet with the knowledge and tension that comes from the support and oversight offered by the faculty members. Over time, they gain more cultural capital as they accumulate experience and knowledge, social capital by working with other physicians and developing a reputation. Ultimately, they also gain symbolic capital as they come to be recognized as increasingly more competent and given ever-increasing degrees of autonomy, as well as increased expectations and responsibilities.

Second year residents are often characterized as having mastered the systems of working in the hospital setting, knowing the basic workings of the setting (computers, reports, where to go for information), but still refining their skills at diagnosis and treatment, as well as developing their time management skills further. They have the

social and cultural capital to function at a higher level of autonomy and competency than their interns colleagues, yet still receive a good deal of oversight from faculty and other mentors.

Third year residents are able to manage more and think in broader terms about the patient population as a whole. Their confidence is tempered by the realization that residency is ending and their time in the safe learning habitus will give way to complete autonomy and independent practice. It is in the third year that residents take on obvious leadership roles in the program, with near complete autonomy, and are responsible for educating less-advanced residents and medical students.

This process of moving through three years of residency training is the thread I will follow through my findings and conclusions. Ideally, residents are working to acquire and master the necessary techniques and knowledge, and take on the values of family medicine physicians and healers.

CHAPTER 4

METHODOLOGY

The study was designed to observe and describe the educational setting and the processes by which residents are educated to become family medicine physicians and healers. Data collection was divided into two broad activities over a 14 month period: participant-observation of residents and faculty working together and semi-structured interviewing of individual physicians in a suburban American family medicine residency training program. This project was interpretive and designed to explore how family medicine residents “become doctors” – to understand how they are socialized and professionalized into the role of physician and healer, and how they find meaning in the work they do and process of becoming something new.

As seen in the prior chapter, the family medicine residency is a three-year program divided into “rotations”. Rotations are monthly assignments where residents learn in a particular setting, including in specialties other than family medicine. In addition, time is spent every week seeing patients in clinic. This time varies by year in training and the particular rotation a resident is on. For example, interns may see patients only two half-days a week, while three year residents see patients three or four half-days per week. The overnight rotation, called Night Block, does not require any clinic work since the resident is working opposite hours. In addition to residency orientation, this project focuses mainly on several kinds of family medicine rotations – inpatient, clinic, and related didactics – as opposed to following family medicine residents out to their rotations in other specialties. The transmission and meaning-making around the techniques, values, and knowledge of family medicine – as well as

the family medicine department as field and habitus – lies at the core of this project and was therefore prioritized in data collection and analysis.

Next I will describe how the participants were recruited and describe the classifications of several types of physicians encountered in the fieldsite. I will then describe how participant-observation and interviews were conducted. Finally, I will discuss the data analysis strategies used to derive the findings and conclusions.

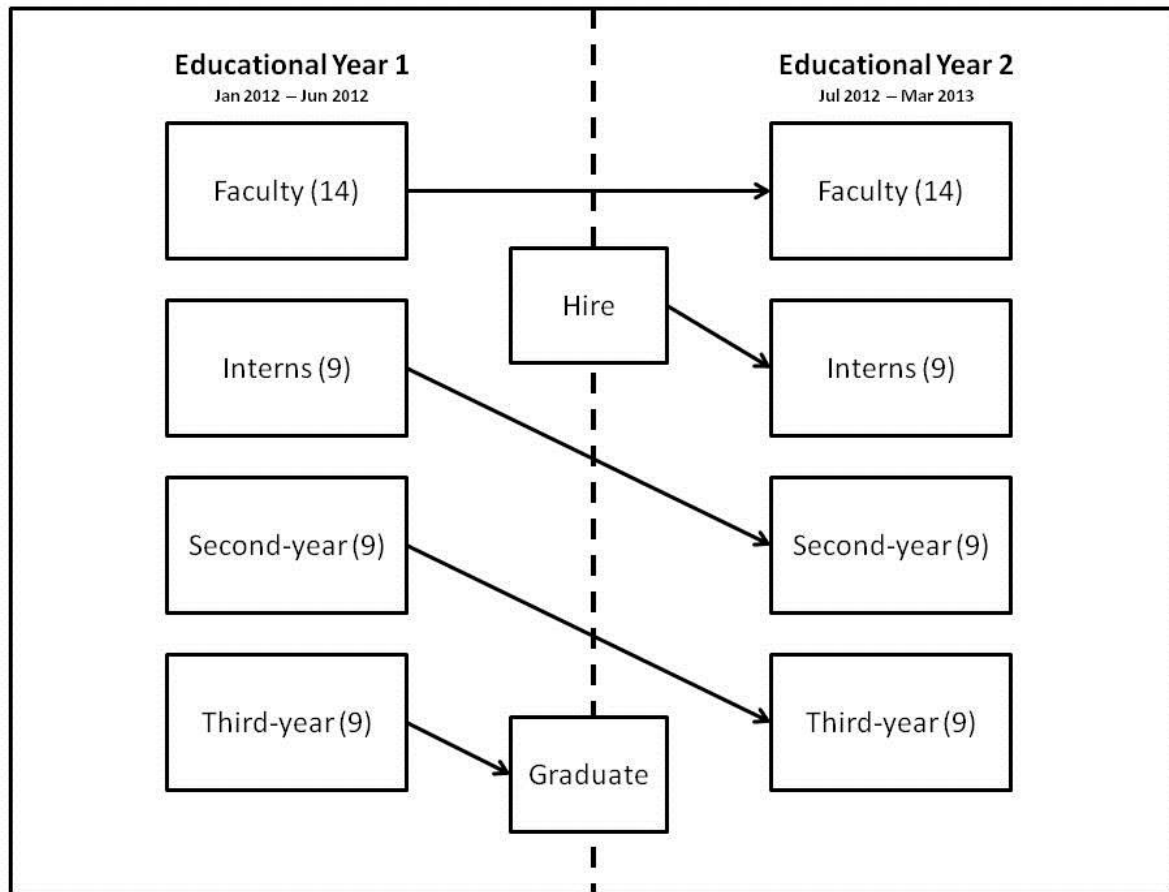
Recruitment of participants

I was introduced to many of the study participants when I was invited to present my project to faculty and residents in an attempt to secure their cooperation. After having Dr. Turner's approval passed to Dr. Hedges, the residency program director, it was agreed that I would present my study and verbally consent the participants, in two separate informational sessions, one with faculty and one with residents. Residents and faculty were consented separately from one another to minimize any possible feelings of coercion.

The sample size was bound by the number of eligible participants; this family medicine residency program has a specific and fixed number of residents and faculty. There are a total of 14 family medicine faculty members, and all were recruited and observed throughout the study. At any point in the fourteen-month study period, there were 27 family medicine physicians in the training program, divided into three nine-person cohorts of trainees, referred to as "interns", "second-years", and "third-years" respectively. As my work began in the middle of an educational year, I was able to recruit and observe 36 residents in total over the 14 month period, with the nine most-senior graduating and leaving the program halfway through my fieldwork period and

nine new interns joining the program. As a result, I was able to work with 50 different family medicine physicians over the course of fourteen months (36 total residents and 14 total faculty members). Figure 1 below illustrates the process of hiring, promotion, and graduation during the fieldwork period.

Figure 1: Categories of physician participants



The three groups of resident physicians differed in terms of the amount of autonomy members of each group had and oversight they received from faculty physicians. Interns have the least amount of practical and technical “know-how” in terms of seeing and treating patients, and therefore had considerable oversight from faculty and more-senior residents. Second-year residents have, in general, mastered many of the technical aspects of being a doctor (able to diagnose and treat disease) and had

often begun exploring more of the broader “biopsychosocial” experiences of being family medicine physicians, taking on more of the values of the specialty. The second-year residents had greater autonomy than interns did. The third-year residents, in general, had the most autonomy from faculty oversight, and had a great deal of responsibility overseeing other less-advanced residents. The leadership had already approved my presence for the study (as described in Chapter 3), but any individual physician could opt-out privately with me via email or personal request, with assurances from myself and the program leadership that my project was entirely voluntary with no penalties for refusal. No physicians refused to participate in the study.

The residents that came to Suburban Family Medicine shared a number of traits and common ideas about their choice in specialty. First, they tended to be in their late 20s, entering residency immediately after medical school. Only one resident in my observations was older, entering medical school later in life after already starting a family. Most residents were MDs with seven DOs working during my time there. The underlying values of DOs suggest a different approach to medicine than MDs. The body-mind-spirit focus of family medicine is foundational in DO programs.

Most of the residents I observed were women (28 as compared to 8 men). Faculty members were more evenly dispersed by gender (8 women, 6 men). While gender was not a focus of this study, this imbalance may suggest something about gender stereotypes at play in the specialty. There may have been parallels in the differing status of women in medicine and family medicine among specialties, leading more women to the specialty. There could be gender differences reflected in power and opportunity combined with expectations from mentors leading more women to family

medicine, in a way similar to perceived problems in public education and recruiting women into STEM fields. A future study could readily address this gender imbalance, exploring for reasons, pros and cons, of a female-dominate residency program.

While patients were not the focus of this study, they were present during important educational moments involving residents and faculty members. From the outset, I knew that it would be important to consent individual patients and hear their voices, even though they were not the target study population. Consequently, I developed the following process for receiving informed consent from patients prior to observing treatment interactions involving them. On an individual basis, patients were given a separate information sheet detailing the project prior to my observations. I approached each patient alone, without residents or faculty present. Verbal consent for my presence during their time with the physicians was obtained in each case. In a few instances, patients were uncomfortable and I opted out of observing those interactions.

Participant-observation

As described in Chapter 3, the fieldsite is situated within a large suburban health system, with separate spaces used by the family medicine residency program previously described. In all, I spent one to three days a week observing activities in these key educational spaces, splitting my time between the family medicine inpatient service, outpatient clinic sessions, and didactic lectures and meetings. On an ongoing basis during participant-observation in these settings, physicians were asked brief questions to clarify my understanding of various activities that took place and things that were said. This kind of informal interviewing is common in participant-observation and was a separate activity from the semi-structured interviewing portion of data collection.

As part of his or her training, each family medicine resident is required to work a portion of each year on the family medicine inpatient service⁶. Each month, a subset of faculty and residents rotate through the family medicine inpatient service⁷. This group, that changes composition from month to month, formed the locus of the observations I made in the hospital setting. Since the focus of this study is on family medicine educational activities, I remained with the family medicine inpatient team during my hospital observations. By following the inpatient team, as it changes membership monthly, I was able to interact with nearly all of the faculty and residents over the course of the study.

Outpatient clinical work is an important educational experience in the residency program as well. As described in Chapter 3, residents spend one or more half days a week in clinic, seeing patients and building their own patient load. This process involves precepting with faculty. Precepting is critical. As residents are not board-certified, they must have a board-certified faculty member check their diagnosis and treatment plans. In order to better understand this educational practice, I observed the interactions between faculty preceptors and resident physicians around the diagnosis and treatment of patients, the decision-making involved in running tests and mechanisms of billing for services. This process was important to observe because of how much time residents spend seeing patients and precepting with faculty members, but also because these interactions were one means by which capital was conveyed and dispositions taken on.

⁶ This portion varies depending on what year of training the resident is currently in: four months for interns, two to three months each for second- and third-years.

⁷ Typically these teams consist of three first-year residents, a second-year resident, a third-year resident, and a faculty member. The residents work for one month and the faculty member, or attending, changed every week.

Every Wednesday morning, the program hosts a series of didactic lectures⁸. Residents were often given special dispensation in order to attend these lectures. Interns on the inpatient service, for example, were not expected to see patients or complete patient progress notes in the morning. As a participant-observer, this setting was an ideal environment to connect with residents who may be rotating in other specialties, to schedule interviews, and observe the group dynamic of the residents. Given that the activity is technically “mandatory”, I was assured to see residents whom I might not have otherwise interacted with in some time.

Data from participant-observation was recording by taking field notes. I focused on the collection of the “social facts” of training and educational experiences. Special attention was given to the lessons taught, the techniques demonstrated, and the values impacted. I focused heavily on the identification and description of the forms of capital mobilized in the field setting. Further, I observed how residents were treated by faculty, faculty by residents, and attempted to assess team functioning overall. Periods of socialization were observed, where residents attempted to make sense of the learning experiences of the day. I observed demonstrations of professional values, ideas, and knowledge, to gain insight into the “capital” residents acquire and use to socialize each other to the specialty. Overall, these observations contributed to a better understanding of the emergent dispositions of residents and provided a rich source of interview questions.

I struck a balance between taking brief notes as I observed and generating longer entries away from the observed group. I mostly followed the social norms of the

⁸ These didactics are much in the style of any classroom learning environment, with a faculty member from family medicine or other specialty providing a lecture on a specific topic and encouraging participation, questions, and discussion from the resident audience.

group. From early on, I sensed that there were instances where openly writing things down was more and less appropriate. While working on the inpatient service, for example, residents are almost constantly taking notes, writing things down, or working at computer stations. My note-taking was less intrusive during those times.

In terms of handling the material collected during participant-observation, I employed this procedure. Each day following my time observing, I dictated what had occurred from my brief notes, elaborating from the memory cues I had written down, and recalling the sequence of events from the day. From using this process, I was later able to separate out – and code – my own subjective interpretations and analyses from the more objective observations (Bernard 2011; Emerson, et al. 2011; Mizrahi 1986).

Interviews

Starting in the fourth month of my fieldwork, I began inviting family medicine physicians to participate in a one time, face-to-face semi-structured interview. A subset (N=24) of the total number of recruited family medicine physicians (N=50) were interviewed⁹. I used a hybrid of purposive and convenience sampling to acquire the twenty-four participants with a mix of residents (N=17) and faculty members (N=7). My sampling was purposive in that I wanted to interview a mix of residents who were just beginning residency, who were in the middle of the training program, and who were looking to graduate soon. Further, I sampled a range of faculty, speaking with the program leaders, but also the newer faculty members. Interestingly, some faculty had themselves been residents in the Suburban Hospital family medicine program and others who had completed their residencies elsewhere, which provided a nice mix of

⁹ Consent for interviews involved a second, written consent for research. A physician's prior agreement to participate in my observations was not an implicit agreement to be interviewed.

input about differences in residency training programs. My sampling was also partially convenience-based. While I approached nearly every resident and faculty member for an interview, not every physician had the time in his or her schedule to make an interview work or wanted to participate in an interview. My goal at all times was to capture a myriad of experiences with the family medicine residency training program. Table 1 below lists the family medicine physicians who were interviewed and the numbers interviewed per category¹⁰.

Table 1: Semi-structured interviews with family medicine physicians (N=24)

Classification	Number interviewed	Women/Men	Time in residency
Interns (first-year residents)	5	5 Women	Less than 6 mos
Second-year residents	4	3 Women/1 Man	Less than 18 mos
Newly-promoted Third-year residents	4	3 Women/1 Man	Less than 30 mos
Veteran Third-year residents	4	4 Women	30 – 36 mos
Faculty physicians	7	5 Women/2 Men	Post-residency

In the end, I interviewed a near even split between all four broad categories of physicians in the program. These interviews ranged from 45 to 90 minutes, were audio-recorded, and utilized a series of open-ended questions on the participant's personal history as a physician, their story of their decision to become family medicine doctors, their understanding of the learning activities and evaluation processes in the program,

¹⁰ For this chart, I have divided the third-year residents into two groups to reflect the length of time spent in the field setting. When I began interviewing, a group of nine residents were preparing to graduate within two months. I prioritized those interviews in order to capture the experiences of the most veteran residents before they graduated and I would therefore lose contact with them. In the meantime, the nine second-year residents were promoted to the third year; their interviews were conducted just following promotion and often reflected back upon their second-year experiences. Once I had completed those interviews, I began interviewing the current interns and second-year residents, who were mostly in the middle of their academic year. Faculty interviews were conducted throughout the interviewing cycle and, given their long-term positions in the program, were less dependent on the promotion cycle.

as well as other topics identified through observation. Though each interview was conducted at the Suburban Hospital, the location varied due to room availability and scheduling issues.

Interview topics were derived from an in-depth investigation of the literature on the cross-cultural literature on the making of healers, around medical education, family medicine, and to explore the role of habitus and capital in the field settings. Emergent patterns uncovered during participant-observation informed a further refinement of interview topics before the semi-structured interviews began. Residents were asked about their time in residency, what led him or her to become a family medicine doctor, and their opinion on what makes a good family medicine physician. Residents were asked about their preferred learning styles, to comment on the knowledge and experience they were accumulating, to reflect on their perception of the progress they were making in training, and what things were most challenging to learn. Faculty members were asked to reflect on the perceived differences between their time in residency and what they observe in residency today, what led them to family medicine as a career choice, their preferred teaching style, as well as what was most challenging to teach to residents. Faculty physicians were asked I also asked what advice each physician would give to a new group of interns. I closed each interview, for both residents and faculty members, by asking if there was anything we did not cover but should have in order for me to learn more about resident education in family medicine.

Data analysis

As mentioned, field notes were taken of all observed interactions in the three training environments – outpatient, inpatient, and didactic lectures. These field notes

were dictated into voice recognition software allowing for efficient and complete transcription. The field notes were instrumental in refining the interview guides. Interviews were conducted based on semi-structured questions, with emergent ideas explored until understanding and clarity were achieved. A close reading of the field notes and careful listening of the audio interviews was done before any coding began in order to understand the data as a broader, more complex whole. As appropriate, segments of the interview audio recordings were transcribed.

Themes and patterns were identified through repeated, careful reading and coding of the material (Bernard 2011; Corbin and Strauss 2008; Luborsky 1994, 1990), allowing for the identification and description of the complex process of professional socialization of family medicine physicians. A thick description of the fieldsite – its habitus, values, and capital – was developed (Geertz 1973, 1994; Wolcott 1999). Specific educational and learning episodes were identified and analyzed for the creation of meaning, negotiation of understanding around complex ideas and techniques, and the transmission of knowledge used to pass on the values and techniques of family medicine. A central idea of “dispositions” – foundational in practice theory – fuels much of the discussion that follows, addressing the central research question of the making of doctors and healers in family medicine.

Reflections on researcher positionality

My position within the fieldsite, informed by my own history and bias, influenced the data collection and analysis. In reflecting on the process of creating and engaging in this project, I have arrived a clearer understanding of my own entanglement with my interlocutors. In this section, I share my reflections about the different phases in my

research, and how my changing positionality impacted these phases. These include the impact on my own history, my moments gaining access to and working within the fieldsite, the later period of analysis, and the position I hold as of this writing. Additional reflections appear in Chapter 9.

My initial positionality in the fieldsite was shaped by the means through which I gained admittance to the program itself. Numerous attempts to locate a suitable family medicine residency program were met with polite refusals and I had begun to grow concerned about the feasibility of my project. When Suburban Family Medicine agreed to allow me access, I was honored to be allowed access. As a result, as I pursued my research it was always with a sense of being fortunate and a desire to live up to the trust they placed in me. I wanted to be a good guest. The result was often a lack of willingness to be critical of the program. Further, the leadership had requested a presentation of my findings and I was apprehensive about what response any criticisms from a doctoral student would be met with. Finally, I did not want to overly interfere with or unduly influence the training I was observing. The result here was sometimes a hesitancy to speak up or participate beyond my observations in the learning I was recording. The result was, at times, not pushing further into patient engagements, learning didactics, or to question what I was being told about the educational processes.

At the moment of gaining entre, combined with sense of being lucky to have gained access, I had accepted without examination the rhetoric of family medicine as a “good specialty”. Beforehand, I had heard frequent claims to family medicine being a specialty that delivered healthcare in a way superior to other specialties. I believed this and as a result, combined with my sense of being honored to be present, led me to be

less critical of the processes I was observing. My resonance with this rhetoric had roots in my own history of working in family medicine at Urban Hospital. The family medicine physicians at Urban Hospital saw themselves as better than other specialties. In my capacity as a behavioral science faculty member at Urban Family Medicine, my charge was in educating residents to be the best family medicine doctors they could be. To improve their communication and engagement with patients, to learn to take care of themselves so they could take better care of their patients, and meet the requirements of the program. I felt a sense of ownership and protectiveness towards “my residents”.

This sense of loyalty extended to the residents in Suburban Hospital, resulting in considerable empathy for my interlocutors, whom I saw as vulnerable learners who did not need me getting in their way. Being this close to my research topic proved extremely challenging. I already had amassed considerable understanding of the way residents were typically trained. I was competent in the language and processes I was observing. This closeness led me to take for granted much of what I observed, to render in my writing the strange activities in a way that was overly familiar, lacking a critical eye. In the end, my past engagements with family medicine combined with the respect I felt compelled to convey, led to some useful though problematic relationships with the physicians; speeding my understanding of what I was observing, but blinding me to some of the intricacies.

On a subconscious level, I think my empathy for the other learners led me to a position where I placed myself in a lower status than the faculty members, on equal footing with the residents. I placed myself in this way into the resident role. I felt the need to participate, but of course could not learn to see patients or administer medicine

without a medical education. I had wanted an immersive experience, but in seeking one I came to lose part of myself as an anthropologist.

In reflecting upon and analyzing the data that follow, I have come to realize that I had a purpose and deserved to be there. In earlier drafts of this dissertation, my writing was often muted; careful to be critical if I took the position of the learner. Who was I to question? I was faced with postmodern notions of “who am I to criticize” and my own respect and admiration of family medicine as a specialty within biomedicine. Could my reverence have prevented me from crossing or even finding the lines the physicians prefer I not cross? I seldom confronted or adequately probed the physicians about their conceptualizations of healing or the problems related to paternalism in care delivery that I witnessed. I hardly noticed when the physicians wrestled with the values of family medicine. It was not until I left the field and began my analysis that the trend began to reverse. A further critique of my own positionality and a revised sense of the educational processes I observed appear in Chapter 9.

CHAPTER 5

ORIENTATION MONTH

In order to trace the educational processes that lead residents towards becoming healers, beginning where the residents began is only fitting. The orientation process was an important period for a number of reasons. First, it established the context in which the formal learning processes would occur for new residents. Second, thinking as a social scientist, orientation also introduced some of the key dispositions and immersed me into the habitus of the residency program. Third, describing orientation relates to the first moments of “making healers” in the field.

As mentioned before, many residency programs begin with a formal “orientation”. The specifics of this process and the degree to which each program “orients” its new doctors varies across different medical specialties and even from program to program within the same specialty. This variation results from the broad ways in which orientation may be designed and structured, as well as the overall absence of specific orientation requirements on the part of accreditation agencies, as outlined in Chapter 3. In my experience and the anecdotes of residents both at Urban Hospital and Suburban Hospital, orientation in residency programs varies from a simple welcome followed by considerable “on the job” training to a more formal program of ritualized introductions, lectures, and hands-on instruction.

I see orientation relating to a similar concept in ancient Greek theater. An opening dialogue delivered by an orator or a main character would instruct the audience as to the context of the play about begin. It would provide pertinent details of the events leading to the start of the play and introduce the characters and settings involved. In the

prologue to *Oedipus Rex*, for example, Sophocles' (2006) opening dialogue takes the audience to the chambers of the King as he accepts a priest and his travelling companions, come seeking his aid and counsel. In thinking about the experience the Suburban Hospital interns were about to embark upon, I remembered this pertinent line: "Well, I will start afresh and once again/ Make dark things clear" (ibid: 12). I will aim to show in the rest of this chapter and those that follow how that sentiment is laced through the family medicine residency training at Suburban Hospital.

Going into orientation, in some senses I observed much of what I expected: an organized social system establishing the foundation for learning experiences. While I also expected considerable focus on family medicine's object, instead I observed dispositions such as "being the doctor" and "taking ownership" of the work to come taking precedence. In other words, there was a focus on physician behaviors but not a great deal on family medicine's values specifically.

Positionality of residents during orientation

Let us consider the position of the various players as they enter orientation. The orientation process involved numerous participants, each with defined roles. The entering class included nine interns, all recent medical school graduates, beginning their training and the taking on of new responsibilities. Working with these new interns going forward are a number of established physicians who will act as mentors and teachers.

These interns were not "afresh" as Oedipus suggests, nor were they completely "in the dark". These were intelligent individuals with upwards of half a million dollars of formal education in medicine. They came with a certain amount of social and cultural capital from their past – embodied in the symbolic capital of being a medical student,

and having been chosen and hired as residents. The new interns possessed the foundation that the family medicine program faculty members believed they needed in order to be educated; basic skills and values developed in medical school. They were at once student and physician, and navigating this tension fueled their journey through the subsequent three years. To mirror Womack's ideas (2009), they had been recognized for their abilities, called to the field of family medicine, and were now entering their "apprenticeship", to begin that social-recognized process of becoming something new. They found their way into a system of mentors who could convey the necessary knowledge and skills to achieve some demonstrable level of competency. Like Quesalid, they are now situated in a social field of experts as initiates; what was absent at first is the target of their healing practices: the patient.

The expectations of new residents were considerably different, and of a greater caliber, as compared to those placed on medical students. The faculty and more advanced residents were there to assure these new residents that they could make the journey, holding considerable faith in interns' ability to do so (as demonstrated by the fact the interns were hired), and designed and implemented an orientation program to establish the best possible start for the interns. This was self-serving as well – the goal of the program was to graduate competent physicians who would carry the reputation (symbolic capital) of the entire program out into the world. The second- and third-year residents had a more immediate concern; the better the intern, the less they had to go behind them and do additional work.

In this orientation chapter specifically though, the goal is to provide a sense of the starting phase of how the social order will be played out. I examine how

professionalization and socialization began within the formal structure of orientation and served to launch the informal experiences of first-year residents that contributed to learning.

Overview of orientation

The academic year for residents begins and ends each July. In orientation month, a new group of interns annually arrives and begins the work of their three-year apprenticeship towards board certification and full licensure, towards becoming family medicine physicians. The main activities of orientation month took place in the settings that I have already introduced: classroom, hospital, and clinic. Activities observed included a mixture of classroom learning, orientation and shadowing on the inpatient and outpatient services, and assessments of the new residents' clinical skill sets.

From speaking with those program faculty specifically leading the orientation activities, I found that orientation at Suburban Hospital was about a number of things – (1) classroom introduction to the requirements and expectations of the program, including a lot of practical “how to” information; (2) an introduction to the practical work of being a physician, in both inpatient and outpatient settings; and (3) to introduce residents to one another and begin to form bonds between them that would carry the residents through their three-years of training.

Orientation involves nine new interns; the following activities must be set up for their first month. These activities occurred in a different order for different residents but every intern had to complete all the requirements of orientation by the month's end. Some tasks brought the group together; other activities divided the group into teams of three, and still others things were done alone. For example, classroom orientation

didactics were typically a whole-group event and the inpatient orientation was done in groups of three. Table 2 below outlines the activities of the orientation month, which will be described in further detail in the next section.

Table 2: Orientation schedule

Week One	Classroom didactics, expectations, assessments (full group)
Week Two	Group 1 Inpatient orientation; others outpatient & skills assessment
Week Three	Group 2 Inpatient orientation; others outpatient & skills assessment
Week Four	Group 3 Inpatient orientation; others outpatient & skills assessment
New Month	Wrap-up of orientation, final lectures, and beginning new rotations

You're the doctor now: Framing expectations in the classroom

As I walked into the conference room, nine nervous residents looked up from their seats. The room was dominated by three large tables arranged in a horseshoe, with chairs behind them, situated so each person was looking into the center. The faculty member designated as the orientation moderator, Dr. Turner, was already there and the residency coordinator was rushing around, bringing the last details into order. This was the first day of work for a new class of interns in the Suburban Hospital Department of Family Medicine and the tension in the air was palpable. I said my hellos and picked a chair near the edge of the horseshoe with a good vantage of the entire room. Looking into the eyes of the doctors present I thought I saw a mixture of fear and excitement from the interns, calm and authority from the moderator. I had the sense of something important ready to begin, this initiation ritual called "orientation", where residents would be officially taking their first steps in their becoming something else. The program director, Dr. Hedges, walked into the room, smiling amiably at the new interns. As I settled in, Dr. Turner called the room to order with a simple suggestion of "let's get started" and introduced the program director, who would give the official

welcome. For these nine, the work of becoming a family medicine doctor had officially begun (Field note: June 29, 2012).

Beginning the journey

In a formal introduction from the program director, Dr. Hedges, began by outlining the goal of orientation. The intent was not only to orient the new residents to the expectations of the work they were to do, but also to forge relationships – to create a bond between the interns, but also to develop relationships with their senior residents, their advisors, and the faculty in general. Dr. Hedges was explicit in the program’s desire to see the new interns bond as a cohort; to acquire a support network of trusted peers; to welcome the new interns into “the family medicine community”.

She went on to address the aim of residency education. Ultimately, the aim was to prepare the residents to practice independently – that everything they would learn should prepare them to work autonomously and competently. The program director also stated that the residents’ skills were to be assessed during orientation – an important step in individualizing the educational path of each intern. She acknowledged that each resident came to the program with different skills and ability.

The program director asserted that this was a supportive environment in which to learn. She asserted that every member of the family medicine residency program was there to help residents become family medicine physicians. Intriguingly, Dr. Hedges immediately went on to discuss identifying what residents lack coming in, acknowledging the considerable learning that must take place. She asserted that it was ultimately not about what each resident lacked, but about trying to get every resident to their next “milestone”, step by step, towards promotion to the subsequent year and

eventually graduation. Dr. Hedges put forward a model where gaps in residents' knowledge and techniques could be identified and addressed. The program utilizes the system of rotations, clinical work, and didactics, as described in Chapter 4, and combines these with close-knit apprentice-mentor working relationships. This problem-based approach helped the program identify the areas of learning residents possess and still need to acquire. This model will become clearer in Chapter 6 in discussing precepting and the taking on of particular dispositions.

Next was a ritualized process of playing an "icebreaker game". This game was designed to familiarize the new interns and participating faculty with one another. The game consisted of a photocopied page full of squares laid out like a bingo card. In each square was written various potential facts about people – "is a vegetarian", "owns a dog", "speaks more than one language". The goal was to mingle among the crowd – a mixture of interns and a couple of faculty members – and have participants sign their names in the squares that apply to them. The only rule was that an individual could not sign their name more than twice on a single bingo sheet. Through this game, I was able to meet and talk with all the new interns and learned a few interesting facts about each one.

The game got people talking to one another, myself included, as I could not very well sit out on an opportunity to get to know my hosts and informants. I was able to sign a number of sheets, talk to most of the interns at least briefly, and reveal a bit of myself in the process. The orientation leader, Dr. Turner, asserted how useful the icebreaker was in order to get this small working group to appreciate their diversity of their experiences and perspectives. "Difference", she asserted, "is a form of strength". While

this reference to the rhetoric of diversity was made early on, I will later show that this element was not much emphasized again as my observations went on. To finish talking about this initial activity, the Icebreaker Game gave a glimpse into the place of teamwork, collaboration, and collegiality through familiarity and personal connection.

One of the main goals of orientation was demonstrated here at the outset: to try to form lasting bonds between members of the cohort. These bonds, by report from the faculty, were intentional. There was a tacit acknowledgement that residency training is difficult under the best of circumstances, and perhaps impossible without the bonds of friendship between residents. Whether the Icebreaker game helped establish these relationships or not remains difficult to assess. It helped me in my positionality, but it was the work to come that more-fully bonded the physicians within the habitus.

Faculty expectations of new interns

At this point, Dr. Turner reconvened the whole group. She then outlined a set of expectations for the new residents. She began by reinforcing her own mantra – of keeping one’s schedule on them when at work. The schedule would give them the knowledge of where each resident should be, what they are supposed to be doing, and whom to contact if they were unsure of what to do. The schedule was a road map through the month. As lunch approached on this first day, Dr. Turner, reiterated how there were goals and a clear intent behind every activity during the orientation month. Even something as simple as the Ice Breaker game was designed to “get that ice broken” between the new residents, and the faculty representing the department. The educational philosophy here was that each step prepared the intern for the next steps to follow.

Regarding the work expected of each intern – especially seeing and treating patients – Turner recommended an approach to learning that had worked for her: “pretend no one is there to help you. Attempt to do the work as if you are the only doctor for this patient”. She was quick to add that this is not really ever the case; but that interns should be empowered to seek help. However, pretending to be alone, even though there was back-up, would be a useful approach to increase confidence and improve performance. In other words, the intern should attempt to take on the disposition of a competent, autonomous family medicine physician, while also asking questions and seeking assistance when necessary. The anthropologist-physician Konner similarly wrote about this aspect in documenting his own training as a physician. He stated, “Essentially, behaving as if one has the competency he or she hopes to acquire aids the process of acquiring it, leading towards ever greater expectations – and attainment – of autonomy” (Konner 1987: xiii). At this point, I first began to wonder about a central tension that framed the work of the residents – the balance between “being the doctor” and “being the student”. Their journey was beginning, and I was already getting the sense that the shift from student to doctor was going to be ongoing, recursive, and challenging.

Turner encouraged each and every intern to “persevere”. Referring to orientation, she stated “everyone survives this month”, and suggested the same held true every month from orientation on. Additionally, residents were expected to “own the work.” From day one, the formal expectation conveyed was that the intern was the responsible party in all things involving that intern. Yet at the same time, Turner stressed that they were not in this alone; they were here to learn. The intent was for the residents to

understand: someday, no one will be there to turn to – the responsibility was something to assume and get used to. Today, none of them were in this alone. Tomorrow, that would change. This sense of “ownership” will be further detailed below.

Current residents' expectations of new interns

Dr. Turner gave the floor over to one of the chief residents. Dr. Tao was dressed smartly and carried herself with every bit of confidence and coolness that the new interns could hope to soon demonstrate. She wore the uniform of the physician; her white coat and professional attire. She greeted the interns warmly but wasted no time getting to work. Hers was the task of outlining the formal expectations of the inpatient service and to share her practical advice with the new interns (Field note: July 2, 2012).

After Dr. Turner's introduction, there was a noticeable shift from the more abstract “big picture” of the faculty welcome to a more specific, implementation-driven series of concrete expectations. These expectations were presented by Dr. Tao, a third-year resident and one of the chief residents for the program. The intense demeanor of the chief and her related speech centered on the work ahead that the new physicians would be doing. In a sense, the work of residency became “real” at this point – the expectations that were alluded to by Dr. Turner and Dr. Hedges were now being spelled out in exacting detail. In particular, the chief was more concerned with the hands-on tasks of the work to come, then the conceptual learning model of didactics, program requirements, safety in learning, and introductions. The message was clear: it's time to “be the doctor”, to “embody the role”, phrases Dr. Turner repeated often in her orientation lectures.

Dr. Tao began with the History and Physical form (H&P). As a guiding document of the work of physicians, these forms occurred in every context in which a physician and patient first encountered one another. Dr. Tao detailed how to use the H&P specifically to take an admission to the inpatient service. The family medicine inpatient service was assigned patients from the emergency room. Patients who were stabilized and needed to stay in the hospital were assigned to whatever specialty could best address the patient's needs. Diabetic episodes, nondescript chest pain, sickle-cell exasperation, and other acute flares of chronic diseases were some of the main conditions that Suburban Family Medicine was equipped to manage. Before the patient left the emergency department, residents were expected to meet the patient and begin the H&P. Dr. Tao encouraged the new interns to "mine" the available medical data on the patient, prior to first meeting that patient, coming from the electronic medical information generated by the emergency department physicians.

It is fascinating that this was the time and place the chief resident chose to begin her orientation of new residents. She did not start where I had expected, with the day-to-day rhythm of the work to be done, where and when to report for duty, or the structure of the team environment – first thing was the H&P. It was unclear why she decided to begin as she did. Perhaps, though I was unable to confirm this with Dr. Tao, she witnessed problems early on in her own training with the H&P. If the importance of this document was conveyed by being the first thing described, perhaps Dr. Tao hoped to formalize the H&P and get new interns on board with a standard practice as soon as possible.

Further, Dr. Tao suggested that the intern was always required to go over with

the senior resident any plan that the intern designed for a patient before going bringing that plan to the attending physician. Blame for miscommunication and mistakes could come back on the senior just as much as the intern could, she explained. She said that it was just as much the seniors' responsibility for the patient's well-being as it is the intern's responsibility. In this description, Dr. Tao was demonstrating how the hierarchy operated – different residents were responsible for specific portions of the work to be done, but importantly the accuracy of the information therein affects everyone on the team. The patient's wellbeing was at risk if information was not accurately conveyed. Perhaps, again, this is why she decided to begin her portion of orientation with the H&P form; the standardized way to collect and convey patient information.

Dr. Tao next explained that the new interns would begin to learn about inpatient medicine by spending a week on the inpatient service. As described in Table 2, orientation operated on a rotation system, based on a three-week schedule, where each week three of the new interns joined the inpatient team, so that every one of the interns had a chance to be on the floor. New interns were paired with a second-year resident to demonstrate for the new interns how to meet the expectations being placed upon them. For the duration of orientation, Dr. Tao explained, the second-year resident would act as a model for the intern, demonstrating the relevant skills and knowledge to work on the floor. The goal was to segue to increased autonomy; to be able to be an intern effectively without a second-year resident providing hands-on mentoring. These newly-promoted second-year residents were themselves fresh from their experiences of working as an intern on the inpatient service. Each of these second year residents had spent four months working as interns on the family medicine inpatient service during the

course of their first year in the program. Due to their own recent experiences of learning this work, these second-year residents were seen as ideally suited to instruct the new interns in the work of inpatient medicine. The second-year residents possessed the necessary symbolic capital, in recognition of their amassed cultural capital, to act as mentors to the new interns.

Describing the inpatient service

Dr. Tao went on to outline a typical day on the inpatient service. Starting at 7am, the team met in the “call room”. A more senior resident – an advanced second year – worked a shift known as the “night block”. This resident was responsible for the care of family medicine patients overnight, and conducted the formal admission process for any new patients assigned overnight to the family medicine inpatient service. Working alone overnight, with limited supervision, the night block resident was tasked with maintaining the work done the day before, rather than designing or implementing any further treatments, leaving this work to the day team. The first goal of this 7am meeting was for the night block resident to “sign out” to the day team. The goal of sign out was to detail for the day team everything that happened overnight and to bring them up to date on any new admissions or occurrences from the night.

Dr. Tao explained that once the night block has signed out to the team, he or she typically left for the day and then the day team reviewed the patients one at a time, assigning new patients to particular interns. They would then prioritize the work for the day. Patients deemed ready to be discharged home took priority, since the hospital must charge by the day – they race the clock to discharge patients before another day begins (typically around 9am) to avoid the patient being charged for another day. Once

the team had their assignments, the group would break, typically by 7:30am, to begin to see patients and design treatment plans – with a central focus on the actions and test results that are necessary to get a patient well enough to go home.

Dr. Tao went on to explain that the team typically consisted of one attending physician (a faculty member), a chief resident (typically a third-year, though sometimes an advanced second-year), a co-chief (likewise a second or third year), and three interns. Interns were assigned primary responsibility for up to six patients with the chief, co-chief, and faculty member assisting and coordinating the overall care of the entire roster of patients.

Dr. Tao explained that the expectation was that by 10:30am, each intern had conducted his or her “rounds”. He or she had seen all of the patients assigned to them and written a “progress note” on each one. The expectation was that the interns have talked to each of their patients, examined them, decided on a course of treatment, confirmed this treatment plan with the chief, and written any orders for the nursing staff to carry out. The goal was to get as much done as possible in these three hours. On occasion, this deadline would be pushed back to 11am if more time was needed. The expectation, Dr. Tao explained, was that if the intern felt him- or herself getting behind, he or she should contact the chief and let them know, sooner rather than later, so the deadline can be adjusted.

At 10:30am, the team would reconvene in the call room to conduct “table rounds”. Throughout the morning, the team would interact and run into each other in the process of seeing patients, but this meeting was designed to bring all parts of the team up to date on all the patients on the service. Questions about patient care and difficult

decisions were brought to the team for discussion. Emphasis was again placed on discharging patients. Dr. Tao stressed the need for interns to ask themselves a question regarding each patient – “why are they still here?” Later in my observations, I witnessed residents and faculty congratulating each other for having patients ready to go home. Sometimes this sentiment was heartfelt for the patients, other times I suspected it had more to do with managing a heavy workload. Table rounds would last from 30 to 60 minutes and involve making certain everything necessary for a patient’s care is being addressed. Every decision, action, or planned action would be assigned to someone, such that there was a clear sense of responsibility.

The work of the morning would be highly team-oriented, Dr. Tao explained. Following table rounds, the group of residents would disperse into more individual tasks. The work of managing patients on the floor remained important however. Following lunch, one of the interns would leave for a scheduled outpatient clinic session. Another intern will stay until 5pm. The third will stay into the night, when the night block returns, to help manage the floor for part of the overnight. Assigning responsibility for tasks – for example, following up on test results – would take the work from the one intern who would be leaving early and firmly placed it under the oversight of one of the two remaining interns. Moreover, the final goal of table rounds was to assure that everyone has shared information about the patients, such that any member of the team would be able to assist the patient, nurses calling regarding the patient, or consultants from other specialties.

Between table rounds and breaking for lunch, the group would typically engage in some sort of brief educational seminar. This could be a topic researched by one of

the physicians or medical students and presented to the team, or an outside specialist may come in and discuss topics of interest to the team. Often, the topic was relevant to something occurring with patients currently on the floor. Dr. Tao stressed how they “protect that time for education”. Formal education time was said to be protected time, but in practice I noticed time was always short, the workload was always high, and “educational rounds” did not always happen as planned.

Lunch and what followed was less structured. The team, Dr. Tao explained, would use the afternoon to act on the plans and decisions from the table rounds, as well as any other work left over from the morning. During this time, interns would follow up on tests ordered in the morning and adjusting treatment plans accordingly, in conference with their supervisors. The team would reconvene briefly a final time around 2pm or 3pm for updates. There would be a final sign-out completed at 5pm to prepare the night block resident as well as the “on call” intern who will stay into the night. The intern will stay until 11pm or midnight, and then the night block will manage the floor until the entire team returns the next morning.

Developing Dr. Hedges’ earlier comments of the importance of communication, Dr. Tao outlined the system all residents are expected to use for “sign out”. This system was designed to assure all physicians were speaking the same language in the same organized fashion, to facilitate a secure passing of information. She said, “The better you can sign out, the more efficient the work will be”. Dr. Tao stressed to the residents that clear communication, with a standardized structure, helped the intern make sense of what would be expected of them, would better respect the time of others, and help prevent miscommunications and mistakes that can harm patients. This predictable

mechanism would help residents organize their thinking and workload. Dr. Tao continued, “In the beginning, everything will be important. You’ll look at everything and think it’s important to talk about in sign out. Over time, you’ll learn to filter. Learn what’s less important”. The highly regimented sign-out procedure was an early example of the disposition of taking ownership for the work of being the doctor, a defined form of efficiency and competency expected of all residents. I more fully discuss this disposition in Chapter 6.

Advice from more-experienced physicians

On the second day of orientation, I was pleased to be invited to a luncheon hosted by the department. This luncheon was designed to introduce the new interns to other members of the residency program. Comprised of the nine new interns, and a collection of available faculty and residents, the luncheon began with introductions. Dr. Turner asked each physician to introduce him or herself, say a little about their background, and suggest a favorite book or movie. Except for the new interns, each person was asked to end their introduction with a piece of advice for the new residents. This was a fascinating opportunity to hear what everyone chose to emphasize; what was most important to understand and focus on in the training environment. I was even able to participate myself, though I opted not to provide advice since my role was not one of faculty member or resident.

Faculty advice fell into two main categories – work-life balance for residents and support in the learning process. For example, one faculty member suggested that residents both need to get enough rest and trust the system to train them well – “rely on the program and support from your fellow residents”. Others suggested that if an intern

needed something or had a problem, just ask questions – better to get the information or assistance rather than going alone and possibly making a mistake. Others iterated with this idea, suggesting interns must reach out to whomever they “click with” among the faculty when help was needed. Faculty also acknowledged a need for balance between work and non-work life. One faculty member told the interns – “You’re entitled to time off. Use it. Don’t feel bad about it.” These brief samples of the types of advice most typically given demonstrate a commitment from the faculty to the training of new physicians and an acknowledgement that the work is challenging.

Resident advice resonated with the faculty advice – and at first glance may be the result of the mixed company. That said, the resident advice was notably more practical – direct actions to be taken – rather than expressing thematic values of the program. This practicality was perhaps not surprising, given the proximity of the second- or third-year resident to the recent reality of being a new intern himself or herself. It was no more than two years ago that every resident in the room was receiving their first pieces of advice here. Advice focused mainly on what it meant to be in the student role. Experienced residents felt the new interns should always be willing to ask questions, to reach out for help and advice, and to learn who knows what you need to know, and seek that person out when you need the information. Ultimately, the most telling piece of advice was that interns should not be afraid of not knowing something. Another bit of practical bit of advice: always finish your office notes on time (usually before leaving to go home for the day); don’t let them get behind. What was being implied here is that the work of medicine is heavy and constant – letting some things pile up can mean considerable effort and overtime to get caught up.

The advice from more experienced residents ran to the personal as well; in a way not seen so directly with the advice from faculty. Much of this resident-to-resident advice took the form of “survival tips”. A number of experienced residents reminded the interns to take time for themselves, even if it is just a few minutes every day. Others encouraged the interns always to keep in contact with family, to keep in touch with the people in their lives. The work hours can be onerous and cause a lot of strain on relationships, one resident reminded the interns. Like the faculty, another resident reminded the interns to use their vacation time wisely. When they are on vacation, they should be on vacation – just not to work, not to even think about work during that time.

Intern responses to orientation

A couple of hours into the first day of orientation, we had a short break to stand up and stretch. The interns looked overwhelmed; stressed-out. There were expressions of panic on their faces; fear is almost palpable through the room. They immediately begin talking to one another. “I feel like I’ve been drinking from a fire hose. I’m going to cry.” They expressed their fear, the sense of being overwhelmed, and they debate whether or not they should all go to Happy Hour later tonight to unwind, before the work really begins. They expressed a small sense of relief in how well organized everything has been so far – that is makes everything a bit easier when the processes are clear. It seems, in the mutual intensity of this early shared experience, the bonds necessary to perform and thrive in residency – those bonds overtly encouraged by the faculty of the residency program – have already begun to take shape (Field note: June 29, 2012).

Up to this point, the voice of the new intern has been particularly absent. From this re-telling, it would be too easy to assume they were passive receptacles for all this

information and orientation. Their reactions when speaking to each other were telling – these conversations among interns showed expressions of being overwhelmed. The conversations I heard when interns talked amongst themselves expressed the suddenness of the expectations being placed upon them. New residents seemed to possess an intellectual understanding of the work of residency, given their exposure during the third and fourth years of medical school. The reality of that work now belonging to them, being expected of them, and starting immediately, placed considerable pressure on the new interns. Further, some of the residents expressed apprehension at the very notion of being called “doctor” – as if the label itself did not feel right, did not apply to them. Expectations to behave like their superiors were being placed upon them, while in a subordinate position. The power they wielded was low, the risk high – could they live up to the expectations?

Later in the second day of the classroom overview of orientation, the new interns were given the opportunity to ask questions. These questions ran the gamut from practical to personal. For example, one intern asked if she should first go to the attending faculty member or the chief resident with a question. This question suggested an awareness of hierarchy in the setting, but confusion in how the hierarchy worked. The questions suggested confusion over who was truly in charge. Dr. Tao suggested that there was not a specific communication hierarchy, so either way was fine – though it was important to check every decision and plan with all the parties involved before implementing it. In practice, however, numerous residents asserted in interview that the chief should be consulted first, to assure nothing was left to chance. That the chief was responsible for the actions of his or her interns suggests the need for attending to

established hierarchy. The faculty was responsible for everyone's actions. The chief was in the middle of a power continuum – needing to assert their authority over the interns per the expectations placed on them, but still beholden to the power of their faculty attending to approve or disapprove of the actions. Circumventing the chief may leave the chief open to criticism of not being on top of the actions of the interns on his or her team. Further, the chief's presumably greater knowledge and experience could catch mistakes that would help the intern save face with the attending physician. This question suggested sensitivity to the professional disposition of a medical community – given the hierarchy that existed, it was best to check and confirm how it worked.

New residents did not understand how some of the basic tasks were to be accomplished. Another question came regarding whether a template was used for standard tests that were ordered repeatedly on most patients – “Do you have a template that you use to order tests for your patients?” This question suggested awareness that ordering tests would be an intern's responsibility but also uncertainty regarding the way to order tests that best facilitated the system of working together on patient care. The answer to the question was yes, and that a computerized system existed that will be explained during the formal inpatient orientation. What was more telling was the phrasing of the question itself. At this point, the new interns were still discussing “your” patients – not “my” patients. This ownership of the work was something that would come with time, and was reflected residents' changing use of possessive pronouns.

Finally, the interns seemed uncertain regarding just how they fit into the new world they were entering. One of the residents asked simply, “Where do we put our things during the day while we are seeing patients?” Not knowing even the most basic

notions of where to report for duty, or where to hang your coat, illustrated the novice state in which these new physicians entered residency. While a practical question, this intern's concerns reflected certain symbolic dimensions: where exactly did the new residents "fit" into the broader social, structural and spatial fields? Moreover, symbolically, how did they really fit in as new physicians at all?

The stress of this shared set of newcomer experiences served to bring the group of interns together. They appeared to talk to one another with ease and began to show a sense of support for one another. For example, in talking to them about their outside interests, one intern, Dr. Williams, seemed shy about her accomplishments as an athlete, and another quickly boasted that the former almost qualified for the Olympic Games. A third then said, "We brag about you because you're one of our own". A sense of mutual belonging had already begun to develop – a sense of community (Anderson 1991; Turner 1969) – that each cohort of residents was said to need to possess (as outlined by Dr. Turner on the first day of orientation).

I'm a doctor now?: Demonstrating inpatient medicine

I arrived at the hospital before morning sign-out was to begin. This was the first day of inpatient medicine for a new team of interns. The group of physicians was seated around a large table in the cafeteria. The new residents were clustered together and seemed a bit overwhelmed by what they were about to undertake – seeing patients in the hospital for the first time as physicians. Three newly-promoted second-year residents were also in attendance. The apprenticeship model had them in pairs – one new intern and one new second-year – for the work of the week. Two more senior residents and one faculty member rounded out group. For the interns this was a new

experience – insomuch as they were no longer students, rather the physicians responsible. Without much hesitation or fanfare, the work of treating patients had begun in earnest for another group of new doctors (Field note: July 12, 2012).

While the first two days of the program’s orientation officially focused on introducing a set of values and dispositions that successful interns should take on via formal didactic processes, I next examine the demonstration of key techniques, knowledge and values as seen on the inpatient service. I outline direct demonstrations of these dispositions and the bodily and intellectual habitus of family medicine in this setting as the interns first began to experience and demonstrate them.

Inpatient orientation

As described in Table 2, beginning with the second week of orientation, three interns each served one week on the inpatient service. Each new intern was paired with a newly-promoted second-year resident to be instructed in the responsibilities and techniques, knowledge, and skills of the floor. The second year “acting interns” demonstrated for the new interns the work on the family medicine inpatient service. Having served four months on the inpatient service already, the current second year residents had mastered the skills and techniques necessary to perform competently on the floor.

As is the case with many inpatient services, the physicians of Suburban Family Medicine worked their “floor” as a hierarchical team. The hierarchy paralleled the degree to which a physician could act autonomously. Each layer of the hierarchy – each role in the team – had different responsibilities, a varied number of patients to whom they were held responsible, and likewise, a varied degree to the amount of work and

responsibility each patient received from that physician directly. The team was organized and managed through its leadership structure as follows. The team was led by an “attending” – a faculty member who, aside from teaching and guiding the work of the group, acted as advisor. He or she worked for one seven-day week and was responsible for all the patients on the family medicine service, though the attending may have not directly provided care to them. Patients were listed under the attending physician’s name – as the residents were not board-certified. In terms of patient care, attending physicians were chiefly responsible for checking the residents’ treatment plans to prevent harm coming to patients; to make certain the best medical treatment was being offered and carried out for the patients.

Since the residents were learning, the attending physician helped assure the patients’ wellbeing and that overall best interests of the patients were served. Legally, the responsibility of patients rested on the attending physician. In terms of resident socialization and professionalization, the attending demonstrated the techniques, knowledge, and values of family medicine as he or she understood and embodied them. This senior physician set expectations for residents to meet. Yet at the same time, attending physicians were intent on balancing these tasks with the long-term goal of autonomy. The attending balanced the needs of residents as students with the expectation and future need to be autonomous and fitting of board-certification.

The chief resident was a third-year that acted as the leader amongst residents, assuring the work of treating patients was done to the standards set by the department (and especially the particular attending). Chiefs operated in a position akin to “middle management” – monitoring the work of the interns in order to satisfy the requirements of

the attending. As I later observed, many chiefs asked their interns to run treatment plans and diagnoses through them, before going to the attending. The chief assured the work of the interns was going well, meeting the needs of the patients, while also getting done in a reasonable amount of time. The chief, for example, could delay the morning table rounds when the morning tasks run long. Over the course of a year, the chief's workload ebbed and flowed, but the overall supervision of interns, ideally, becomes less taxing as the interns' skills improved. As the interns gained more autonomy, could function more efficiently, learned the techniques for writing reports and presenting patients in the "preferred" way, the chief could focus more on teaching rounds, seeing patients themselves, and helping out when the workload got too high.

The chief was accompanied by a co-chief, who was often an accomplished second-year or a fellow third year resident. Though the title seemed to suggest a hierarchical division of authority, in practice, the behavior more often suggested mutual authority and responsibility. For example, in this setting, I did not witness a situation where the title differences mattered a great deal, or where a chief had to "pull rank". The two senior residents shared duties and authority.. In practice, I did observe that a resident must serve as a co-chief before being able to serve as chief resident on the floor, though again I did not notice appreciable differences in their roles.

Interns provided greater levels of "hands-on" care for smaller numbers of patients, while the chief and co-chief served in a more supervisory position. In general, the entirety of the family medicine patient roster was divided among three interns. As the family medicine service was capped at 18 patients, each intern was responsible for up to a maximum of six patients at any given time of day. The cap was a guideline;

occasional additional patients, above the 18 total, were given to the chief and co-chief to be directly cared for. Intern responsibilities included admission, evaluation, diagnosis, generating and enacting a treatment plan, monitoring progress, and discharge. It was the intern's responsibility to get to know the patient, exam them, gather pertinent information for diagnosis and treatment, and to present this information to the team during "rounds".

The resident portion of the team remained fixed for a one-month period, with the faculty attending changing every week. During orientation, the second year residents stayed for the entire month, with a new team of interns joining the service each week, for the last three weeks of orientation month (July). The final three interns stayed into August, but were now the interns solely responsible for the work of providing care to patients. Their second-year mentors went on to other rotations. Given this outline of the work of inpatient medicine, I turn now to my observations of that first day for a group of new interns.

First day of inpatient work

What follows exemplifies the days spent observing and shadowing the inpatient team during orientation. Each day unfolded in much the same way: I arrived at the hospital in the early morning, just before 7am, and joined the family medicine team, following them throughout the day. To give a more full sense of what this experience was like, I begin with a description of the first day of inpatient work for a new team of three interns and continue by shadowing an intern and her second-year mentor as they conducted rounds.

When I arrived on the first day, as for many others that followed, some members of the team were sitting around the large central table. The residents frequently socialized in this space, discussing the drive into work, their families, friends, and the activities they engaged in during the rare moments of down time. Over time, it became a prime spot for me to engage socially with the group and contribute my own stories; all while listening to them interact and bond. The team was waiting for the arrival of Dr. Bierce, the attending for the week – and with a few minutes remaining the team talked among themselves. There were three new interns who kept relatively quiet, still attempting to find their place in this new setting. Overall, the group seemed to enjoy their brief shared down time, to socialize and laugh together. Even I was included, asked about my weekend plans and received a recommendation for a good restaurant.

The chief resident for this month was Dr. Tao. While the group was socializing, she appeared quietly focused, presumably on getting organized for the morning rounds to begin. After ten minutes or so of the group socializing, she called the group's attention. With a little time left before Dr. Bierce's arrival, Dr. Tao outlined the typical activities of the inpatient work day. The morning, she explained, began at 7am with a quick "huddle", going over what happened during the night, receiving a systematic report, or "sign out", on all the patients from the night block resident. They discussed which residents would be assigned to which patients, particularly new patients. They prioritized the work to be done, with a heavy priority placed on discharging patients that were ready to leave. The interns were expected to see all their patients and write progress notes on each, preparing or amending the plan for treatment. They would reconvene at 10:30am for "table rounds" where they would review the work of the

morning, with the chiefs and attending confirming or helping revise the treatment plan for each patient.

Dr. Tao reiterated how the table rounds may be pushed back to 11am if the work was taking too long. The team would break for lunch around 12pm and reconvene in the afternoon, around 2 or 3, for a second “huddle”. By 5pm, the team should have all the treatment plans for all the patients in motion, and be ready to report to the night block resident for overnight monitoring and care. Dr. Tao and her co-chief, Dr. Probst, encouraged the new interns to follow their second year residents very closely, to learn from their example.

As Dr. Tao was finishing, Dr. Bierce arrived. With a simple “hello”, he took his seat. Dr. Bierce was slim Caucasian man in late 30s or early 40s, with a neatly trimmed beard and shortly cropped reddish-brown hair. He often presented a calm, friendly approach to his work and interactions with the residents. Dr. Tao began the table rounds. The “huddle” got underway. “Who can be discharged?” was the first question the attending asked in assessing the list of patients. The group prioritized potential discharges, deciding who could safely be sent home. As described above, discharges received top priority for the work of the morning. Insurance billing was a factor, given that discharges not completed by 9am were charged for another full day of hospital admission. Patients each had certain key criteria to meet for discharge, depending on the disease in question. These criteria were sometimes talked about by residents in planning their work. For example, a patient who was taken off of food for digestive issues must be eating solid foods on their own before leaving; in particular, they must have a bowel movement to be considered “safe to leave”. As one resident put it, “Once

they poop, they go home.” I found it interesting that the physicians used the term “safe” in regards to leaving the hospital. It connoted not that the patient was “cured” and healthy, but rather no longer needing the level of care provided in a hospital setting. I decided to pay attention to ideas of “safety” in these types of discussions going forward.

The night block resident verbally “hands off” the patients from the overnight shift. Typically, there is little in the way of details – simply an update of where in the process of treatment each patient is, with more detail given about new admissions¹¹. Further, there were written progress notes in each patient’s electronic medical record that all the physicians could access and read for themselves. This verbal handoff however provided a concise narrative of the events surrounding the patient, but also provided another moment for interns to demonstrate that they could give a practiced, organized presentation of patient information. Within a few minutes, the night block resident had finished her verbal handoff and quietly packed up and left.

The discussion then turned to formally assigning new admissions and forming pairs of interns and second-year residents. Dr. Tao set expectations for the new interns – they would begin the week observing, do more hands-on work on their second day, and by the third day were expected to write their own progress notes. At this point, the group broke into teams and began the work of seeing patients. Recognizing the time involved in this transition, Dr. Tao decided immediately to push “table rounds” back to 11am. The teams had 3.5 hours to see six patients per team.

Having given this general overview, what follows next are a focused series of patient encounters, following a key second-year informant and his new intern, designed

¹¹ Verbal hand-off is a problematic system, by numerous accounts; the locus of more medical errors than any other part of inpatient work (Solet, et al. 2005, Vidyarthi, et al. 2006, Arora, et al. 2005).

to provide an impression of the nature and rhythm of the work done. In this way, I began to learn about the embodied habitus, the demonstration of techniques, and the transmission of normative behavioral patterns during orientation. The initial framing descriptions about these activities were now over and the hands-on work was beginning for the interns.

Shadowing an intern-mentor team

That first morning, I shadowed the second-year resident Dr. Bonowitz and the new intern Dr. Williams. Dr. Bonowitz was a tall, thin Caucasian man in his late 20s, with glasses, light brown hair and a receding hairline. He carried himself in a confident but reserved manner; erect, carefully poised, but somehow distant. I seldom heard him speak outside the encounters I am about to describe. He did not socialize often with the new interns but I saw him share a friendly, working relationship with his more-established colleagues. Dr. Williams was a tall, thin African-American woman, also in her late 20s. She had a very athletic build, befitting her as the intern who had almost qualified for the Olympics. She was often quiet as well, but when she spoke it was with confidence in her abilities. Privately, she reflected to me that she understood she had a lot to learn, but also knew she already had a lot of knowledge and skills. I wondered if some of that confidence came from her prior training as an elite athlete and the mindset and disposition required there as well. She seemed very eager to learn.

I followed the pair out of morning rounds and asked to shadow them for the day. They smiled and agreed. We walked together without much conversation until we reached the nursing station closest to the room of the pair's first patient. Getting started, Dr. Bonowitz grabbed the chart for their first patient and sat at a computer terminal to

access vital records and test results. He told Dr. Williams that she would see this patient, with himself acting as observer. This was an interesting departure from the established order as explained by Dr. Tao: Dr. Bonowitz asked Dr. Williams to begin right away and not spend all her time observing. Below, I will describe further how this decision unfolded in practice.

Dr. Bonowitz silently reviewed the patient's chart and then handed the chart to Dr. Williams. She likewise reviewed it quietly. Neither asked questions, though Dr. Bonowitz asked Dr. Williams to examine the patient and assess patient's current state. Once both doctors had reviewed the chart, they entered the patient's room. She was an older Caucasian woman, perhaps in her mid-60s. Let's call her Mrs. Jones. She was in the hospital for a second bout of stomach pains. Dr. Bonowitz said good morning to the patient, though Dr. Williams did not. Instead, Dr. Williams began her examination. Her exam and interaction with the patient was strikingly clinical – all business, designed to gather the necessary information to ascertain the patient's progress and improvement, or lack thereof. The patient made passing comments, about her pain, about her concerns regarding a potential procedure – these were mostly unheard as the new intern was more concerned in gathering the information to write her note and report to her colleagues. The patient eventually fell silent; she seemed to surrender her concerns to the work of what these two residents were doing.

In witnessing this patient-doctor dynamic during the initial exam, I found myself thinking about how for a new intern, and possibly other new interns, the ability to simultaneously listen to patients and fulfill the responsibilities of a thorough medical exam could be challenging. Some of these medical responsibilities may be less obvious

to the patient or of less interest to the patient than what they want to express to the physician. The patient's need to be heard and have their illness experience understood could be in tension with the inexperienced resident's need to conduct a thorough, accurate physical exam. The collection of medical information took priority. This interaction was certainly diagnostic, perhaps curative, but left something to be desired in terms of learning to listen to patients or how to discuss their treatment collaboratively.

I started wondering whether perhaps a more advanced resident would have had more interaction with the patient. For example, while Dr. Williams was conducting the physician exam, pushing on the patient's stomach, Dr. Williams looked to Dr. Bonowitz and he took over speaking to Mrs. Jones. This interactional exchange, taking only a moment, suggested something about the power relationships between the two doctors. Was Dr. Williams subtly calling out to Dr. Bonowitz, asking for the help she was told she could expect? Perhaps, Dr. Bonowitz was waiting for her to ask before stepping in. Another interpretation is that Dr. Bonowitz was not focused on the patient interaction either.

Dr. Bonowitz then spoke to the patient. On the one hand, his demeanor was very focused on the task at hand, asking Mrs. Jones to describe her symptoms specifically. Yet some of his questions were also more collaborative in nature: for example, he directly asked Mrs. Jones if she felt ready to go home. The patient seemed to hesitate in answering the question directly, instead expressing concerns about how her mother had died. Perhaps Mrs. Jones was worried that her own symptoms, mirroring her mother's, portended her own death. The doctors did not acknowledge these concerns. Instead, Dr. Bonowitz moved on and offered a follow up clinic visit within a few days of discharge

– a standard, structured follow-up process. Then he assured Mrs. Jones that as long as she was feeling all right, she would be going home today. He never received a clear answer from the patient on whether or not she was ready to go home.

In reflecting on this early education moment, I find the dynamic here very telling. The second-year resident was able to demonstrate some of the values and ideas of acting in the role of a family medicine doctor. He asked the patient to express herself. However, some of the aspects I might consider “healing” as described in that literature (e.g. acknowledging and addressing statements pregnant with meaning) were not present, at least at that moment in time. It was as if both doctors, consumed with the tasks at hand (Williams just trying to get the exam right; Bonowitz with making sure Williams was well instructed), missed the patient’s deeper concerns in this interaction. Deeper still is a dissonance between meanings of being “ready to go home”. To the physician, as described above, a resolution of symptoms to a “safe” degree meant the patient should go home and finish recovering. The patient had other concerns about her grief over her mother’s death – and concerns about possible missed cancer. The discourse emblematic of healing – and the holism of family medicine’s object – could have better uncovered and addressed this concern for all the parties involved. The biomedical focus on symptom resolution is only a part of family medicine’s dedication, and the doctor-patient healing relationship was not solidified in this encounter.

As the doctors left the first patient’s room, they immediately entered the room across the hall, where the second patient was already dressed. This patient was an African-American woman in her twenties, who moved quickly around her bed packing her belongs. She was eager to leave the hospital, and I was not able to ascertain what

had led to her admission in the first place. The residents did not spend much time with this patient, rather knowing from table rounds that the patient was ready to leave, they took the opportunity to say goodbye. Within moments, the pair left the room and moved down the hall to the closest computer work station. As we sat down, Dr. Bonowitz would comment, "It's 8am and we already have two discharges". My first reaction was to note that the counting up of the successful discharges was what the residents focused on and how they had internalized the message that discharging patients was an important marker of success in managing the inpatient service. .

Reflecting back on this interaction later on, I further saw discharging patients as an investment in symbolic capital as well. If that the family medicine team in general, and the residents in particular, can discharge patients rapidly, it signals that they are providing good care, keeping costs at a minimum, and readying beds for the next patients. The physicians had little power over who came to their inpatient service, but they demonstrated considerable power over who left it and when. The criteria for these discharges were set up through the institution (insurance requirements), the biomedical practices of the field, and the expectations and training from faculty attending physicians and chief residents. I had yet to witness a disagreement between physicians on who was ready for discharge, though later I would encounter patients who disagreed, straining the power dynamic by questioning the physicians' authority and judgment over discharge decisions.

At the computer workstation, Dr. Bonowitz spent the next hour instructing Dr. Williams in how to prepare discharge summaries. On other occasions, I similarly saw that a great deal of care was placed in these instructions. For instance, I observed

numerous second-year residents showing interns, step-by-step, how to prepare discharge summaries; which computer menus to click on, where to sign, how to place orders for nurses to go over discharge materials with patients. Dr. Bonowitz also spent time explaining what phone numbers to memorize, or keep close at hand, how to make sure the patient goes home with the correct medications, and which medications need to be administered by another service (for example, cancer treatments must be administered by oncology, high-level antibiotics by infectious disease). From this repeated type of interaction, I deduced that the technique-driven skills of inpatient medicine were those skills the second-year residents were most newly adept at and eager to demonstrate. The computer techniques were quantifiable skills they could pass on. The doctors could shed light on their own cultural capital through demonstrating these tasks; and by extension communicate to the interns the greater degree of symbolic capital possessed by virtue of being a second-year resident. A power message here is that Dr. Bonowitz knew something that Dr. Williams did not. Dr. Williams needed this technique in order to be successful in the eyes of the inpatient leadership.

However, perhaps this imbalance in knowledge was not entirely the case. While the duo worked on discharge summaries, I asked Dr. Williams about her experience writing progress notes. I observed that she seemed more confident, more skilled, in this regard than other interns I had observed. Most importantly, she knew her way around the specific computer programs used for electronic medical records, writing notes, and putting in orders, even before Dr. Bonowitz's instructions. The ability to navigate electronic medical systems was clearly valued in the program; the work could not be

done in the same way without computers. Dr. Williams was able to perform competently through demonstrating knowledge of these bureaucratic aspects of doctoring.

I was curious as to how she was able to demonstrate these skills so early in the program. She explained that she had done a two-week observership at Suburban Hospital with family medicine, prior to applying for the program. She learned a lot about the computer system, commented regarding her mentors “I’m not as fast as these guys, but it takes practice”. This explanation was unexpected, and illustrated a secondary benefit to rotating through hospitals during medical school – the faculty get to know you, your face and your work. The potential resident can demonstrate their cultural capital – their level of development as a medical student – prior to applying for residency, hopefully increasing their chances of getting in. Yet she did not convey her past experiences to Dr. Bonowitz. Her position was to accept his authority in guiding her actions, established by the orientation model laid out by program leadership, to be mentored. She had spent years in the student role and seemed to fall easily back into here, despite her own local knowledge.

After our conversation, while finishing up the discharge summaries, Dr. Bonowitz asked Dr. Williams take on a few more tasks. He laid out expectations incrementally, placing upon Dr. Williams the expectations that would be hers alone once this direct apprenticeship ended. It was not my impression that he was singling her out for special encouragement, only helping her to become the autonomous intern that every intern was expected to become. He encouraged Dr. Williams to begin making phone calls to patients’ families and to work on her own discharge summaries. He also informed her

that she would be expected to see patients on her own soon, and report back to him what she found.

After explaining the ramping-up of expectations, Dr. Bonowitz took the lead again, taking Dr. Williams off to see another patient. Here, Dr. Bonowitz demonstrated for Dr. Williams his own approach to examining patients. Importantly, Dr. Bonowitz was demonstrating a suite of skills and attendant values. They entered a patient's room together. The patient was a middle-aged Caucasian woman in her late 40s admitted for difficulty breathing and to diagnose a possible seizure. She was extremely obese. Her room was cluttered with personal possessions, lying on the floor and in the chair next to her hospital bed. Propped up in her bed, she smiled and greeted the doctors as we walked in.

The way Dr. Bonowitz's phrased his opening question demonstrated some sensitivity to the barrage of questions patients receive while in hospital. He began his question, "Since this is my first time meeting you" and asked her to explain what brought her into the hospital. Throughout my time at Suburban, I frequently saw physicians use some variation of this phrase whenever they met a new patient. I never directly witnessed the expectation that this phrase should be used by residents – or patients for that matter. The fact that many physicians in the setting used the phrase, but no one told the new interns directly to begin using it, suggested an important informal shared technique in patient communication.

Dr. Bonowitz listened to the patient's story, asked a number of clarifying, mostly yes-no questions, and collected the patient's account of the hospital admission and how she was feeling. At this point, Dr. Bonowitz segued to the physical exam, asking the

patient to sit up. She struggled and seemed weak, unable to comply. A nearby nurse, as well as Dr. Bonowitz, did not offer to help her sit up, watching the patient struggle. Dr. Williams stepped in and helped the patient. It is unclear why Dr. Williams decided to intervene while others did not. One interpretation may be that while not distracted with the pressure to examine and evaluate the patient herself, Dr. Williams was more able to concern herself with the patient directly. Other interpretations could relate to differences in power, empathy or sensitivity shown. Each medical staff member's personality, prior life experiences, job role and gender differences may have all contributed. As an intern, I also wondered whether Dr. Williams was expected to be more hands-on, even when the nurse was present.

As part of the physical exam, Dr. Bonowitz engaged in something I had never seen before. He attempted to assess the patient's strength by having her squeeze his fingers using both hands – she would squeeze two fingers on his right hand with her left, and two on his left with her right. This was to assess her physical strength and to determine if she was weaker on one side than the other. He instructed her to squeeze both hands as hard as possible, to “try and break” his fingers. I saw other residents use this technique, with the same request to “break fingers”. Odd as the phrase may sound, I think the intent was to cause the patient to squeeze as hard as they were able. While Dr. Bonowitz demonstrated this technique for Dr. Williams to watch, none of the healthcare staff or the patient commented on or joked about the fact that this is not the most “normal” of social interactions in this society. Rather, they all just went through the motions and got the task done and results recorded . After finishing his exam, Dr. Bonowitz thanked the patient for her time and the residents left the room. I was left

wondering what exactly this exam demonstrated for the new intern, what information it provided the team for treating the patient, or what the patient took away from the encounter.

This exemplar is quite typical of the kinds of interactions I witnessed throughout my time on the inpatient service. The pair of residents continued seeing their patients in much the same way, leading up to the table rounds at 11am. Throughout the day, the pair encountered other residents. The chief and co-chief, for example, came around expressing their own expectations that progress notes and discharge summaries be properly written and warned that they would be checking for accuracy. The attending, Dr. Bierce, came through to check on the residents and see patients for himself. Clearly, I was being socialized into the system as well as my field notes also tended to emphasize these discussions of “how the work was getting done” as opposed to more about how patient-clinician partnership was being formed or hindered for example.

In reflecting back, it was a dance of sorts where the work got done; often juggling the needs of multiple patients at the same time, learning and understanding that certain things had to happen before the next event could occur. Some patients were getting better, some get worse, some were ready to leave, and others expected to stay. Meanwhile, the residents were constantly doing – advanced physicians instructed the less advanced, showing the appropriate way to manage the enormous workflow. Learning to navigate that workflow was of great importance in this stage of training.

Discussion

From orientation, I learned a number of things that can contribute to answering my central research question of what it meant to become doctors and healers in this

family medicine residency training program. First, the taking-on of “the work of being a doctor,” as detailed above, was given primacy, pushing interns into a new role almost immediately. Secondly, the hierarchy and workflow of inpatient medicine was an important arena for socializing interns to the hierarchy in the department and the importance placed on discharging patients. Thirdly, the interns struggled with this transition to being a doctor and the department took pains to help establish relationships; these relationships helped cement symbolic importance of the work to be done through shared interaction. Throughout these orientation processes however I was struck by the lack of any deep focus placed on patients themselves. As shown through a series of doctor-patient interactions above, many opportunities were missed to both focus on family medicine’s object and make the patients more central to the process of learning to be a family medicine healer. I began to question how healing can emerge here without a more explicit focus on patients.

A dominant theme of orientation was clearly a focus on taking on the role of the physician, to “be the doctor”. The classroom speeches and early inpatient experiences provided the interns clear expectations and role-modeled appropriate behaviors for them to emulate. Dr. Hedges, Dr. Turner, and Dr. Tao all used phrases like “you’re the doctor now” and “embody the role” to place clear expectations on the overall expectation of ownership and responsibility for the work to come. This phrase was a symbol for the new interns, alerting to them to the need to assume responsibility, and to pay attention as these phrases are demonstrated by their new mentors. To operationalize this “embodying the doctor”, Dr. Turner challenged the new interns to think of themselves as the only person responsible for the care of their patients. If they

behaved and made decisions with this importance placed upon them, they would step up to and meet the expectations of the program, perform better, and ultimately be awarded with the symbolic capital to perform in ever greater degrees of autonomy. The evocation of the term “embody” again and again during the orientation month meshes with Bourdieu’s writings on practice. Bourdieu felt that internalized, embodied social structures guided the formation and implementation of practical knowledge and social action (1984). This “taking on the role” disposition was critical; it served the foundation on which all the learning that led to becoming a family medicine physician was based.

Interestingly, a deeper discourse around family medicine’s values and what it meant to be not any type of doctor, but a family medicine doctor, were nearly absent. This orientation could have been designed for interns in any medical specialty; the distinct attributes of family medicine’s object were not highlighted. The broad values of working hard and “embodying the doctor role” were given primacy, but where was the “family” in this description of the work of medicine? The work of the intern was described in terms of skills assessments, about asking for help, and learning computer systems. It was evident that the leadership was successful in designing a supportive learning environment for the interns in some senses, but more in supporting them to towards technical tasks and bonding as a group.

What is more to the point was the lack of patient focus. If family medicine claims for itself a patient-centered, holistic approach to patient care, what does that mean for successfully taking on family medicine’s object when the orienting ritual of their entire three years of education does not substantively mention relationships with patients or demonstrate effective patient communication? Dr. Tao began with a lengthy description

of the tool the department uses to record patient signs and symptoms, but did not demonstrate how such a conversation with a patient would unfold. She spoke elsewhere of the importance of “sign out”, but not about family medicine’s dedication to continuity of care. Dr. Bonowitz spent the majority of his time with Dr. Williams demonstrating computer skills and chart reviews. The pair’s interactions with patients reflected an overall lack of focus on the doctor-patient relationship. Dr. Hedges welcomed the interns to the “family medicine community” but did not convey meaningful ideas about embodying family medicine’s values to the residents. Ideally, these values would have been highlighted by program leadership and modeled by faculty and senior residents for the new residents from the outset.

As I analyzed orientation and how family medicine’s object was being handled, I realized the need to relate these topics to my central focus on healing and how healers are being made. This awareness led me to question how to approach the definition of healing in the fieldsite. I wish to move beyond Kleinman and Good’s distinction between disease and illness, curing and healing. In the philosophical work of Canguilhem’s (2012) writings on medicine, there is useful broader discussion of some of tensions I was now already seeing between physicians and patients in the fieldsite. What medicine owes the patient, Canguilhem contends, is “the best-studied, best-tested, and most-used treatment currently available” (ibid: 54). What the patient expects is often something different, and satisfying that expectation lies at the heart of healing. How then can a physician hope to ascertain, and therefore address and heal, that expectation without focusing on the patient and communicating effectively? The doctor’s perspective, Canguilhem repeated asserts, is often the organic state of the patient and

his or her health, and the orientation at Suburban was certainly focused in that direction. I will return to further considering the ideas of Canguilhem in later chapters.

A great deal of the early hands-on learning involved taking ownership over developing skills in diagnosing and treating patients, as well as writing progress notes and interfacing with computerized medical records and prescription systems. No direct instruction was provided regarding how to speak to patients, and what use to make of the information patients provide. It was not indicated that those other types of information that patients provided could be important contributors to the diagnosis and treatment of disease – or whether healing ultimately occurs.

During the patient encounters I observed in the orientation phase, the residents focused on the physical exam of the patient and later discussed the progress notes and discharge summaries as relevant to each patient. No discussions were had about how the patient would adjust or process the personal experiences of their sickness. Perhaps this focus on the technical skills of early doctoring is not entirely surprising given the conceptual model Sinclair (1997) presents in his work on medical education. Sinclair (1997) makes a distinction between “basic” and “advanced” medical habitus in psychiatry, that particular skills and dispositions are acquired before a more sophisticated, personal style emerges.

These opening weeks clearly remained focused heavily on basic, technical, disease-focused learning. The symbolic weight placed on these diagnostic activities conveyed a message to the interns: diagnosing and treating disease was of higher importance than attending to the patients’ illness experiences. Seeing this, I was now confronted with new ideas about how to think about how healers are being made in this

setting. I resolved to better explore this focus via my data. What might the lasting effects be when learning first takes the form of biologically-driven treatment and management of disease, rather than attending to the illness experiences of patients? What then are the long-term implications for the making of family medicine healers in this setting and American biomedicine more generally?

Knowing that family medicine claims to be both a patient-oriented and relationship-based specialty, I now also found the preoccupation with patient discharge and related “safety” issues during orientation to be somewhat unexpected and jarring in thinking about the making of healers here. In their demonstration of appropriate care, the chief resident and attending physician role-modeled for the new interns a keen primacy on patient discharge. On the one hand, it could be argued that this is a very patient-centered approach. After all, it is common thinking that patients often want to get discharged from the hospital and go home as soon as possible. Yet, while that may often be true, I was already finding the way conversations about discharge proceeded to be somewhat strange - and possibly at odds with what I had perceived family medicine’s object and notions of healing to be. In particular, I was not thinking that the rapid path to discharge and related safety issues were going to be the central focus of these discussions – as I found to be the case during my observations from the orientation month. To reiterate, it was the first question Dr. Tao asked during table rounds; which patients were “safe” to go home. This question conveyed important symbolic capital regarding the professional responsibilities of the team to access patients as medically ready to leave the hospital. They assessed patients’ progress

towards wellness in a clinical sense and prioritized the financial concerns of the hospital and patients themselves by avoiding additional accrued costs.

As indicated, this focus now left me with numerous concerns. First, what does “safe” actually signify? From a technical viewpoint, the patient was medically stable and not at risk of needing immediate medical intervention. They could recover at home. In the thinking of my physician study participants, patients were being labeled as cured or on their way to returning to a state of wellness without further intervention. This approach speaks to Mizrahi’s (1986) notion of “getting rid of patients”. The residents were eager and often self-congratulatory about discharging a patient; it became a symbol of their success as physicians. The term “safe” was a signifier that they had completed their expected tasks for the patient and the medical world would agree with their assessment of patient readiness. As with Bosk’s (2003) idea of technical errors, the team had performed their tasks well and the patient had recovered; no error was made. However, what of the moral dimension that Bosk warns? What does the physician owe the patient in the decision to send the patient home?

The patient may have been “cured”, but without assessing the patient’s desire to go home, the healing relationship remains unrealized. What’s safe for the medical system, in other words, may not be safe for the patient’s sense of resumed health and wellness. The clearest example came from the woman with stomach pains described above. Dr. Bonowitz asked if she felt ready to leave the hospital but never received a complete answer. He failed to hear the patient’s fear and find that “coming to terms” between doctor and patient that Canguilhem asserts is at the core of healing practices.

I was thinking about how a more collaborative approach would also conform to family medicine's object, to patient-centeredness taken more deeply. In this sense, the hierarchy of the medical habitus placed the patient's emotional concerns below physical health. Again, if family medicine views itself as distinct from other specialties, particularly in their focus on a whole-patient approach, why then was a disease-focused approach prioritized over an illness-focused one? Why not teach both of these techniques, both "basic" and "advanced" dispositions, simultaneously? I keep exploring these key questions relating to healing in subsequent chapters.

I would certainly like to explore further what this orientation process meant for the interns later on as they become family medicine physicians. As I documented, orientation is a meaningful and memorable education phase. I showed that many residents have not even become used to referring to themselves as "doctor". Clearly, this is a key time, the almost ritual-like boundary marker wherein the person "becomes" the doctor for the first time, though the process will be ongoing. This is a rite of passage, a movement from one stage of life to another – an assumption of a new set of dispositions. These early rites of passage take the intern through a tension – between doctor and student – and bring them through the first days and months of acting as a physician. They were, in a sense, displaying the capital of having graduated from medical school and outwardly displaying their new social role for the first time. Without this critical step, the other work as designed would not have been possible.

There was an ongoing discourse, in other words, around the values and principles of medicine, drawing into conscious thought those cultural values of the habitus. The family medicine community holds certain ideals; statements that not only

guide the new interns towards “right” action – the appropriate capital to acquire and demonstrate – but succinctly summarize the values, beliefs, and expectations of this habitus. This orientation process was very telling in communicating the relevant and high-capital values, skills, and knowledge for the interns to pick up – as well as a lengthy discussion of the critical dispositions that the interns *must* develop if they are to be successful.

The program placed emphasis on the bonding between residents, starting from the Icebreaker Game on first day of orientation. Friendships and collegiality aided in the development of an apprenticeship model between new and more senior residents. The moments for bonding were brief but abundant through orientation on the inpatient service. Moments of downtime punctuated the work of inpatient medicine and allowed the residents to form bonds that supported one another, but also helped in the assimilation of new capital, reinforcing the work to be done by virtue of seeing their fellow interns working as well. The sense of community lent symbolic importance and encouragement that the work they were undertaking was critical to development and yet attainable through cooperation.

The new interns were encouraged to ask for help when it was needed, reflecting a central disposition of maintaining a safe learning environment; questions were encouraged and the mentors acknowledged that the new interns were still learning. The program was preoccupied with notions of safety, foregrounding it here in orientation and working to assure it for patients as well. Asking questions was expected and even encouraged; if an intern needed help, they just needed to ask – “we’re all here for you”. A contrasting notion of “pimping” appears in the medical education literature (Brancati

1989), where faculty and senior residents drill newer residents on esoteric medical questions and humiliate them for not knowing the answer. Overall, at Suburban Family Medicine, I did not witness this type of teaching from orientation on. For the most part, residents were treated as professionals who were expected to own the work, while also being acknowledged as students who were still learning. More examples of how the student and physician role were contrasted in the residency education program will be forthcoming in the next chapters.

The advice interns received from both faculty members and more senior residents were also a demonstration of key dispositions at play in the program. Through this advice, many key values, beliefs, and dispositional attitudes emerged in an unstructured, possibly unintended way. Much of the advice about handling residency was surprisingly consistent. The possibility should be acknowledged that all the speakers might have simply been speaking to normative expectations and not expressing deeper individual feelings. On the other hand, the data will show that these dispositional attitudes were heavily present in the field. There were important and often subtle power dynamics at play within the orientation activities. As explained above, orientation introduced numerous expectations placed by faculty and senior residents upon the new interns. However, the mechanisms by which these expectations impacted the actions of the interns were less clear. Rouse's (2007) work on power and practice theory explains how the alliance between the quest for authoritative knowledge and the influence of political power influences the actions of actors within a particular habitus. The physicians held the mutual commitment to training towards competency and board

certification, towards obtaining that authoritative knowledge. Mentors, both faculty and senior residents to varied degrees, held the power to judge the progress of each intern.

The new interns were introduced to this power dynamic long before residency training. Educational systems are set upon the premise that someone with a claim to knowledge will impart this knowledge to those who are seeking it. Undergraduate and medical school education set the bar of learning high for these interns. Entering residency training involved further indoctrination through “The Match” (Chapter 3) that created tension around being accepted to a program. Once hired, with the stated goal of seeking board certification, the words and expectations of those who had achieved what the interns were setting out to achieve carried the power to influence the actions of those interns.

Throughout orientation, the leadership explained in detail paths to successful navigation through the program. The unspoken subtext was an implied risk in not following this advice. Dr. Turner, Dr. Hedges, and Dr. Tao all clearly laid out the expectations of “being the doctor” and “taking ownership” of the work. The interns were told explicitly how the formal activities of orientation would unfold. There was no choice given on the matter. The leadership held power by virtue of their capital, their authority to bestow markers of competency on the interns as they progressed. These were markers that the interns sought by virtue of their desire to become competent and eventually autonomous, board-certified family medicine physicians.

The advice given during lunch sparked a number of curious power issues. First, the interns were not in a position to give advice, but rather accept it, despite perhaps having advice to give each other too. The capital they possessed suggested their advice

was not yet valuable. Faculty members and more-senior residents could give advice. The luncheon was an innocuous moment that defined the power structure. The rhetoric of safety is seen again and again; encouraging questions and to learn from one's mistakes. This rhetoric may not always pan out, as will be seen in Chapter 7. The senior physicians were giving the interns permission to be learners, yet simultaneously asking them to act as competent physicians.

I was left with a number of questions that I would like to explore further in the future. Why were certain physician faculty members involved in orientation and others not? Dr. Tao's message dovetailed very closely with Dr. Turner's and Dr. Hedges'. Was she chief resident because she followed the established power structure of the habitus so closely? The second-year residents were also often eager to "give back" as I learned in their interviews, but were they selected because of their ability to teach – to convey the expectations and help reinforce the power dynamic towards learning? The interns were focused on meeting the shared expectations being placed upon them. Any lateral exercise of power was often in the support of one another and the bonding they experienced, mutually influencing each other's actions towards improved performance. The Ice Breaker game furthered the process of bonding this group of interns together for mutual support. Considering the interns would often be working separately from one another, reflecting on the shared connections between them could provide a sense of *communitas* in going through these challenges together. The present power dynamic – explanations and demonstrations of what behaviors would cause the leadership to bestow promotion, trust, and eventually competency – influenced the actions of the interns. In talking with the interns during orientation, they expressed wanting to succeed

which involved learning what the mentors were offering and being willing to behave accordingly in order to get it.

These first experiences placed a premium on often technical, biomedically-focused medical practices. These opening weeks also established the underlying power dynamic for the three years to come. Exactly what sort of healer was being made remains unclear at this moment. As we will see in subsequent chapters, this dynamic was not straightforward or always equally accepted. Symbolic capital was continually meted out and owned in particular ways as the interns settled into the learning environment and made it their own.

In sum, it is important to remember orientation's place in the larger educational processes of making family medicine doctors. Orientation was the initiating process, the opening act of a multiyear educational program. Orientation marked the beginning of the social transformation of new residents, all of whom are newly graduated medical students, into active, role-assuming (and board-certified) physicians. A focus on family medicine's object was not obvious at this stage; rather the focus was on the technical work to be done. Where the learning and education of the orientation month was overtly geared towards the preparation of new interns for the work ahead, the months and years that follow will be more formal, diffuse and varied. The learning focused instead on learning through doing (Coser 1979) – the maxim “you're the doctor now” operationalized in the expectation that interns take ownership and demonstrate their skills as learning physicians.

The residents have a great deal left to learn. They are taking ownership of their new work expectations for the first time. They are beginning a three-year journey

towards becoming board certified physicians and competent, socially-recognized, autonomous healers. The complexities of this journey, the formal and informal learning that takes place, are explored in greater detail in subsequent chapters. I now move to outline key learning activities residents undertook more generally in their three years of training. By exploring the demonstration, interpretation, and assumption of additional key dispositions, I explore further the values of family medicine, engagement or lack thereof with its object, and the emergence of a local definition of healing.

CHAPTER 6

BEING DOCTORS

I now describe some of the activities undertaken by residents as they moved beyond orientation. To understand this next educational phase, it is useful to recall that faculty members consistently described resident learning as following an “apprenticeship model”, wherein residents and faculty work together to teach each other and to teach those not as far along in the process. Another framing concept frequently used was one of “learning by doing”. The program director, Dr. Hedges, explained it this way:

What we're aiming to do is train doctors to become family physicians at the very core. And how we do that through a residency program is going to be largely through what I still think of as an apprenticeship program. What that means to me is that it's "learning by doing" and primarily learning by doing and having teachers alongside the learner continually in order to learn. It also means though, when I say that, it's not just one-on-one. There are multiple levels of learning and as each learner progresses in their capabilities then they also start to teach the people who are behind them in that learning process. So we have- not only do we have faculty members teaching, we have third-year residents teaching second-residents who are teaching first-year residents who are teaching medical students. And that all of that hierarchy in learning is all important because it's part of how we are all learning together (Interview: February 25, 2013).

Following on Dr. Hedges’ quote, I apply the framework of practice theory to the observed broad dispositions and accumulation of capital, while attending to the idea of “learning by doing”. The educational activities observed reflected the changes in residents’ behavior and values over time; their overall process of professional socialization within the habitus. This frame – “learning by doing” – is in keeping with the broader theoretical framework of practice theory; it is practice theory in action – taking on the expected dispositions of the particular habitus through “prestigious imitation” (Mauss 1973).

Taking on the role

From the onset of the program, new residents were expected to display certain emblems of professional identity – to dress and behave as a physician. These emblems allowed the physician to enter the particular social space of the doctor by displaying the proper symbolic capital, even if they were still in the process of accumulating it. How to act like a doctor revolved around particular symbolic acts of “doctoriness”. Specific meaning was conveyed in the way a physician dressed, how they addressed patients, and how they interacted and communicated with one another as professionals. I will first illustrate how residents took on the role of family medicine physician through their appearance and expected daily behaviors.

Looking the part

Early on, I was struck by the way in which the values of the program were directly referenced and made overt; for example, there were discussions around “professionalism” and “communication”. Professionalism began with appearance – an aesthetic embodiment of the physician’s role. Residents were expected to be well-groomed, with clean business-like clothing – and most importantly, to wear their white coats. Residents were first exposed to this requirement in orientation, with Dr. Turner asserting that as new residents, each intern was entering a “professional community” and needed to look the part. Her recommendations were very specific – avoid gym shoes and “scrubs” whenever possible, dress professionally and carry yourself as a representative of the department. She made no other comments on what constituted “professional” attire – a shared understanding was assumed. No one told the residents

specifically how to dress, only what to avoid. Yet from the moment I entered the field, residents were dressed according to these professional expectations.

Scrubs were not absent in the setting; though, wearing scrubs too often was frowned upon. There were certain rotations where scrubs were acceptable – particularly Night Block, where a resident was working overnight in the hospital, or Surgery, where scrubs were a more routine uniform. Residents on these rotations would often arrive for morning meetings, didactics, or rounds still wearing scrubs, and it was not long into their first year that I noted interns wearing scrubs more often. Further, I never saw a faculty member wearing scrubs – or anything less than professional attire; though ties were sometimes optional for men. Ultimately, the habitus of the fieldsite was such that scrubs were not deemed “entirely professional”, needing to be worn in only their proper context.

Why did scrubs not convey this professional identity? Scrubs are symbolic of “doctorness”, synonymous with the image of the hospital physician, and ubiquitous throughout popular media, much in the way the white coat is. Further, other career paths and types of work require similar “professional attire,” so nothing about business wear suggests “doctorness” per se. Yet this shared sense of outward symbolic dress – professional business attire – communicated a shared level of professionalism. The only remaining difference was the white coat: a key symbol that sets the doctor apart as discussed earlier (Blumhagen 1979; Branch 1998; Wear 1998).

Faculty members had a variety of approaches to role-modeling this symbolic bodily habitus. More often than not, faculty members only wore their white coats when seeing patients, and even then not every time. An important example emerged in the inpatient service, where some attending physicians, particularly Dr. Bierce and Dr.

Sharma, seldom wore their coats at all. It is unclear why faculty members sometimes chose not to wear their coats. Dr. Bierce, a younger doctor often cited as a favorite of the residents, seemed to prefer not to wear one. By not wearing his coat, was Dr. Bierce trying to convey youth, closeness to the residents, or casualness in his leadership style? In watching the inpatient team of physicians interact on the family medicine service, another interpretation occurred to me. Perhaps, Dr. Bierce was attempting to convey his advisory role; that the ownership of seeing and treating patients, of being the doctors, rested with the residents. He was there to help, not necessarily to do the work of seeing patients directly.

Even though some residents abandoned their coats in clinic as they entered their second year, interns in general seemed disposed to wear theirs at all times. This difference – when they start taking off their coats versus leaving them on – made me wonder if the coat was a sign of increasing security and demonstrating a certain comfort level in this position. Potentially, the interns were simply trying to make sure that they avoided an “easy mistake” in conduct by wearing the white coats at all times. Length of time in the department (intern or more advanced), setting (inpatient vs. outpatient), or personal preference all appeared to factor into the decision to abandon the white coat as weighed against the expectations conveyed from others wearing the coats.

Regardless, the symbol of the white coat remained a potent one as new residents went through the process of becoming doctors (Blumhagen 1979; Branch 1998; Wear 1998). As outlined in Chapter 1, detailing the foundational work by Blumhagen (1979), the white coat is a symbol of healing, bringing Western notions of “purity” to the treatment of disease. Further, he asserts, the white coat symbolizes

professional identity and commitment to patients. The use of the white coat among residents and faculty members conveyed these ideas broadly, designating the wearer as a socially-recognized physician and healer to patients and colleagues. The fact residents were expected to wear their coats at all times was designed to convey a sense of competency and symbolic capital necessary to perform as a physician which in the case of some residents may not yet be attained. The white coat helped prevent patient confusion and bolster the resident's confidence.

However, it is Blumhagen's later assertion that I find most intriguing: the white coat may in fact distance the physician from his or her patient, placing the doctor in a position socially above the patient. The power of this symbol is difficult to assess directly; is the white coat responsible for some of the social distance I observed, as with the patient encounters with Dr. Bonowitz and Dr. Williams in Chapter 5? I offer an additional thought. The white coat may in fact have served to protect the new resident. The social and symbolic capital conveyed by the white coat may have covered for the resident's inexperience, causing others to treat them as having the competency that they are expected to be attaining. This would help to explain why some, particularly faculty members like Dr. Bierce, no longer felt the need to wear the white coat all the time: his level of experience was such that he could convey his competency and symbolic capital without the symbol, but instead through his actions and approach to patients. This suggests something about the role of behavior beyond "looking the part". The white coat can only take a physician so far; the appropriate social behavior is necessary to succeed and it is to this behavior that I now turn my attention.

Acting the part

Leadership and mentors in the program exercised power over the residents by placing expectations on resident behavior. These behavioral expectations were laid out in clear, overt terms, specific actions new residents should and should not take. Some of these took the form of policies and procedures, including explanations of how to carry out certain tasks. Others were less obvious, more informal, and took the form of role-modeling.

As chief resident, Dr. Tao provided a great deal of information to the new interns during the first month of orientation. Dr. Tao stressed the need to “take initiative”, to “be aggressive” in information-seeking. She asserted that no one was going to fail an intern for asking a question. Essentially, she was encouraging them to take the initiative in being the doctor, but also take the initiative in being the student. In a particularly telling moment, I recall Dr. Tao’s careful reminder to new interns during the classroom didactic portion of orientation:

You’re the doctor now. You have to take it all on. You’ll be the senior resident someday. The more initiative you take and the sooner you learn to take that initiative, the more comfortable you will feel. You’ll impress your attending physicians. They’ll see how competent you are and they’ll teach you more (Field note: July 2, 2012).

This statement – “you’re the doctor now” – was critical to this early stage of professionalization. Dr. Tao demonstrated the importance of this disposition of ownership and responsibility. Dr. Tao reiterated Dr. Turner’s assertion from the first day of orientation – “you need to pretend like there’s no backup. That you are the only doctor and really take ownership. Don’t step back and expect everybody else to do the work”. Dr. Turner encouraged the residents to take on the role of physician, to be scared and proceed anyway. She said, “Embody the role. This is a safe place to be

scared and just do it. To be the doctor. To step forward and be the doctor. Be scared. It's safe. It's ok. Just do it". Clearly, the expectation was for new interns to behave as competent physicians, even if they were not ready, keeping with Sinclair's (1997) fieldwork experiences.

This "embodying" was easier said than done, as was demonstrated by some of the reactions of the residents. Some comments I heard early on in the training program include, "I haven't said 'doctor' to anyone yet," and another commented, "I see myself tripping over that word." Other agreed it was "terrifying" to consider being a doctor and taking on the responsibilities that come with that word. The term carried symbolic meaning for the interns, one different from the meaning carried by those outside of medicine. For these interns, being called doctor seemed to convey at this point, "responsibility," "taking lives in my hands," or "what did I get myself into?". As I have already begun to show, it was not long before the residents were working as doctors. A shared set of high expectations, and struggling to meet them, would lead to a sense of *communitas*, that may in turn reinforce the learning to come; a topic for greater exploration at another time.

Communication was another central value of family medicine residency training. Dr. Hedges, for example, stressed on numerous occasions how effective communication was a key focus of the three-years of residency training. Learning to communicate effectively was critical to the successful assumption and demonstration of a proper disposition of the family medicine doctor, a symbolic value of the role of the doctor and a key skill in the delivery of effective healthcare. What exactly was "communication" and how did one determine if it was "effective" or not?

Central to the notion of communication was “continuity of care”; making certain pertinent information about a patient was accurately passed on to the responsible physician. Continuity of care, symbolized in the so-called “sign out” or “hand off”, was a critical enterprise I witnessed many times, particularly when doctors were leaving the inpatient service or preparing to work the entire service through the night. The idea behind “continuity of care” was to transfer responsibility for a patient or patients from one resident to another, a social mechanism for transferring “ownership”. Residents were directly responsible for knowing vital information about their patients. Thus, establishing continuity of care among members of the healthcare team was especially important for preventing mistakes in patient care. Key goals were expressed as to keep patient care organized and moving towards the goal of restoring physical normal functioning and eventual hospital discharge, and to check the logical approaches to diagnosis and treatment for less-experienced residents.

There have been numerous studies around the problems of a “verbal hand-off” and the mistakes that can occur (Solet, et al. 2005; Arora, et al. 2005). A great many medical errors can be traced to this sign out process (Vidyarthi, et al. 2006). Those training the interns went to pains to stress the importance of careful written and verbal hand off of patients. For example, Dr. Tao stressed to the interns how they were the “continuity” overnight when on-call. The night block was there for backup, but it was the intern’s responsibility to make sure they knew exactly what was happening with all the patients on the service for the night. This discourse around communication and embodying the disposition of a good communicator placed pressure on the interns to learn to perform their duties competently. Importantly, patients’ wellbeing rested on the

thoroughness and accuracy of the communication practices between residents, and between residents and faculty attendings. However, this all suggests a degree of paternalism; the patient is passively in the care of the physicians, what does this continuity say about family medicine's focus on longitudinal care? I will discuss this in more detail later in the chapter.

Learning by doing

A major disposition in the educational model, as first labeled by Dr. Hedges above, was "learning by doing". Through this process, they fulfilled the purpose of being in residency training, to learn to do the work of a family medicine physician, to acquire the appropriate dispositions, acquire and display capital, and become the doctor. As the three years of training unfolded resident physician skills and knowledge base increased, and with those increases was an ever-greater "assumption of responsibility" (Konner 1987: xiii).

Thus through the educational processes of the family medicine residency training program residents took on the particular techniques, knowledge, and values of family medicine through engaging directly with them; by "doing". Through apprenticeship, residents were steered towards the appropriate cultural capital and external behaviors, and towards the accumulation of the competency necessary to graduate and practice autonomously. Finally, the residents were expected to take on certain values, attitudes, and beliefs that are central to family medicine's approach to holistic patient care, to learn to listen to patients and incorporate the patient directly in treatment decisions. I begin by exploring one of the central learning activities all residents frequently engaged in: clinical precepting.

Clinical precepting

The precepting room was an important space where the residents conducted a great deal of the work of seeing patients. The residents interviewed patients to learn what health concerns had brought the patient into the clinic. The residents then began to design a treatment plan with the help of faculty members, here after referred to as “preceptors”. The residents listened to patient accounts of symptoms, engaged in physical exams, and organized this material into a formal presentation for the preceptor. The residents demonstrated their diagnosing and treating skills to the faculty preceptor through these presentations.

The goal of precepting was to convey the necessary level of attention to the facts of a patient’s disease, to determine the choice and interpretation of the appropriate tests towards diagnosis, and to design (and explain to the patient) a treatment plan to address the patient’s (and the physicians’) concern(s). Further, this process moved the resident towards a mastery of diagnosing and treating diseases common to family medicine – flus, common colds, heart disease, diabetes, asthma, etc. – and learning when the resident should refer the patient to a specialist.

Clinic sessions ran in half days, morning and afternoon, with two to five residents seeing patients nearly every day. The number of patients on a resident’s schedule varied depended on their status within the program. In a four-hour block, an intern would see four or five patients, second-year residents between six and eight, and a third-year resident eight or even nine patients.

Faculty members typically saw a patient every 15 to 20 minutes, meaning they could see a dozen or more patients in the same four hours. Faculty, however, did not

precept their patients; a process that added time to each resident-driven encounter. During resident clinic hours, the faculty member stayed onsite and waited for residents to see patients and prepare a presentation of what information they have gathered and what they intended to do to address the patient's concerns. Precepting duties rotated among the various faculty members in the department. The preceptor's role was to guide the resident's presentation towards clarity and conciseness, to help guide the resident's logical decision making regarding diagnosis and treatment, and to point out things the resident may have missed. The faculty exercised their authority to expect particular behaviors from the resident in their presentations, behaviors that would impact the way they performed medical practices.

The social act of precepting was a formalized process each resident had to learn and master in order to progress in the program. After seeing a patient, and gathering the information necessary to make a presentation to their preceptor, the resident prepared their thoughts, perhaps looked up notes in the electronic medical record from prior office visits, and waited for the opportunity to speak to the preceptor. At times, the residents had to take turns, but for the most part, as I observed, the ebb and flow of patient care meant the wait was seldom long, since other residents were busy talking to their patients or preparing to treat them. The resident would approach the preceptor and ask if the preceptor had a moment or was ready for them to precept. The preceptor was usually ready and the resident sat down next to the preceptor and began to outline the patient's concerns and the resident's medical findings. The preceptor looked up the electronic medical record of the patient they were about to discuss and the resident launched into a description of the patient and "history of the present illness." The

resident would list and describe the information obtained from the patient and the faculty member responded with probing questions designed to guide the resident.

Precepting was a formal presentation with a normative format. The opening was often formulaic; for example, “Mr. Jones is a 57-year-old African-American man who came in today to have his blood sugar tested and discuss better management of his diabetes.” Next came the observations made by the physician. These findings formed the backbone of the diagnosis. Then the physician gave their assessment, matching the patient’s purpose of the visit with a possible diagnosis, as well as assessing the patient’s progress if a longitudinal goal is part of the visit (for example, weight loss). The plan was left to the end; what the resident intended to do to treat the patient’s disease.

Intriguingly, the entire precepting process was inserted in the middle of what most patients would expect of an office visit. Following the examination yet prior to any “declaration” of diagnosis and treatment recommendations, the resident literally left the patient’s room to precept. The resident was not yet considered autonomous enough to process all the incoming information, to diagnosis the disease with enough accuracy, and to implement an appropriate and viable treatment plan without supervision. Precepting was so vital an activity in residency education that the social encounter with the patient must be interrupted to engage in this important activity. Precepting was a form of ritualized social performance. Residents were learning how best to communicate patients’ information and stories to faculty members in a socially-appropriate way within the profession. The faculty member held certain expectations of the ways in which residents presented their findings and argued their case for treatment

plans. Being able to take on this approach in a way that the preceptors could accept and work with was part of the process of becoming family medicine physicians.

Ordering tests

A key moment in the precepting process involved the acquisition of the techniques and knowledge necessary to use medical tests appropriately. At times, testing could be confirmatory of other observed signs and symptoms or exploratory when the physical exam revealed only vague details. While the technical information a test could provide was easily known to most residents and easily referenced online or in manuals, a more nuanced decision-making process was needed in determining if a particular test was necessary, appropriate, or even advisable.

Key learning moments took place during instances when a preceptor and resident disagreed over which tests to order and the resident's defense of their proposed test. The preceptor was typically willing to listen to the resident's rationale for a particular test, but ultimately carried more capital – cultural and symbolic – in the negotiation. The power of the preceptor's mentoring role meant the resident was dependent on the preceptor's approval to advance and gain more autonomy. Residents tended to order a lot of tests, and precepting often involved slimming down the number of total tests ordered. Preceptors operated with two basic rules around medical testing: for what fundamental reason was the test being ordered (appropriate for the suspected disease, truly diagnostic or just confirmatory) and what impact would this test have on the patient (financial, emotional, or physical discomfort)?

Consider this interaction between the preceptor Dr. Bierce and a second-year resident, Dr. Rana. Dr. Bierce was the younger faculty member who preferred not to

wear his white coat, as described above. He was friendly and direct in his response to residents' questions and concerns. He often allowed residents to make their own medical decisions, as long as they could adequately explain the rationale of the decision. Dr. Rana was a soft spoken woman from India, though she had lived a long time in the United States and was educated in an American medical school. The issue at hand was Dr. Rana's desire to run a B-type natriuretic peptide (BNP) blood test on a patient suspected of having congestive heart failure. Dr. Bierce pressed the resident for her rationale for running this test, "What is it that makes you want to do this test?" The resident explained that the patient was overweight and occasionally short of breath. The patient did exercise, but not often in her assessment. Otherwise, there was no clear indication that the patient was at risk of heart failure. Dr. Rana finally conceded that she wanted to run the BNP because she had concerns about the patient's long-term heart health. The test was therefore confirmatory of a theory she held about the patient's current risk, not to identify a particular disease.

Dr. Bierce offered the suggestion that perhaps the patient was just out of shape, suggesting that the simplest answer was often the best one. Further, he suggested administering an electrocardiogram (EKG) which was a simpler test that can be done immediately with no blood draw involved. More importantly, Dr. Bierce urged, was the discussion to be had with the patient. The importance of his heart health – to focus on regular exercise – should be the central issue, not the test for a potential disease that the patient's physical symptoms did not support.

Pressing Dr. Rana further, it came out that the patient felt he got plenty of exercise because his job required him to be on his feet all day. Dr. Bierce confirmed his

medical agreement with Dr. Rana's concerns; this was not enough exercise given the patient's risks. He tasked Dr. Rana to literally "probe with the patient" – to understand the patient's point of view on exercise and to negotiate ways to get more active. In Dr. Bierce's words, the "value of the visit for the patient" was not in getting tests for something that seemed medically unlikely, but to help the patient develop a vision for the future, to find ways to improve his health overall.

In this way, Dr. Bierce was demonstrating to Dr. Rana something important about family medicine's "object" and the approach to take with the patient accordingly. Asking Dr. Rana to talk to the patient about his behavior demonstrated where values were placed that could lead to the particular healing practices. By placing "value" on the patient's exercise and activity level – and having Dr. Rana convey this emphasis to the patient – Dr. Bierce was showing how health and the family medicine approach to disease was more comprehensive than running tests and administering medications. Expected to display this disposition, conveying the appropriate cultural capital, Dr. Rana was then able to try and use her symbolic capital as a physician and her growing confidence as a family medicine doctor to try and advise the patient about these health and lifestyle issues.

I did not observe the patient directly in this case and I am left to speculate as to the outcome. The resident returned to the patient's room and expressed that she was able to pass on this advice. Presumably, he was already aware of these suggested behavior changes, but given the backing of Dr. Rana's symbolic capital of being a physician, the hope was that the patient would change his behaviors to better his overall health. From what was presented above, we can see that this is a better example of

modeling how family medicine physicians can engage with this specialty's object in patient care than the examples I presented in the orientation chapter.

Yet I have concerns about two aspects of this resident-preceptor interaction as it relates to the patient and healing practices. First, was Dr. Rana's initial hesitancy to speak to the patient and rely instead on testing. Presumably, if the test had been run and indicated something problematic for the patient's health and wellbeing, she would have felt more empowered, from a positivist, medically-driven position, to be adamant that the patient consider for behavior changes. Subjunctivizing for a moment, talking to the patient without this evidence may have been an uncomfortable position for Dr. Rana to be in, pushing her outside those tests to which she had come to rely upon. Second, Dr. Bierce urges the resident to really understand the patient and help him develop a vision of the future. What does this actually mean in practice? The patient's concerns were heard but not incorporated in a real way in this encounter. In a sense, the physicians rejected the patient's sense of his own physical activity out of hand. The medical management was handled paternalistically. The power hierarchy was not one of service, but of the preceptor placing behavioral expectations on the resident, who in turn was expected to place other behavioral expectations on the patient.

This next interaction again involves the preceptor Dr. Bierce, but now with the resident, Dr. Clark. Dr. Clark was a third-year resident, a few months from graduating. She was African-American, friendly, if a bit quiet at times. Dr. Clark had already decided on a short list of tests for a patient, but speculated further with the preceptor, Dr. Bierce, about adding more tests to provide some additional information. Referring to the blood necessary to run her tests, Dr. Clark reflected, "I guess I feel like I'm poking her already.

What else can I add to her list?” Dr. Bierce was careful to focus Dr. Clark’s attention back to the immediate problem, explained that the additional tests would not offer much if any more information and in the end, Dr. Clark ordered the tests upon which she and Dr. Bierce had agreed.

In this case, Dr. Bierce urged Dr. Clark to show restraint and focus in her work. By way of conjecture, Dr. Clark may have been putting forth the extra effort to run more tests in acknowledgement of the imposition the patient was already experiencing. More deeply, she may have had misgivings about her own ability to diagnose the problem the patient was experiencing, hoping to cover more possibilities with additional tests. In this case, despite her position as a third-year resident, she remained the apprentice. The educational process demonstrated by Dr. Bierce helped Dr. Clark to move away from additional testing. He essentially cautioned her away from the notion of testing for everything towards being a more critical thinker and more careful doctor. The resident was still learning to do only what was needed to address the problem at hand, to make sense of the patient’s circumstances and not investigate matters beyond that scope.

In a sense, however, Dr. Clark showed commitment to do everything in her power for the patient, to diagnose the problem efficiently and thoroughly. The disposition of “holism” may suggest the idea of testing for everything and anything that may be troubling a patient. But the tension here was with the disposition of maintaining focus on the problem at hand, remaining efficient, and becoming a critical thinker, one not dependent on broad batteries of tests where her skills as a physician could guide her to more appropriate testing and diagnosis. How would this dynamic have changed or been addressed by the physicians if the patient had insisted on every possible test

instead of the other way around? We will never know, given the interaction I observed did not focus on the patient's point of view in this decision.

In an economic sense, broad batteries of tests may not always be covered by insurance. The physicians' medical practices were structured and bounded by other sociocultural institutions that, if ignored, may cost patients and go against the idea of attending to patients' concerns. For example, I present an interaction between a resident, Dr. Johar, and the preceptor, Dr. Douglas. Dr. Johar was a second-year resident; a woman of Indian descent with whom I had little other interaction. She was friendly, always very well dressed with designer clothing, and did not seem interested in spending much time interacting with me. Dr. Douglas, on the other hand, I knew very well. She was my first faculty member contact in the department, with a personal background in anthropology, who frequently engaged with me about my research, my personal life, and her own family.

Dr. Johar, in this case, in the course of a related physical exam of a patient, had taken the necessary sample for a pap smear in order to test the patient for cervical cancer. Dr. Douglas' first question was to ask if the patient was due for her yearly pap smear. Having checked the Electronic Medical Record (EMR), Dr. Johar was able to tell that the test was not yet due. Dr. Douglas advised not sending the sample to the lab for testing, since "they won't pay for it". The definition of "medically necessary" in the case of routine screenings must conform to the mandates of the insurance companies, which will only cover one such screening test per year. This patient may have had to pay out of pocket for this test; a test the patient did not ask for.

While a simple idea, an awareness of a patient's broader circumstances – beyond their immediate health concerns – helped preserve the whole patient, and potentially the patient-physician relationship. We see a preceptor relating family medicine's values to a resident's immediate needs, helping her to negotiate between different meanings of "holism". The resident was attempting to be comprehensive and preventative – to show the holism of family medicine – and ultimately serve the patient in a way she felt was best.

Dr. Douglas demonstrated to Dr. Johar that providing for patients extended beyond their immediate health concerns. In this case, patient care extended to the wallet. Financial and insurance-driven concerns molded the practice of the family medicine physician. This was framed by Dr. Douglas not as a limitation on their practice, but as a factor in decision-making that impacted the patient, and therefore must be taken into account in order to be a "good" family medicine physician. The disposition of holism and treating the whole patient included awareness of these financial components of routine medical care.

I have shown several instances in which preceptors have guided residents through careful consideration of the use of medical tests towards taking on the broad disposition of a family medicine doctor, one committed to holism in patient care. Exploring the decision making involved in ordering tests and the role tests play in patient care provides a clear example of the ways in which contested meanings of holism impact decision making and help residents become careful thinkers in their approach. Appropriate forms of practice were demonstrated to residents, conveying

relevant cultural capital emphasized by the preceptors' symbolic capital as board-certified physicians and designator educators.

The faculty members involved in the above dialogues each had specific opinions about how best to “handle things” when it came to medical testing. In general, Dr. Douglas demonstrated a pragmatic approach to medical testing, “I prefer not to over treat. Advise the patient how to handle [the symptoms], how to watch the problem, and to give lots of reassurance to the patient. This is the best way to handle things.” Similarly, Dr. Bierce urged talking with patients over additional testing, to explain more carefully to patients what the resident views as ways for improving their own health.

What was telling was that the residents were often told to do this kind of talking with patients without a great deal of guidance as to how. While this lack of guidance may be seen to conform to the assertion that residents need “be the doctor,” more direct modeling could have been offered by the preceptors. What exactly should a resident say to a patient who may want a particular test because they simply “need to know” or to negotiate a new meaning of “exercise” for a patient who feels they are already very active? How does a resident give the kind of reassurance Dr. Douglas was suggesting? While some techniques, like presenting the case to a preceptor or providing rationales for testing, were thoroughly covered in residency education, approaches for talking with patients were left to the resident to figure out for himself or herself. All of this leads one to ask: How can a resident demonstrate “patient-centeredness” without direct demonstration? As will be shown in Chapter 8, faculty and residents see patients together on the inpatient service, I almost never witnessed this level of collaboration in the clinics.

A different procedure was in place for newer interns. During their first six months in the program, preceptors personally saw each patient with the resident after precepting. This practice happened less and less as residents were deemed by preceptors to be more competent in diagnosing patients and developing treatment plans. The expectation was that preceptors saw a resident's patients less and less; that the resident should eventually be able to see and talk to the patient alone. However, in my observations, the preceptor's visits were designed to check the intern's diagnostic abilities and typically involved another moment of precepting afterwards, where the treatment plan was negotiated and decided upon. Following this final discussion, the intern was still left to explain the course of treatment and negotiate other matters with the patient alone. The focus here was on mastering the technical approaches to diagnosing disease and designing treatment plans. Attention to the patient's illness experiences was left, like with more advanced residents, to the intern to complete the explanation to the patient on their own. I remained troubled as to the degree to which residents were expected to engage in complex dialogues with patients in the clinical setting, without the degree of oversight and hands-on demonstration by preceptors that went along with diagnosis and treatment decisions.

Managing pressures

Residents were expected to balance a tremendous amount of new information coming their way, learn to see patients on a specific time-delineated schedule, learn to make appropriate decisions based on this information, organize their thoughts in a way that can easily and appropriately be communicated to other physicians, and learn to effectively communicate back to patients. This taking on of so many different techniques

and vast amounts of knowledge was formally acknowledged through positive evaluations from preceptors and other faculty. Ultimately such learning was rewarded through promotion and eventually graduation. Less formally, the further a resident progressed in the program, the more they were expected to achieve. Next, I further discuss how residents learned to manage the pressures that came along with the work. The demands impacted a resident's ability to manage their time and forced them to make sense of difficult emotional moments.

Time management was a constant concern of residents in their work, as has been pointed out by others (Yoels and Clair 1994). Residents were progressively expected to see more patients in the same window of time. The assumption was that as the resident became more skilled at evaluating, diagnosing, precepting, and explaining treatment plans to patients, the less time they needed in discussion and direct guidance. In observing the work of residents, time constraints remained a concern throughout the three years of training, often leading to frustration. The process expected more and more out of each resident as he or she advanced in skills and competency.

The goal of a fifteen minute office visit was often unrealistic. Patients and residents alike frequently required more time. The tension between meeting the demands of the program as established by the business model of medicine (including the insurance companies' expectations) and family medicine's dedication to patient care created pressure on the residents to become ever more capable time managers. This limit was contradictory to family medicine's espoused values of patient-centered care and more holistic approach to the personal experiences and contexts of patients' lives.

The fifteen minute window challenged the emergence of a doctor-patient relationship. I include the following vignette as an exemplar of the pressures residents faced.

This instance again involved Dr. Johar and Dr. Douglas, precepting together. During precepting, it became evident to both doctors that a more thorough physical examination was necessary to diagnose the problems the patient was experiencing. The patient had come to the doctor with a single, focused concern – a lingering sinus infection – and was not interested in the more-thorough exam. Further, the patient had become agitated because the appointment was taking too long and was threatening to leave. She had only come in to the clinic for one specific concern, and feeling that Dr. Johar was adequately dealing with that concern, was not interested in some of the broader worries the physicians had. The patient's time was important too and she wanted it to be valued. Interestingly enough, the concern of the patient seemed not to figure into the discussion that followed. Dr. Johar was visibly upset and Dr. Douglas offered encouragement, "Don't let her bring you down". The resident quickly responded, "For the first time in what feels like months now, I'm on time". She went on to explain how she felt like her time management was on target that day and yet the patient was still feeling pressured and wanted to leave.

To me, this was to be a valuable teaching opportunity for the preceptor, although one only partially capitalized upon. Dr. Douglas did provide encouragement to Dr. Johar, and Dr. Johar was not criticized for making the patient wait. However, nothing was said regarding the patient's experience, reflecting with the resident what it must be like to be the patient in that scenario. The patient was motivated to come to see the doctor, had an agenda of her own that she needed assistance to address. The patient's

illness experience was not the central concern of the preceptor and resident at that moment. Instead, the patient became a symbol of “being behind”.

The preceptor’s encouragement, not to let the patient “bring you down,” suggested a tension between patient and physician that may, in the end, be emblematic of a contemporary broader problem in doctor-patient relationships in American biomedical settings. Having too many patients means the doctor gets behind and faces additional pressures from a tight schedule, regardless that many such patients need their physicians for their own specific reasons and are seeking healing practices from them. The object of family medicine took a backseat to the emotional responses of an overwhelmed resident, and the preceptor facilitated this reordering.

Further, emotional reactions like these may have had a negative impact on the making of doctors, and perhaps diminished commitment to understanding patients’ illness experiences. Frustrated when even one’s best efforts to stay “caught up” were unsuccessful may lead residents skipping important components of patient conversations, avoiding “complicated” topics that may exist outside the obvious, more-technical aspects of diagnosis and treatment. For example, assessing a patient’s emotional wellbeing may greatly increase the length of an office visit, and cut into the time available for subsequent patients. In a hierarchy of priorities, the patient’s needs here came second.

This contradiction was not to say that residents do not, through the course of their education, to see and attend to patients’ social and personal concerns. Next I want to consider what happens when a resident becomes entangled in the emotional work of providing care for a seriously sick patient; how the pressures of caring came to weigh

on the residents personally. I again observed Dr. Clark, the advanced third-year resident, seeking advice from her preceptor, Dr. Bierce, about how best to discuss a complex health issue with a patient. Dr. Clark was in the unenviable position of negotiating “hope” with a patient. Dr. Clark had seen this patient for some time, monitoring a series of masses growing inside her. The immediate concern was that these masses were cancerous and threatening the patient’s life. By the time I came to hear the interaction between Dr. Bierce and Dr. Clark, the screening tests had shown the masses were not cancerous. Rather than immediate relief, Dr. Clark’s concern was balancing the patient’s expectations. She was very concerned to “not get her hopes up” and that the patient’s health may still be at risk. The masses were still in the patient’s body and the masses were still growing. Worse still was that the physicians were not sure what these masses were.

To help Dr. Clark, Dr. Bierce referred to “cautious optimism”. He suggested that she should convey to the patient the value of being optimistic and enjoying life despite the challenges. He said Dr. Clark needed to convey a commitment to keep searching for answers. Interestingly, mirroring my discussion of testing above, Dr. Bierce did not give Dr. Clark any particular scripts to use or encourage her to find a language to which the patient would respond. Was a disposition of patient-centeredness enough to convey the importance of the words to be spoken?

The important message in “becoming” conveyed by this vignette was the role of providing responsible and thoughtful care to patients. Dr. Clark was very concerned for her patient’s emotional state and the way she would process this diagnostic information. How to handle the role of the uncertainty was at issue here. This incident caused me to

think more deeply about how, “managing hope” is a mutual social negotiation between patient and healer, a topic that medical anthropologists have continued to be interested in over time and cross-culturally. The patient was receiving good news that the current testing did not find evidence of cancer. The physician was able to bring this “hopeful” information and with it some better chance of better health. The lack of information and failure of the diagnostic power of medicine clouded that hope.

Dr. Clark’s concern was commendable, but the patient was treated as an empty vessel, in a sense; one expected to take on Dr. Clark’s words of hope and encouragement. The negotiation, in other words, may be as much about giving the good news as explaining the bad – while the patient did not have cancer, the physician and the patient had no clear notion of what was happening in the patient’s body. By extension, whose hope was really being negotiated here? The “cautious optimism” stemmed from the lack of information of exactly what was medically happening with the patient. Were Dr. Clark’s worries coming to the fore, beyond the patient’s worries, in terms of her inability to diagnose? The fragmentary nature of American biomedicine means patients with complex medical conditions may see different specialists for different diseases and illness concerns throughout their body. Balancing and organizing these complex treatments, as well as explaining these complexities to patients, often falls to the primary care physician. I observed that preceptors and residents often discussed the problem of patients coming to them overwhelmed with information from specialists. Managing this complexity represented a more advanced technique for residents to learn and can be argued, is an important part of family medicine’s holistic approach.

One such instance, again involving Dr. Johar, demonstrated how challenging the management of information could be for both the patient and resident. A patient with multiple health issues had come to see Dr. Johar to help make sense of her complex physical state and health concerns. After seeing numerous specialists, the patient was overwhelmed with information and expressed annoyance to Dr. Johar at the entire medical system. In seeing numerous doctors, who perhaps were not speaking to one another, the patient was left without a clear sense of the overall state of her health. Unfortunately, the specifics of this patient's condition were lost to me in the dialogue. While missing the medical specifics, I caught this important negotiation between Dr. Johar and her preceptor, Dr. Bierce. Interestingly, Dr. Johar expressed concerns that she was being blamed for the communication and information problems the patient was having. Dr. Johar was symbolic of the entire medical system and took the brunt of the patient's emotions. After listening to Dr. Johar convey the patient's frustrations, Dr. Bierce commented, "This is an opportunity to sell the concept of continuity of care to the patient. You can advocate for her. You can get her records from other doctors and digest them and see where you can help. Then she may start to see you in a different light."

This particular example touches on two critical issues in family medicine. One, family medicine envisions its role, part of its operational values, to include the continuity of care, to act as patient advocates in navigating the healthcare system. This is one definition of "holism". As I heard frequently in the setting, specialists often failed to communicate effectively back to the primary care physician. Family medicine recognizes that problems emerge for the patient when, in Dr. Bierce's words, "The

primary gets out of the loop.” Family medicine faculty members considered this a major problem and therefore educated their residents in how to address this issue head-on. They advocated for an active role in managing patient’s complex health concerns and attempted to illustrate to residents the importance of coordination in healthcare delivery. Recognizing the patient may become confused and frustrated by an overload of information, family medicine considered it their task to guide the patient, demonstrating holism and patient-centeredness.

Secondly, Dr. Bierce was able to point out an opportunity to win over a patient, to help them feel better, and help resolve their dissatisfaction. Ideally, this relationship would allow the patient to see the same doctor again and again, such that Dr. Johan could learn the patient’s story, gaining a longitudinal perspective on the patient’s health. In this way, Dr. Johar could better serve as a broker between multiple medical subspecialties. In a sense, taking on these ideas inflated the primary care doctor’s role, creating a sense of superiority over other specialties. Given the history of family medicine as a specialty, this rhetoric framing of their role as primary physician cemented their status and importance, suggesting the power that comes from being the first physician interface a patient has with the larger health system. Hence, why the resident was told to “sell” the patient on the value of family medicine.

As residents continued “learning by doing”, the role of the preceptor changed. The decision-making process of diagnosis and treatment was paramount in the first year of training, with often lengthy discussions of appropriate tests and treatment plans. Later, residents were expected to be more holistic, to attempt to convey to their patients techniques allowing them to be healthier in their lives. The preceptors began to act in a

more confirmatory manner, vetting the presentation as given by the resident without adding a great deal. The advanced residents had amassed more symbolic capital, emblemized by their freedom to act more autonomously.

Another interaction between Dr. Douglas but with a different third-year resident, Dr. Katsaros, demonstrates this succinctly. Dr. Katsaros was one of the chief residents, having accumulated considerable symbolic capital as one of the top residents in the department. She was a white woman in her late 20s or early 30s, thin and tall, with a calm demeanor. Her interaction with Dr. Douglas appeared more like that between colleagues than between apprentice and teacher. At the end of a brief patient presentation, less than a minute, Dr. Katsaros ended with “and that covers everything. Unless you think I missed anything?” To which Dr. Douglas replied with a smile, “No, sounds good” and the resident was off to enact her treatment plan with the patient.

These sorts of interactions appeared to be the norm with the most advanced residents. Overall, the third-year residents all acted confidently and were granted a great deal of autonomy. They had been tested again and again through precepting and with each successful “test” the resident accumulated more trust, more autonomy, to not simply act as a family medicine physician but to be one. In fact, the most advanced third-year residents – those within six months or less of graduating – often do not engage in precepting, granted the autonomy and trust that comes with earned symbolic capital of full competence as technically proficient physicians. They learned to anticipate accurately the questions of their preceptors, gathering information ahead of time to address those.

What was less clear was whether or not the residents had made improvements in fostering effective healing relationships with their patients. To reiterate and expand my concern from above, the faculty preceptors expect the resident to develop skills in communication and be able to form lifelong relationships with their patients; however, they did not appear to directly measure or evaluate those skills. The evaluative focus seemed to be predominately on appropriate diagnosis, testing, and treatment options; less on what family medicine says about its own approach to medicine – patient-centered, holistic, and ultimately healing, relationships.

Residents' roles in the precepting process changed as they progressed through the program. However, they still struggled to find the time and focus to address more emotional, psychological, and social concerns of the patient. The tension between the fifteen minute office visit and the number of more complicated issues residents faced resulted in a challenging decision. The tacit notion was that the resident could still “do their job” if they simply diagnosed and treated the patient for the concern that brought them in. As family medicine physicians, the values of the habitus pushed the residents to incorporate more and more into each office visit, risking falling behind in their schedules, and alienating the very public they hoped to help. Residents came to family medicine because they were attracted by its way of thinking about disease and illness. However, as shown in the precepting process, the balance of time and expectations of preceptors challenged this central value of family medicine.

Faculty reflections on clinical precepting

Having shown multiple examples of learning by doing in precepting situations, I turn now to reflections from the preceptors themselves in order to characterize more

fully this process of learning clinical medicine. Dr. Bierce explained that his main challenge in precepting residents was in deciding “how to let them fly”. He said the goal was to bring residents to the point that they were able to perform on their own, but he did not want to overwhelm any resident with too much too soon. He debated with himself while precepting each resident about how to approach their individual learning.

This thought-process included considering how much information to give the resident, how much guidance and how many questions to ask and expect answers to. He wanted to nudge the resident towards his way of thinking, what he considers the appropriate culturally-constituted way of being, without leading the resident into every answer and fostering dependence on the precepting process. He asserted that every patient, every resident, and every teacher was different, and when all three came together, it made for a unique and complicated dynamic. He claimed to attend to these differences and tailor his lessons and precepting to the needs of the patient, the educational level and needs of the resident, and his own strengths in conveying the methods of family medicine diagnosis and treatment. Dr. Bierce articulated different teaching methods, using particular hand gestures to demonstrate his point in each case. He explained how he could teach some by holding the resident up – and he made a gesture holding his palms upward and pushing up. I often saw this sort of precepting, particularly with newer residents, who appear overwhelmed with all of the early work and learning. He said newer residents appeared to need the extra support in order to begin to process all the new information, techniques, and expectations coming their way. These explanations were each accompanied by pantomimed gestures.

He explained how he could push them forward – here he made a forward motion, palms open and pushing laterally away from his body. I witnessed this with the advanced second-year and third-year residents in particular, where they have begun to master the technical aspects of diagnosis and treatment but must be reminded of the broader cultural and social issues of the work they do. In other words, they must be reminded to keep the contexts of patient’s lives and how these impact health and illness front and center.

He then hammered one closed fist into his open palm and explained “you can hammer them”. I seldom witnessed this in the setting, though as discussed in the next chapter, in some instances residents do not perform well and may even be asked to leave the program. Finally, the preceptor could pat the resident on the back, encouraging them, or carry them along over your shoulder. This pat on the back was fairly common in precepting, across most faculty members, to encourage the residents that have performed well.

From these descriptions, I took away that preceptors like Dr. Bierce attempted to be aware of residents’ personalities, progress in the program and mold their teaching practices accordingly. Sometimes he assessed that residents needed more support and Dr. Bierce attempted to give this. Other times, he pushed the residents to defend their thinking as illustrated in some of his resident encounters described above. Overall, Dr. Bierce appeared to take his role as preceptor seriously, knowing he was responsible for mentoring the resident as they learn.

Dr. Wen, a faculty member who previously served as the program director, and had been with the department since its inception, often reflected on the differences

between residents in terms of their training and level of development. As something of an elder statesman, Wen's symbolic capital among the residents and fellow faculty was considerable and his words carried the weight of experience and deep thought on the matter of residency program training issues.

When asked about his approach to teaching and guiding residents, Dr. Wen stated: "With respect to teaching I think it depends on the venue. In our office, for example, in precepting, perhaps the more important thing is to sit back and understand what the resident is truly asking." Dr. Wen further elaborated on the concept of "truly asking":

They're presenting cases- for example, a first year will come and ask a question, and really is asking a genuine question, "What's going on? What am I going to do next?" And you go through the process of education in that respect. The second years are coming in and saying, "Ok I have these different things and all this here. What am I missing?" So what they are looking at, they are having a fill-in-the-bank type of thing. But they're also pressured by the knowledge that they are working in a time frame. They are trying to get all this into a certain amount of time. And they're saying, "Well, what else can I learn?" You're just filling in the blanks and challenging them to expand. The third years are truly asking not so much all the other two things. What they're asking about is, "I have a plan. And you are now my reference point. How did you set your limits? At what point do you decide someone is post-thing or pre-that? How did you set that and why is that of value here?" The difference is the third-years are really using you as a sounding board to check their knowledge base. And that's what they're asking. So when you teach, you have to really understand the question being asked and then be able to respond in an appropriate fashion (Interview: August 29, 2012).

He advocated recognizing the developmental stage of each resident, to approach each resident at his or her level of competency and understanding. Experienced faculty members like Dr. Wen have the longitudinal perspective to see that growth and change occurred many times in residency, even if the residents themselves failed to recognize it. Dr. Wen reflected:

One of the important things is to always step back and realize who it is you're talking to and what level they're at... It's fascinating to see how they grow... For example, the first years are asking questions about "How do I order this meal? How do I order fluids? Or nursing care for this patient?" Whereas the second years will start talking about, "This is a fascinating case of-". So now they've gone from the individual patient to the disease process. And the third years almost talk about management of the whole thing. In other words, when a patient comes in with a stroke, they're already thinking discharge planning. They're already thinking about rehabilitation. And care for the family. And other things too. It's interesting as you watch people grow to understand what their needs are and how you can make an impact with them (Interview: August 29, 2012).

In reflecting on these categories of residents, Dr. Wen suggested the progress each would make – and was expected to make – during their three years of training. The types of questions residents asked changed over time, developing into deeper concerns about filling in gaps in one's knowledge base, finding the answers to more complex questions like subtly differentiating between one disease and another, and growing past the more basic concerns of "What do I do?".

As the diagnostic and treatment skills of the physician mature, faculty often responded to resident questions with a question of their own. I'm paraphrasing when I say "Well, what do you think is the best course of action, doctor?" Faculty preceptors acted through an awareness, a tension, between where the resident was in their learning process and helping the resident to transition to a greater degree of competency and display of their capital. It was not enough to learn what to do, but to gain the confidence to make these decisions when no one was guiding them to the "correct" answer.

There were limits to learning however. The precepting process measured progress on the technical aspects of medicine more directly; it is less formalized and less clear how they assess the residents' ability to heal, to form a relationship with

patients that engendered trust and listening. Precepting focused heavily on the shared physician expectation of providing direct medical treatments for a particular disease and other financially billable services. I have heard preceptors state unequivocally, “Learn to code properly so you get paid for the work you do.” The tacit focus was always on billable services, with a great deal of effort spent training physicians to code the activities they engage in such that the insurance provider will pay appropriately.

The result of this way of learning was that the residents’ approach to patient health became formulaic. On one hand, the residents were being effectively socialized by preceptors’ expectations to the overarching medical disposition of diagnosis and treatment of disease. The patient’s present complaint was now known and understood, a repetition of other complaints from other patients, which can quickly be targeted and addressed without deeper thought. While this ideally left room for a more holistic consideration of patient’s illness experiences, I found the opposite often to be the case – the resident instead could efficiently and rapidly move on to other work. Time management and increased diagnostic competency became a way to process patients quickly and with less deliberation. Yet it is that very deliberation that family medicine values state as necessary to understand the patient as a whole. The resident, in a sense, was becoming institutionalized, molded by the particular habitus into a particular type of doctor.

Didactics

As detailed in Chapter 3, family medicine residents and faculty met weekly on Wednesday mornings for academic lectures. These “didactics,” as they were called, operated in a way similar to college lectures, sharing information and insight about

topics of importance to the practice of family medicine. The didactic sessions differed from the active learning strategies of “being the doctor” and “learning by doing”. This teaching modality placed residents back into the role of classroom-based student for a formalized time each week. The ethnographic details that follow illustrate the tacit differences between “learning by doing” and a more traditional lecture setting.

These lectures were important and lent significant weight by the faculty and chief residents, by virtue of a mandatory attendance policy. Further, the ACGME requires didactic lectures as a mechanism for preparing the resident for their future lives as board-certified physicians. So important were these lectures, the family medicine inpatient suspended their regular morning rounds to attend. Further, attending physicians in other specialties knew these lectures as the family medicine residents’ “protected time” and were expected to excuse them from their work obligations for the morning. Certain specialty rotations were less amenable to this – surgery or night block for example – because the practical tasks did not permit as much flexibility in scheduling – night block residents left in the morning to go home and sleep; surgeries were scheduled ahead of time and often lengthy, requiring the residents’ attendance for the duration. Finally, the healthcare system was spread out to other satellites. I heard it said that if a resident needed to drive more than 10 minutes to get to lecture, they would often not attend – especially if they have to leave that site, attend the didactics, and then return to work. While attendance was technically mandatory, there were exceptions. Lectures had high importance, but not higher than some other activities.

Over the course of fourteen months, I observed an array of different lecture topics presented by various experts. These experts were sometimes drawn from the

family medicine faculty. Additional expertise was drawn from physicians from other specialties, possessing particular knowledge and techniques of use to the family medicine residents. A partial list of topics covered includes: food allergies, administering pain medications, discussing the use of drugs and alcohol with adolescent patients, sexuality (both adult and adolescent), childhood safety (e.g. talking to parents about the need for helmets while riding bicycles), hemorrhoids, recognizing signs of domestic violence, assessing risk of patient suicide (referred to as “suicidal ideation”), the care and management of pregnancy, behavior change techniques for smoking cessation, reading EKGs, treating back pain, dermatology, diagnosing and treating the elusive “tummy ache” (called “pediatric abdominal pain”), and general lectures on “preventative care” (often revolving around nutrition and diabetes management).

The depth and breadth of topics demonstrated to me some truth behind the stated value of family medicine to be holistic, to treat patients as whole persons, and to attend to patient wellbeing at all ages and life stages. Each of these issues was something that as primary care physicians the residents will (or already had) encountered in their clinical practices. By the end of my fieldwork, I was left wondering how a single physician could be expected to absorb and master each of these topics, and the treatments and interventions that accompany each, over the course of only a few hours per week. What was the ultimate goal and intent of these didactic lectures and their role in the family medicine residency training program? To answer this question, I will explore in depth a series of didactic lectures sessions I observed.

Here is how events typically unfolded. Residents filed into the lecture space beginning around 9am. Many of them brought food or drinks with them and settled in for

the series of three to four 45-minute lectures. The gathering did not occur all at once, with residents coming from their various rotations throughout the hospital, some driving in from clinics and rotations outside the main hospital. Often the last to arrive were the members of the current family medicine inpatient team, positioning themselves at the back of the room, nearest the doors, ready to respond to pages and phone calls from the inpatient service. The atmosphere was relaxed with residents chatting casually with one another, catching up on personal news or discussing recent experiences in their rotations. Bonds of collegiality were obvious not only among same-year residents but also across and between all three years of trainees. Many of the residents appeared tired or distracted by other work.

In general, faculty members attended in a more limited way, as they were not required to be present. The person giving the lecture was often, but not always, a faculty member in family medicine. On some occasions I observed more faculty members present for specific topics or activities, but in general appeared to be an activity designed and intended for residents and their direct learning. This should not be interpreted to mean that all the residents attend every lecture, every week. Attendance was an ongoing issue for the weekly didactics and had resulted in some punitive measures, as will be discussed below.

Typically, the presenter entered the room and set up a PowerPoint presentation with the laptop and projector already present in the room. He or she presented a series of slides that detailed the broad topic itself and often times case studies of particular patient encounters relevant to the topic. Each lecture ran for 45 minutes, with a brief break between lectures to set up the next. Typically, four lectures filled each morning in

succession; the residents remaining in place as the presenters rotated through. The audience of residents was often sparse, despite the didactics being a required activity. Frequently, only half of the entire body of 27 residents attended. What stood out in these observations was the behavior of presenters and audience. Interactions involved only sporadic dialogue, questions and answers, and almost passive attention from residents. The presenters struggled to engage the audience and made comments to that effect from time to time.

Residents spent time working on their laptops and iPads during the lectures. I noted that most were accessing medical records of their patients, preparing progress notes, or signing reports electronically. On occasion some were visiting websites unrelated to their work. In general, many residents appeared barely aware that a lecture was taking place. There were some that would maintain interest, presumably because the topic engaged interests. The topics themselves were often presented in a way that inundated the listener with raw information and statistics, seldom drawing out discussion or debate, presented as it was with the certainty of medical fact. In general, a humanistic application or open debate around proper courses of medical treatment and patient relationship-building were much less emphasized. Residents themselves commented on the dry or unnecessary nature of these lectures, as one commented to me privately, "I have other work to do". Each lecture invariably ended with the presenter asking if there were any questions from the audience, which there seldom were. This progression marched on; lecture after lecture, week after week, without any significant differences in the dynamic.

There were noteworthy instances when the pattern changed and the residents became more engaged and interactive. Typically, these were opportunities for residents to display their unique cultural and symbolic capital as it related to a given topic. For example, during a lecture about domestic violence, Dr. Monroe, a third-year resident nearing graduation, relayed a story her patient had told her. This patient was a woman who had chosen to live at a shelter to avoid her significant other, a man who had been abusive to her. One day, as she was leaving the shelter to go to work, there were roses and a note from her significant other inside her car. The woman was clearly scared, according to the report Dr. Monroe gave. The reason, Dr. Monroe pointed out, was that this woman had the expectation of safety at the shelter, that she could not be located by her accused abuser. Dr. Monroe was unsure what to do to help the woman, besides listening and suggest finding a new shelter or somewhere else to go. It was unclear in the end if she did anything more active for the patient. The point Dr. Monroe ended with however was that the patient was scared and the patient's safety was compromised.

Dr. Monroe expressed regret that she did not know what else she could do for the patient. In this instance, "being the doctor" involved Dr. Monroe's opportunity to relay to her fellow physicians the importance of the patient's broader life context, to demonstrate sensitivity to issues of patient wellbeing beyond diagnosis and treatment of disease. Whereas "being the doctor" would have been more compelling if she had demonstrated or mentioned any direct practices that would help the patient. Dr. Monroe displayed empathy in sharing her concerns and perhaps her regret with her colleagues.

This was an interesting moment displaying a need for another kind of healing sense beyond the way the residents were being trained regarding diagnosis and

treatment. It also showed a healing sense that fell outside Dr. Monroe's current abilities. The disposition of listening to a patient's concerns was demonstrated, but it was not made clear what a physician should do with that information in critical moments like this. If one of the values of family medicine was to encourage this level of trust with patients, then it follows that the tools to address such expressed concerns needed to be acquired. There was little feedback from the few faculty members in the room as what to say to this patient beyond referral to another women's shelter or for the woman to get a restraining order. The potential expectation of the patient towards a collaborative relationship with the physician was not explored.

At other times, the lectures revealed tensions within the physician hierarchy. Certain residents possessed capital that others – even some faculty members – did not. For example, Dr. Probst, at the time nearing the end of her second year, demonstrated her own approach to back pain. As an osteopathic doctor (D.O.), Dr. Probst had received additional medical school and graduate medical education in “osteopathic manual manipulation,” a form of hands-on treatment for bone and joint pain, similar to chiropractic medicine. The faculty presenter, Dr. Hurston, was an allopathic doctor (M.D.) and did not treat back pain in the same way, favoring pain medication and referrals to physical therapists. The faculty presenter was asking how the residents approached back pain, presumably to get a sense of the skill development of the group. Dr. Probst said, “Give them an adjustment and send them home”. She had displayed her cultural capital about alternatives to allopathic treatments and appeared very confident in her proclamation. Dr. Hurston reminded Dr. Probst, “We don't all have what you have, which is the ability to fix this directly with physical manipulation”. This

example points to an important process in the making of family medicine doctors; that not all physicians progress at the same rate or acquire the same skills at regular intervals, if at all.

On some level, it seems as though this encounter was off-putting to the faculty member – her retort dismissive of Dr. Probst's abilities. Drawing attention to capital that more senior physicians did not possess may have been seen as disrespectful and certainly challenging to the faculty member's power and authority. Regardless, the point was that in this case a resident became engaged with the didactic only when that resident's cultural capital and personal interests meshed with the topic at hand. In this situation, the resident could demonstrate and embody their level of skills, knowledge, and development.

A number of lecture sessions throughout the year were given over to test preparation. Residency training was inundated with testing – for continuing licensure, practice board exams, and yearly assessments. Preparation sessions involved a faculty member working from an established book of test bank questions, derived from past board and licensing examinations. These were often very focused questions about a patient's particular disease, sometimes including pictures to challenge residents to visually identify an ailment. These sessions required residents to directly participate, oftentimes rotating questions around the room, resident by resident, where a resident was expected to be able to answer the next question on the list. Being unable to at least offer an answer was not well-accepted, and residents were firmly but kindly pushed to offer an opinion or a guess on every question. Frequently, the more advanced residents knew answers the interns did not. This kind of out-loud question and answer, combined

with the anxiety of “being next” and not knowing what question may be coming, was sufficient to keep residents attentive and involved in a way the other didactics did not. This was the most actively involved – the most “learning by doing” – I witnessed during didactic lectures.

Here is an example that both demonstrates this educational moment and one particular moment where my positionality as participant-observer came into sharp focus. During a dermatology test preparation session, I was called upon to identify a skin condition based on a particular image. I looked at the image and thought it was probably ringworm, but didn’t offer that response. Instead, I explained that I was not a physician, nor even a medical student, but an anthropologist. The presenter laughed and said I could have a pass and gave my question to the intern, Dr. Cunningham, sitting next to me. Everyone in the room laughed in a good-hearted way and waited for Dr. Cunningham’s response. She said, “Is it ringworm?” and the faculty member agreed with her assessment and moved on to the next resident and the next question. I leaned over and joked, “Hey, you stole my answer”. Dr. Cunningham glanced at me and said, “Well, you could have answered. I didn’t know the answer any more than you did”.

I was struck by this statement. It made me think more about the intern’s sense of her own knowledge, how she handled her lack of confidence in her answer, and how she felt that she needed to socially perform here. As a new intern, Dr. Cunningham’s cultural capital was in its early stages of development. Likewise, her confidence and sense of symbolic capital were low in that her attitude seemed to convey the sense that she’s “just” an intern. It was intriguing that four years of medical school did not engender in her a confidence in her knowledge base. Further, my own involvement in this

encounter could have influenced her response by virtue of her assumptions about me as a researcher. The moment reflected the ways in which I did and did not fit into the group. She responded to me as someone who knew as little as she perceived herself as knowing; a fellow learner. Yet, her statement perhaps suggested that knowing as little as an outside was not exactly encouraging. Incidents like these made me think more about researcher positionality over time – a topic that I return to in Chapter 9.

The following is another example showing varying interest levels among the residents in didactics. On a morning in July, less than a month into the training of the new class of interns, I walked into a morning session and observed that all nine of the interns were present. They were seated together on the right side of the room and their presence made it obvious how few of the second- and third-year residents were present (only five non-intern residents in total). Further, when the lectures began, the interns were clearly more focused on the material, taking notes and trying to absorb everything that was being said. Meanwhile, the other residents were behaving as described above; attending to other work. Dr. Bierce was the faculty member who began the lectures on this lecture and the interns were engaged enough to ask questions. For example, Dr. Cunningham, the intern who engaged me in the discussion about dermatology above, was eager to display her knowledge of EKGs, claiming openly that her medical school course in cardiology was very challenging.

Within a few months of regularly attending these morning didactics, I noticed these new interns were becoming less and less engaged. It seemed likely that the workload and expectations outside of lectures, combined with the demonstrated behavior as displayed by second- and third-year residents, were sending a message to

the new interns. The message was that the lectures were something to attend, but not necessarily something to pay attention to, unless one is called upon directly to ask questions. It is permissible to do other work; the balancing of priorities put didactics lectures behind other tasks. The faculty seemed to permit, if not endorse, this behavior. The power to make these decisions for themselves, to manage their workload as they needed to, led residents to exercise their own decision-making. They opted to focus on other things.

In observing the way residents used this lecture time, I saw that three additional purposes were served by these sessions. They were: 1) a way to “touch base” in order to conduct business relevant to the entire resident group, 2) to continue to bond and solidify friendships and working relationships, and 3) as a break from the demands of “being the doctor” during the rest of the work week.

The first of these other purposes was to conduct business relevant to the residents. During orientation, Dr. Tao referred to the didactic sessions as their “pow-wow” and explained that it was an important moment to see everyone and reconnect, to stay close to one’s cohort. Residents were scattered throughout the hospital, throughout a multi-site healthcare system, and could only count on Wednesday mornings to reconnect on any regular basis. Therefore, while lectures were an opportunity to learn, she explained, they were also an important opportunity to reconnect with their peers. Friendships developed between residents, Dr. Tao asserted, and these served to help manage feelings of stress or depression, to develop teamwork, and to make the work less onerous overall.

A fascinating discussion unfolded one morning as the resident body attempted to decide who among the faculty deserved “teaching awards”. Each year, the family medicine residents chose a number of attending physicians, both within family medicine and in other specialties, who they see as having been influential in the residents’ training. The residents had complete autonomy in this regard, to decide upon and bestow these awards – in the form of a placard – to each of these influential physicians. The residents in the group nominated faculty members and other teaching physicians, recalling stories of the instruction they received. On this occasion, the debate was interrupted when Dr. Douglas arrived to present a didactic lecture. As a reminder, Dr. Douglas was my first contact in the department, who first spoke to me about resident education and helped me gain access to the fieldsite. When she entered the room, the residents abruptly stopped talking. To witness the residents go silent when Dr. Douglas entered the room was surprising because normally a sense of open dialogue pervaded the program. It seemed that the discussion about teaching awards was something only for the residents.

It was an hour before Dr. Douglas completed her lecture and left. Afterwards, the debate continued. There was a clear difference when the residents spoke amongst themselves and governed themselves within their own hierarchy of residents. The group exercised a collective sense of agency and control through these nominations. For each faculty nominee, votes were taken and at times consensus could not be reached. The discussions reversed the normative patterns of the mentor conveying capital to the apprentice. It also speaks to what the residents want and will tolerate from an educator.

I have left out even the pseudonyms of those nominated and the residents involved intentionally given the sensitive nature of this debate.

One debate appeared to get heated, around a nominated faculty member who had given poor evaluations to numerous residents. As one resident commented, “How can she get an award when she gave us horrible evaluations?” To which another replied, “She makes me cry, but she’s amazing. I learned so much.” Some faculty and residents here seemed to value a heavy hand, a strict system of evaluations. This tendency on the part of faculty members, as expressed above, recalled instances recalled in medical education literature where “pimping” – the act of an attending posing difficulty questions to a learner, often in rapid succession – is the norm (Brancati 1989).

What is unclear from this brief exchange is whether the “horrible evaluations” were warranted. Perhaps this faculty member was exacting, expects a great deal from the residents, and was highly dedicated to teaching. It is easy to criticize when a teacher is harsh; less so when perhaps the learner benefits from this harshness, increasing their performance and knowledge base to meet expectations. In a recent article reexamining the “pimping” concept, Kost and Chen (2015) posit that “pimping” is a disingenuous term and should only refer to questioning done with the intent to humiliate or shame the learner. The authors caution that simply asking questions of residents and setting high expectations is not ipso facto an abuse of power. However, given the data I have shown about the value placed in this program on having a supportive learning environment overall, this practice seemed frowned upon at Suburban Family Medicine.

This particular faculty nominee was set aside for a later debate, on another Wednesday, when perhaps more residents would be present to decide the matter once and for all. I was intrigued by the measure of power and agency the residents possessed in these instances, the room to reflect on their own pathways towards education and becoming doctors, and how they processed dealing with normative patterns of harsh instruction that were the hallmark of medical education in years past. This conveyance of symbolic capital was telling. It reversed the normative patterns of the mentor conveying capital to the apprentice. More importantly, it speaks directly to what the residents want and will tolerate from an educator. I also wondered, where were the faculty nominations for those who taught dynamic and effective patient-centeredness? That this faculty member mentioned above was nominated for a teaching award demonstrates a complex relationship between the stress and pressure of learning and the expectations of residents on how they should be treated. Throughout these debates, the residents jointly made sense of, and contested each other's views of, this faculty member's assertive critiques. Some took ownership for their own performance and considered that they may very well have earned the harsh reviews. The debates and faculty nominations gave voice to the learners, illustrated the investment residents had in their own learning, and demonstrated some of the complexities of master-apprentice relationships herein.

Another alternate purpose of the didactics time was to cement and develop bonds with fellow residents. Residents did not work the same rotations together and often found themselves the only family medicine resident working in on particular rotation. Often, the only time these residents would see one another was during the

Wednesday morning didactic sessions. Given the overt efforts that the program placed on forming bonds and working relationships, I was not surprised to observe the engaged way residents interacted with one another before and between lectures. There was a lot of informal talk and socializing in the cracks between scheduled talks. Even I was drawn into these dialogues, with questions about my weekend or progress on my research.

One resident in particular, Dr. Pryde, commented to me during her interview how important her friendships with some of the residents had been to her continued wellbeing and success in residency. Her bond with the other residents served as a sounding board for diagnosis and treatment of patients; but more important, she reflected, for venting her frustrations and stress around the job. These bonds, when so much was riding on the work being done, including helping manage an often overwhelming workload, facilitated the work of “being the doctor”. The shared experiences – the first overnight call shift, the first patient death, the first bad evaluation – all served to foster a sense of community between and among the residents. Forming these bonds also nurtured the sort of collegiality necessary to perform autonomously, yet collaboratively, in American family medicine. She felt that it was during didactic lectures that she could most easily interact with her best friends in the department.

Through these shared experiences and struggles, the residents reinforced the teaching to which they were exposed. If the values and ideals expressed to them and demonstrated by faculty members represented the disposition of family medicine, it is through their working together that they reinforced these values, made sense of them,

and came to identify closely with family medicine culture by virtue of acquired mutuality of cultural ideas.

Finally, I contend that the time spent “learning” but not necessarily “doing” served as a sort of sanctioned break, protected time away from the hectic schedule the remainder of the week. These lectures were a chance for residents to not only get other work done, but also a chance to be “off the clock”. The rest of the week, a great deal was riding on the residents’ performance, diagnosis and treatment skills, and ability to communicate with patients. For one half day a week, these pressures were removed. For these moments at least, residents were not being asked to make decisions, at risk of harming a patient, or inadvertently ending a patient’s life through a mistake or lack of options. At times, they were still called upon to display their accumulating cultural capital, for example during the question and answers session detailed above, but in general less was riding on their performance. While they remained in the role of the doctor, in a sense they could take comfort in the familiarity of being the student again. “Being the student” meant a moment away from “being the doctor” and a return to a former role that served as a break away from the rest of their work. In many respects didactics symbolized a prior phase in residents’ lives. They were back to being students for a time. They were once again the passive learner they were, not necessarily the active learner they were regularly told and expected to be as a resident. Some residents commented that they did not learn well this way; lectures did not provide to them the same depth of experience and learning opportunity as doing the work themselves.

The faculty members seemed aware of this contradiction in teaching and learning modes and commented on it in passing during their presentations. They attempted to

keep the residents engaged by asking questions or using multimedia. Dr. Wen commented on how he did not use the PowerPoint lectures and instead stood and walked among the residents, engaging them with the material. Dr. Strauss, while presenting on pain medications, and the use of epinephrine pens, commented, “I’m not going to go into this very much because you’re going to forget it anyway”. Yet this awareness by faculty members of the potentially ineffectual nature of didactics did not prevent the program from filling every Wednesday morning with lectures. An alternative interpretation suggests these lectures accomplish precisely what they were designed for, to “break the ice” on a range of new topics so the residents were exposed to ideas first here and maybe triggered to remember something when they encounter the actual thing with patients. Further, the lectures demonstrated the importance of the expressed values of family medicine – showing that the faculty members were serious about the range and depth of what family medicine physicians are expected to do for their patients.

In a recent study of didactic lectures, Chen, et al. (2014) concluded how learning remains the primary purpose of this activity. However, social interaction and reinforcing professional identity were listed as tertiary benefits of these half-day lecture sessions. These authors’ data were derived from a series of focus groups with residents across numerous specialties and I question whether normative responses were given. Residents were expected to learn in these settings and their self-reports were much in keeping with this stated goal. I argue, given the amount of social bonding and lack of participation in active learning I observed, combined with interview data discussing the importance of coming together as a group, that these didactic lectures have a greater

value as a social field in which residents can bond and support one another. In closing, the informal uses of lectures were more directly related to the process of becoming than the lecture material itself, a form of learning different from the one the program set out to implement. The social and meaning-making benefits of lectures, I argue, represent their chief value to the residents. The deeper meaning-making of “becoming the doctor” seemed to occur between the cracks of the formal lectures.

Discussion

In this chapter, I described an array of processual practices that demonstrated the professional socialization of residents towards the broad educational goals of the Suburban Family Medicine habitus. The taking on of numerous dispositions was outlined and described, including “looking the part”, “learning by doing”, “being the doctor”, and “being the student”. Within these, we find the residents encountering and negotiating what it meant to be “holistic” and “patient-centered”. The role-modeling here provided guidance to the residents regarding appropriate behaviors and ways of being. However, as I moved through my fieldwork in this educational habitus, I expected to see an ever-more deepening engagement with family medicine’s object. Instead, I continued to find a focus on techniques and approaches to patient care that mirrored biomedicine more broadly. Second- and third-year residents continued to approach patients largely in a disease-focused way. Resident-to-resident mentoring involved hands-on training and passing on of cultural capital mostly of administrative and diagnostic techniques. The role-modeled and patterned behaviors of faculty members placed higher symbolic value on technical rather than humanistic, healing-centered practices. The educational

modalities placed the residents into situations where they could obtain the necessary capital to perform autonomously, after years of training.

Underlying much of this dynamic was the fact that while doctors, the residents were not yet licensed physicians, and had not yet begun to fulfill their role autonomously. From the first day of residency, the new interns were told they are physicians now and to begin acting like it. What exactly did that mean? Some had not become accustomed to even being labeled “doctor”, had not performed in their new role directly, and were in some ways more akin to medical students. I contend that assertively expecting interns to “be the doctor” led overwhelmed learners to look immediately to other who could guide them to appropriate behavior. Social transmission of dispositions came through a process of expectation and demonstration. Learners looked to those with symbolic capital to guide action towards fulfilling expectations. Expectations from faculty and senior residents, resident peers and patients, all drove transmission. Transmission occurred through habituation – repeated and affirmed performances of particular behaviors eventually become dispositions emblematic of the particular habitus – including the social history of the department, specialty, and biomedicine in general.

In particular, the residents were expected to learn particular techniques, skills like entering data in medical records and learning to decide what tests to order. As the physician came to repeatedly demonstrate skill in these tasks (cultural capital) they received less and less oversight on these matters (symbolic capital) and were permitted to work more autonomously, given their increased competency. The residents did these smaller, more regimented tasks and moved to more complex skills requiring greater

degrees of critical thinking. These early skills were then used almost mechanically. The actions or words felt uncomfortable, like new shoes, causing the action to be furtive and hesitant, maybe even painful – even beginning to call oneself a “doctor” fell into this category. As time passed, residents came to more fully embody these dispositions. The intern became more comfortable with using the techniques, more skilled. The second- and third-year residents became more comfortable mentoring others as well as doing the work.

Important power dynamics appeared throughout the educational activities described in this chapter. On the surface, the process of making family medicine physicians seemed well ordered and linear. The susceptibility of residents to the influential power of mentors came from a shared commitment to acquiring competency and expert knowledge mentors imparted in order to achieve board certification. Chief among the actions influenced by those with formal power over the residents was the assumption of the disposition of “you’re the doctor now”. This disposition placed a premium on certain activities, guiding the actions of the learners by virtue of the mentors’ position to bestow marks of progress on resident development. Residents were seen treating patients and reporting to supervisors, precepting in particular ways with mistakes in formatting and thoroughness corrected by the preceptor. They took on the important symbol of the white coat, to look the part of the doctor. They learned techniques for ordering tests and managing the pressure of the daily work. In these ways, residents were steered toward right action, in a way symbolic of becoming a “good family medicine doctor”.

Yet at times, the residents resisted these expectations, exercised power laterally amongst themselves, and made their own decisions regarding the learning that was expected of them. This was most clear during didactics. That the residents were often observed attending to other work and often not actively engaged in the didactics suggests that residents had the agency to resist the format through which this capital was being conveyed. In interview, residents expressed frustrations over exposure in lecture to topics that would have helped them if received sooner. Further, they felt the need to engage with other work to get “caught up”. Being forced to attend to this additional work suggests a hierarchy of expectations – simultaneously meeting both the needs of the didactics and the needs of the medical paperwork seemed impossible. In other words, the residents chose to conform to some expectations over others, interpreting some work as more important. As a result, they chose to not pay attention in didactics in order to meet the higher expectations placed on them by attending physicians, preceptors, and patients. That the faculty members did not put a stop to this practice suggests at least a passive acceptance of this organizational reality.

Didactic lectures were a source of knowledge accumulation and yet revealed the contested nature of learning that unfolded in making new family medicine doctors. The lectures were a requirement but attendance was mixed at best. That the lectures covered particular medical and procedural topics suggested the higher symbolic capital placed on medical knowledge in the setting. Topics such as “patient communication,” “physician wellbeing,” and “stress management” were not focused on. Given the rhetoric around family medicine’s holistic approach to healthcare and safety in learning, this skew towards a biomedical focus was surprising. Regardless, considerable amounts of

knowledge and cultural capital were packed into these lecture sessions, despite the contestations in residents' use of that time. Further research into the role of didactics in shaping residents sense of their own power and approach to patient care is warranted.

Interactions among physicians, both residents and faculty members, created moments of competition, where residents were able to display their capital and resist the normative modes of education to which they were exposed. Dr. Probst in particular was keen to display her power and capital around physical manipulation, a skillset that as a DO was not available to MDs. Dr. Hurston was quick to resist Dr. Probst's attestation of greater authority by downplaying its significance and redirecting toward the skills more commonly available to MDs. Dr. Probst attempted to push up the hierarchy of authority, to show her progress in the program, and displayed a competence that presumably would serve her well in the future. Reminded of her place in the hierarchy, however, Dr. Probst did not push the matter further.

Residents also exhibited displays over power over one another, at times reinforcing their role in the larger hierarchy. Dr. Tao most obviously displayed this power over other residents in her role as chief. She established expectations of the interns from their first moments on the inpatient service. Her continued power derived from her demonstration of right action that would lead to a successful team effort on the floor. Her symbolic capital derived from her achievements leading to her promotion to chief resident, and in turn, she mirrored the expectations placed on her in her expectations of the interns. "Learning by doing" became a central disposition in this power dynamic. Every resident had something to "do" and their work was part of a structure of efforts, reliant on the work of others. This led to "learning" towards symbolic recognition of the

amassed cultural capital in each resident towards promotion. In other words, the power hierarchy, reinforced through dispositions and expectations, afforded residents little choice if their desire was the accumulation of expert knowledge. Even residents carried labels acknowledging their relative levels of expertise (e.g. intern, third-year, chief) that conveyed their progress and successes for others to emulate.

Finally, an interesting reversal of the hierarchy was seen in the negotiations among the residents privately in selecting mentors to acknowledge. For example, the debate regarding a particularly demanding attending physician revealed different ideas about learning. Some felt that being made to cry was a useful method of forcing learning to occur. Others felt the approach was too harsh. Lateral power among the residents meant that those on both sides of the issues ended up debating to a standstill, tabling the issue until more residents could add their voice to the discussion. In this case, shared power existed in a sort of democratic mode, where each resident had a voice to express their opinions and vote for their preferred mentors. Ironically, this award process reinforced the normative power hierarchy – residents were not given similar awards. Instead, these awards served as an acknowledgement of the power to teach possessed by those in positions of authority above the residents.

It was in precepting that power issues became most obvious towards the making of particular kinds of family medicine physicians. Changes in precepting over time showed advancement of residents in the educational model and a conformity to the habitus, professional socialization towards demonstration of the expected behaviors. As we saw, the activity of precepting changed greatly for residents, depending on their skill level and point in the three-year training program. Interns, for example, tended to

precept at length. This was because they were struggling to identify and treat the disease at hand, but also because they have not yet refined the information management process necessary for efficient precepting. Second- and third-year residents precepted more quickly, demonstrating they had taken on the dispositions and techniques necessary to treat patients.

The most advanced residents, like Dr. Katsaros, had achieved the sort of competency that led Dr. Douglas away from thorough precepting, reinforcing that Dr. Katsaros had taken on the proper disposition to be trusted to treat patients safely. Dr. Johar and Dr. Clark both struggled to manage patients who themselves were struggling with challenging health issues and an abundance of medical information. Both took and used advice from their preceptors. The preceptor was empowered by his or her greater experience and the symbolic capital the program attributed preceptors by virtue of their role in the educational process. The assumption appeared to be that learning how to order tests, to treat patients, and manage stress were skills the preceptor could impart, and the resident was expected to learn. The residents themselves lamented their struggles when the process of treating patients did not go smoothly, but I did not witness residents directly resisting the expectations of preceptors.

In considering other power dynamics, how should we make of the absence of patients from precepting discussions and decisions? In the educational model, the physicians – and preceptors in particular – determined “what was best” for each patient. The plan was too often formed independent of the patient. In a similar vein, understanding of the patient’s perspective was framed often as something to work around rather than work with. The sum result was a power dynamic that suggested the

preceptor could best speak for the patient's concerns without consulting the patient directly. The preceptor would help the resident to think about insurance costs, different framing of physical exercise, or managing a patient's sense of hope. The discourse around family medicine's commitment to patient-centeredness became rhetorical and somewhat hollow without direct demonstration by preceptors and only perfunctory commitment to the patient's perspective and holistic understanding in practice. In the normative hierarchy of power in the habitus, patients were at the bottom.

In general, the educational result of precepting was the technician-physician, able to display the appropriate techniques of gathering information, ordering tests, and assessing the patient's symptomatic circumstances. The preceptors began to add on more advanced techniques identified as important to a patient-centered, family-medicine style of providing care. Yet still this process did not instruct residents how to engage the patient directly. Finally, advanced second-year and particularly third-year residents segued to less and less direct precepting. They had acquired the cultural capital (knowledge and skills) and social capital (collegiality and proven trustworthiness) to practice with less supervision. They were granted the symbolic capital of competency and rewarded with greater autonomy.

However, I contend that healing for patients is tied directly to family medicine's object. Should residents have been granted this level of autonomy when the formation of healing relationships with patients was less well addressed in the educational process? Without hands-on instruction in how to speak to patients, I question the entanglement with patients' and the information conveyance needed for patients to make sense of their illness experiences. The practices I observed were very often not in

keeping with family medicine's object. While patients' fears, concerns, hopes, and social circumstances were discussed in precepting, incorporating these more often took the form of working around them, correcting patient misconceptions, or reflecting on physician reactions to challenging patient circumstances.

Canguilhem's work (2012) helps to shed light this complexity. Canguilhem points to a problem with the dominant thinking on disease treatment – that a return or restoration of health can and should be achieved. However, “the restitution or reestablishment of the anterior organic state may prove illusory when confirmation rests on functional testing rather than simply relying on the satisfaction of the man who stopped calling himself sick” (ibid: 55-6). Medical success is defined within medicine by restoring the previous state of the patient rather than assessing patients' satisfaction with the outcomes of treatment. Healing for physicians is the treatment and curing of disease. So even if health is restored, the patient is changed, “the body declines” and there is no complete “return” to health (Geroulanos and Meyers 2012: 10, 18). Healing for patients is not a return to what was before but the achievement of a new state of equilibrium between the body and the environment, requiring the patient's direct investment and meaning-making (Metzl 2010; Klein 2010).

At this point in my fieldwork, I had observed little discourse among the physicians that engaged the patient's sense of meaning on their own disease or illness experiences. The practices resulting from precepting were often biomedically-focused and paternal. The values of the specialty espouse more than medical interventions, but an active relationship between the physician and patient towards the distress of disease and incorporating the patient's perspective in treatment. In pursuing relationships with

their patients, I would have expected discussions among the physicians regarding what ought to happen between doctors and patients beyond curing disease.

At times, the approach to healing I observed became almost formulaic – what test most appropriately matched which disease and which treatment was most appropriately called for as a result? The formality of precepting presentations, the expectations of imitation from the mentors, and the reliance on tests established a set of normative practices. Often, the healing needs of the patient were not sought. For example, recall the woman whom Dr. Bonowitz and Dr. Williams were attempting to discharge from the hospital. Her symptoms were resolving, her stomach pains abating. They had diagnosed and treated her disease. Her experience and fear, stemming from her broader social milieu of a family history of stomach cancer, was not addressed. The physicians were learning to manage disease, but not to understand the patient. Through role-modeling, Dr. Bonowitz was conveying the importance and primacy of this approach for the new intern, Dr. Williams. Further, the patient-physician expectations of a clinic visit were often misaligned, as was the case with Dr. Johar's patient who simply had one concern but whom the physicians were concerned needed an entire physical. As a result, the resident lamented being behind schedule, not the inconvenience she had placed on the patient, or the potential worry her concerns had ignited in the patient's mind.

American public health scholar, Philip Alcabes (2015) points to, like Canguilhem, a sense of wellness and whole-patient treatment by referring to healing as “a dance, an entanglement, a form of knowing” (85) for both the patient and the physician. The human encounter, he contends, is the heart of the exchange and without a deeply

discursive understanding of the patient within their context, with their hopes and fears, the preservation or establishment of “wellness” is half-formed and incomplete. An insistence placed on learning techniques to diagnose and treat, over skills in patient interaction, was reinforced through nearly every precepting interaction I observed. The preceptors spent more time debating tests to run than assessing the patient’s experiences in a patient-centered way, normalizing a focus on disease processes.

Patient-centeredness as I observed it became a way to discuss and contest a patient’s personal context (e.g. this is a patient who claims to exercise) and thus led to paternalistic attitudes (e.g. but I am concerned they are not exercising enough). On occasion, especially in Dr. Monroe’s case of negotiating hope with her patient, the physician listened to her patient but then was at a loss regarding what to do with that information. Her uncertainty clouded her power to control the patient dynamic, questioning her claim to medical authority. At times, the values expressed suggested that the patients could not determine for themselves what was best, but are left dependent on the physician to make decisions for them. The physicians worked in the patients “best interests” without assessing what those interests were (Bosk 2003: 169). Further, like with the test ordered for a cervical cancer screening, the physicians were working towards larger societal concerns of preventative measures that may not have been in the patient’s best interest.

Paternalism is problematic, “because it disguises the fact that other motivations are always at stake” (Moncrieff 2014: 46). The residents were being shown a way to engage with patient health that was driven by certain prevailing attitudes about expert knowledge and roles in biomedicine, insurance companies (financial concerns over

payment), time management, and screening for prevention rather than patient's concerns. Healing then became more of an exercise in curing, often without entangling with patient-centered notions that directly involved the patient's point of view. The result was an educational process that sent particular unspoken messages to the residents. The power the preceptor wielded in conveying competence and eventual autonomy – the resident was being evaluated all the time – impacted resident behavior. Residents were sent the message that patient concerns were often secondary to the physician concerns. The diagnosis and treatment plan were formulated in among the physicians, communicated to patients without much direct mentoring as to how, and used the patient's story to understand barriers to adherence. The power was often primarily in the physicians' hands, which runs counter to a notion of patient-centeredness. Family medicine's value of patient-centeredness became rhetorical, an empty signifier ready to be filled with whatever the physicians wanted at the time.

I am reminded of the work of Charles Bosk (2003) in managing medical failures. In a sense, not conforming to the core tenet of family medicine's value system becomes something of a moral error, a failure to follow the stated code of conduct of the profession. Not focusing on patients as individuals and discursively engaging them in meaning-driven dialogue around their experiences – the foundation of healing as conceptualized by Canguilhem – the physicians do not embody family medicine's object. Further, because the faculty role-modeled this behavior and acted under the expectation that theirs was the example to follow, residents reproduced this behavior. The “group standards” established expected behaviors and the residents followed suit (Bosk 2003: 179). I began to recognize a dissonance between the values of family

medicine as they were discussed between the physicians and within family medicine's own broad literature and the behaviors I witnessed. Approaching healing became an exercise in discussing patients' concerns but often these concerns were secondary to the physicians' priorities. Only infrequently was the patient's social milieu used in diagnosis and treatment; though frequently mentioned in precepting, it was not utilized. At this point in my field work, it appeared that the diagnosis and treatment of disease had taken family medicine's object in a more biomedical direction that was further away from the particular values of the specialty.

In conclusion, this chapter illustrated the foundational processes of the professional socialization of family medicine physicians, albeit with concerns over the place of and attention paid to family medicine's object and nature of observed healing practices. The residents acquired techniques and knowledge that furthered moved them towards competency in diagnosis and treatment, though they often did not fully engage with family medicine's broader value system. Further, the residents experienced the hierarchical power of their mentors while, at times, contesting and defining power for and among themselves. The result was a complex learning process where the residents took on dispositions not entirely in keeping with family medicine's object, sometimes contested the learning they were engaged in, and did not often concern themselves with patients as subjective actors in the medical environment.

CHAPTER 7

CASE STUDIES

In order to better illustrate the taking on of capital, while also further exploring local definitions of healing practices, I have developed a series of ethnographic case studies. The case studies are constituted from observations and interviews, as intimate, in-the-moment episodes between and among the physicians. Herein, we see the physicians engaged with their own values and practices as well as others, focused on particular expectations and dispositions, and conversing over the particularities of working in and learning their specialty.

The goal is to garner, through a closer examination of paired working relationships, a better understanding of how residents take on family medicine's object. The first case study explores the early socialization of a new intern as she worked with an established second-year resident. The second case study explores changing resident attitudes about collegiality over time and the course of training. The third case study explores how the process of becoming could go awry and what happened to a resident who did not proceed on a normative educational trajectory. Together, these studies provide a closer look at key moments in the educational process of making healers in the program.

Transition to teaching

The first case study examines a specific resident-intern team working together during the intern's first week on the inpatient service. By focusing on the teaching and learning interactions between these two residents, important techniques and knowledge are clearly illustrated. Further, we see how expectations of the residency program are

embodied by the more-senior resident and demonstrated to the intern, who in turn is expected to take on the demonstrated dispositions. Further, power dynamics in the educational setting become more obvious: both those between residents and between the resident and faculty mentors. I first provide background on each resident separately and then describe and reflect on the interactions I observed.

Dr. Pryde

Dr. Pryde was a young Caucasian woman in her mid- to late-20s, with a warm, unassuming personality, who often engaged with me during my time at Suburban. As an intern, she was one of the first with whom I felt a sense of camaraderie. She often poked fun at me as the “tag-along”, commenting that I’d been around long enough to make fun of, and that at times claimed I looked as lost as they felt. She expressed a desire to choose her own alias for my field notes, and was pleased when I told her the name I had already chosen, recognizing immediately the pop culture reference. As a key informant, I feel it is fitting that she finds a place as part of the first case study.

In my fourteen months with Suburban Family Medicine, Dr. Pryde’s evolution and professional socialization particularly stood out to me. When relating her story, Dr. Pryde began by detailing the difficulties she faced in getting into residency. She had a challenging time with test taking. As she described, “I was not the poster child candidate”. However, she knew the Suburban’s program well, having worked there through rotations during medical school. Her first rotation of medical school was with Suburban’s Family Medicine inpatient service; one of her last was with Suburban’s Family Medicine’s outpatient clinic. She explained how the residency program took a chance in hiring her, though her initial board exam scores were not strong. She said of

herself, “When it comes to clinical work, I’ve got it. But when it comes to taking a test, it’s been a rocky road for me”. In telling the story, she expressed her fears that residency was not going to happen for her. She put in the work, but that was not the only criteria programs used to select residents – test scores played a major role. Dr. Pryde felt lucky and very grateful towards Suburban Family Medicine.

As a result, when Dr. Pryde began her residency training, she felt she had a lot to prove, and continued to feel that way when we spoke. She explained how she was very scared in the beginning and put a lot of pressure on herself to succeed. As Dr. Pryde received positive feedback, she felt that she had established a place for herself and her confidence began to grow. However, she acknowledged residency was not over yet; she was still in the middle of it and there was still a lot of effort yet to put in:

...I always feel that I'm trying to do the best that I can do. Always searching out for feedback. Making sure I'm doing the right thing. Trying to be the person that treats her patients differently than you see sometimes- you know, you see sometimes patients just become a pathology on the floor. So I always try to cater to their needs and things like that. I find sometimes to my detriment, because I'm overexerting myself, you know, giving up a lot of my time sometimes. But I don't know; it matters. Doing those little things. Because when the patients are happier, the care is better, and it all kind of trickles down (Interview: November 21, 2012).

In a deeper sense, her quote appears more focused on herself than on patients. Her sense of her own progress in the training environment was measured by her own notion of doing what was best for her patients. This rhetoric suggests that patient happiness was the natural outcome of the behaviors she feels were important to undertake, not necessarily in assessing what physician behaviors patients wanted.

Dr. Pryde was quick to add that she was also very good at managing her time, remaining focused on the performance her mentors were monitoring. “Time is

something I hold in very high regard,” and explained that she planned her days out very carefully, arriving for events and meetings ahead of time. She felt she had mastered the constant issue of time management that troubled many residents. But she still experienced a great deal of stress. Dr. Pryde pushed herself to excel, admittedly took on too much, and sometimes the stress got to be too much. She often called her mom to “cry it out”. With family support she has been able to “suck it up, and get back to it the next day”. She found ways to process and overcome the challenges she faced.

The choice of residency programs proved to be a good one for Dr. Pryde, in that the way she learned dovetailed with the mentorship approach of the program. She spoke at length about being a hands-on learner. Dr. Pryde’s clinical skills developed through doing the things she was asked to do, to be present and be engaged, and learn through being shown and trying new techniques herself. She was involved, hands-on, because “I know that’s how I learn best. I can’t just sit down in front of a book and learn something”. From the telling of her story, I saw that Dr. Pryde possessed a keen awareness of her strengths and weaknesses. Through observation of her work over time, I saw many instances of how she succeeded in making use of her strengths and working through her weaknesses, as I will detail below.

Dr. Pryde credited her success in obtaining these skills to her childhood and upbringing. Growing up, she had a challenging childhood, and became very observant of what worked best in any given situation. Her mother was a single parent that struggled to provide financially for her family. As a result, Dr. Pryde was committed to minimize the burden on her mother, translating this commitment to her work in residency: “How can you make life easier... for anybody else, because then ultimately

it's easier for yourself. If you show up on time for things, people don't look at you and think you're a slacker". In residency, Dr. Pryde's approach translated into a strong work ethic and motivation to prove herself. She felt that she was lucky to be given a chance when she was not the strongest candidate. Dr. Pryde spoke of being constantly aware of being evaluated and living up to the expectations of those around her. As a result, the opinions others had of her work motivated her further. She tended to work ahead on tasks, rather than allow patient notes and computer records to pile up. As indicated earlier, these bureaucratic and time management skills were heavily emphasized in this residency training program. She was also a keen observer of other residents, marking what did and did not work for others here.

She felt that most residents try to "do the right thing" and "prove themselves" to their teachers and peers. She said this dedication was particularly true of family medicine: "People who go into family medicine, for the most part, are people who are dedicated to the practice. You don't go into it for the money, obviously. Usually people in family practice are just more dedicated to the patient." She compared her experiences as a medical student rotating in family medicine versus her time in internal medicine. While both are primary care specialties, Dr. Pryde noted differences. In her experiences, internal medicine focused more often on the disease of the patient, rather than the patient themselves. Internal medicine, Dr. Pryde felt, did not explore the patient's social background, or dig as deeply into social causes for particular diseases – causes that may stem from lifestyle or environment. Family practice, she felt, was more tuned in to the person and "so, I think people that go into it are more compassionate people". She was quick to acknowledge there are certainly compassionate physicians in

other specialties, but “when you choose family medicine, you have that good stable ground of being a very compassionate person”. Thus, she believed that there was something distinct that drew certain types of people – and drew her – to family medicine. Dr. Pryde was one of the people in the study whose reflections most directly referenced family medicine’s object.

Reflecting on her own time as a new intern, Dr. Pryde expressed joy in the opportunity she had to work with a second year resident during her first weeks on the floor. Dr. Pryde gave credit to the residency program for seeing the value in a lengthy orientation. She liked having the support, in the moment, to get used to the work that was expected of her. She felt the department’s approach was a good way to “make you feel a little more at ease” before going into her first “full-blown” intern month. Having someone “right there” with her was helpful – she was eager to jump into the role, and display her capital and affirm the department’s decision to hire her, but felt she was not “thrown in” over her head.

Now as a second year resident, Dr. Pryde had the opportunity to help teach the next class of residents. She expressed her eagerness to take on this role and help the new interns adjust to the work. Dr. Pryde felt it was a challenging and somewhat uncomfortable position for her. She did not consider herself to be a teacher. What she tried to impart to the new interns were the “coping mechanisms” she had learned in her intern year – “what to do when things aren’t going right. What to do when you’re uncomfortable with what you’re doing; you’re not sure where to go, who to talk to, what to make sure you’re doing yourself”. She felt her role was not to teach the medicine, but to convey her “little words of wisdom” – the medicine comes eventually, but she felt she

could offer more by explaining how to perform and meet the expectations day-to-day on the floor.

On numerous occasions when Dr. Pryde was a new intern, I witnessed her struggle with a patient presentation or be late to inpatient table rounds because her work on the floor had run long. A few short months later, she was a second-year resident and the apprehension was largely gone. Dr. Pryde had become a strong teacher and advocate for those for whom she was responsible. On a couple of different occasions when Dr. Pryde was a second-year resident, I saw her skillfully fill in missing information for a medical student or intern report, preventing the likely annoyance from the chief residents on the floor. Dr. Pryde felt she could prevent the painful lessons for others and help them to be more successful from the start:

To me, that's the important stuff to teach them because they're not going to get it until they've fallen and broken their ankle themselves. If I can save them from that, if I can give that to them, because I've gotten it myself somehow, learned it the hard way, then I will (Interview: November 21, 2012).

Dr. Pryde carefully explained to each new intern how to manage patients, how best to work with each attending – things she learned during her internship.

Dr. Pryde was always friendly, always willing to talk and entertain my questions, and above all was willing to reflect on the process of learning and becoming a family medicine doctor. Her story was one of determination and perseverance. From learning about her experiences “making it through early residency”, I learned much about what it takes to become a family medicine physician. Further, Dr. Pryde provided useful examples in our conversations of how a resident can approach becoming a doctor and how those experiences can turn into a dedication to the training of new residents.

Dr. Deepah

Dr. Deepah was one of the new interns at Suburban Hospital whom Dr. Pryde mentored and worked with closely. Dr. Deepah was young, in her early 20s, and of Indian descent. She tended to be soft-spoken but willing to engage when I approached her for an interview. When I sat down to speak with her, she had been in the program only a few months. I was eager to speak with her about her experiences during orientation month. Having worked hand-in-hand with Dr. Pryde, someone who was so interested in the importance of having a good early start in residency, I felt Dr. Deepah would provide insights into these early learning experiences. Dr. Deepah was on her third inpatient month when I interviewed her.

“You just adapt” – this was how Dr. Deepah explained how she had come to learn the basics of residency work. From the start, Dr. Deepah discussed how challenging residency had been. Adapting to the work, the rules, and the proper procedures has been difficult for her. She eventually “got the flow” and came to know what she was supposed to be doing. She felt fortunate to be part of this program and enjoyed working with the faculty members and her peers. Dr. Deepah reflected on how great her intern class had been and did not have “anything negative to say”. She felt the process was “what I expected” and felt she was off to a good start; just two-and-a-half years left to go. It was a lot of work, but she came in knowing that. I was hoping to get Dr. Deepah to express her opinions more richly, rather than these quoted statements that sound a bit like platitudes. I was left wondering if perhaps her sense of my positionality, that she saw me as an authority figure, led her to keep private any possible criticisms. I pressed her to reflect on her earlier learning.

When she was in medical school, she heard people talk about how hard residency was – especially intern year. “You’ll just be thrown into things. You’ll have to quickly adapt. Which is all true.” She explained that her first month on the inpatient service was her most challenging so far; “the floor” was busy in general and when trying to “learn how things work” and “how to deal with patients and nursing staff and learning the EMR (electronic medical record)... you’re learning everything at once that first month. That was definitely the hardest month.” She felt the work became progressively easier. For Dr. Deepah “there is a huge difference between the first and the second [month], and once again a huge difference between the second and the third... it’s still hard, but you’re not running around figuring things out the second or third time.” She felt she was able to take better care of patients and “learn more” during her later floor months. The cultural capital Dr. Deepah acquired in the first month helped her perform more competently and autonomously in the second; likewise with the transition between the second and third months. In this way, Dr. Deepah had moved towards increased competency and transitioned to being an autonomous intern on the inpatient service.

An intriguing distinction emerged in Dr. Deepah’s interview regarding learning and the skills she was mastering. When asked, she clarified her opinion of “learning” and defined it as having more time to read up on patients, and to read about the diseases and symptoms she observed during the day. She reflected,

During that first month, you spend so much time learning the system, how things work... so in that first month, I felt like I didn’t have as much time to read up on my patients as I wanted to... it was just a lot more learning how things work, how I can function efficiently. So it was learning in a different sense... learning the routines, learning what happens when talking to attendings... there’s a certain amount of skill and things that I had to learn; how to give them the short succinct story about what’s happening with their patients. And all of that took time (Interview: February 20, 2013).

Even having rotating here as a student, having had experience with Suburban's EMR, it was still challenging for Dr. Deepah. She felt her time with Dr. Pryde was useful. She reflected: "You're going to make some mistakes, but someone is right there catching it".

However, Dr. Deepah did not identify "figuring things out" as learning, but instead labeled the accumulation of textbook medical knowledge as "learning". The focus Dr. Pryde placed on computer reports and managing Dr. Thomas' patients did not receive the same symbolic weight, in Dr. Deepah's assessment, as learning how to diagnose disease and implement treatment plans. The social capital of knowing and working competently with the other physicians or the cultural capital that comes from learning the social structure of the work did not receive the same status. Finally, though Dr. Deepah said she could focus on the patients more the second and third months, this "reading up on patients" was focused on their medical records. Learning to better speak with the patients was among Dr. Deepah's priorities.

Dr. Deepah's case helps to illustrate the lived experiences of residency education. Her conceptualization of "real learning" stemmed from the evaluation process to which interns (and all residents) were subjected. While the program faculty members implicitly understood that learning the computer system was an important step, they were not directly evaluated on such tasks. Yet, the interns needed to learn the basic rules of the habitus, take on the disposition of basic competency – that they could enter data into the computers, order medications, and communicate well with their colleagues. Perhaps, how to dictate notes or interact with colleagues were almost prerequisites for the "real learning" of medicine. In other words, there was a sense

among the residents that learning to survive, to perform in the social and physical structure of the place, was a prerequisite for other more-complicated orders of learning.

Within a few months, Dr. Deepah felt that she had gained a great deal of hands-on experience and was able to respond appropriately to various common ailments:

You just know what to do. You've seen the cases enough. I feel like I've seen enough COPD. I've seen enough congestive heart failure. I've seen enough pneumonia. And this is like the bread and butter of family medicine inpatient; to know what to do, who to consult, what I'm looking for, what I'm looking for in the patient to see that they're clinically improving. Those are not things that I necessarily have to look up or read UpToDate¹² on at this time. Having gone through, you just know what to do, so it makes it easier, it's less time consuming, you know what to order, you don't have to look it up (Interview: February 20, 2013).

Interestingly, she continued to place greater value on a more bureaucratic sort of learning related to medical charts and textbook knowledge; the cultural and social capital she had accumulated in medical school and earlier in residency. For example, some of things she learned to order for the first time – her first abdominal CT scan, for example – involved computer glitches and “trial and error”. She explained that in the beginning she often double and triple checked her computer work, orders, and reports.

As indicated by Dr. Deepah's account, there seemed to be an implicit emphasis placed on rote, task-driven report-writing and consulting medical records over learning to speak to and interact with patients in some important but more complicated ways. This conceptualization of learning emerged and was reinforced in her earliest residency training experiences. I turn now to examine the interactions of Dr. Pryde and Dr.

¹²UpToDate as described on the company's web portal: “UpToDate is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine, and the only resource of its kind associated with improved outcomes.”

Deepah *in situ* working together on the inpatient service. These events took place during Dr. Deepah's first days on the inpatient service.

The senior resident's apprentice

To see how learning was transmitted between generations of residents, I observed Dr. Pryde and Dr. Deepah working together during the first week of inpatient orientation. I followed Dr. Pryde and Dr. Deepah on their rounds over the course of two days. Together, the two physicians worked through medication orders, patient progress notes, and checked test results on the patients for whom they were mutually responsible. Dr. Pryde showed Dr. Deepah how to do the work, to use the computer, while observing and providing guidance. Dr. Pryde took care to explain to Dr. Deepah step-by-step how to navigate the electronic medical system, modeling how the task was done, how long test results take to show up in the computer system, and explaining that it was Dr. Deepah's responsibility to know these things. By going through these steps, Dr. Pryde was demonstrating the autonomy Dr. Deepah was expected to take on; to manage the workflow of her portion of the inpatient service.

Beyond these bureaucratic learning exercises also came moments when Dr. Deepah was expected to interact with patients and their families. Here, Dr. Pryde's teaching became less hands-on. For example, it was a common hospital policy to acquire consent for any blood tests. A patient was unconscious but needed blood work done. The family then, Dr. Pryde explained, must be approached in order to obtain consent. She showed Dr. Deepah how to fill out all the necessary forms ahead of time on the computer and how to print out the necessary documents to show the family. However, little was said about exactly how to obtain consent from the family. Dr.

Deepah was told to simply go and obtain consent. No instruction was given on interfacing with the family, only that the consent was necessary and the family's agreement taken as a given.

Further, with nothing more than a warm smile, Dr. Pryde explained that she expected Dr. Deepah to go and talk to the family alone. I remember the look of apprehension on Dr. Deepah's face. Dr. Pryde sent Dr. Deepah off to see the patient, "You can go in there and do it because I trust you". This simple statement was coded with a good deal of meaning. Dr. Pryde was conveying her faith in her student, investing her with the expectation to try and succeed. However, nothing was demonstrated or explained regarding exactly *how* to speak to the family; were there types of words to use, phrases to avoid, or a certain demeanor to take on? Dr. Deepah was simply pushed in and expected to perform the task correctly.

I caught up with Dr. Deepah as she was leaving the patient's room, having successfully obtained the consent for blood work. The visit with the family lasted only a couple of minutes. She did not tell me anything of how the interaction itself went except to say she successfully obtained the family's consent. Looking back later, I see that I should have probed more here, but I was new to conducting this fieldwork myself and still figuring out the right questions to ask. I do recall thinking that it was disconcerting that her main impetus was getting the form filled out; nothing about the patient or their family was said. As my work went on, I questioned this focus, as it did not map on to what most anthropologists and other scholars convey about healing practices – to assess a patient's understanding, or in this case, the family's experiences. Further, the values of family medicine were not served by this approach. The interaction took for

granted that the well-being of the patient, seen hierarchically as being completely within the hands of the physician, would prevail in acquiring consent, regardless of any potential problems the family may have. A paternalistic stance, where the physician must simply be trusted to do their work, was leaned on and did not include engagement with family medicine's object – literally, in this case, with a patient's family.

Further, Dr. Deepah seemed intent on the next task to complete rather than speaking to me about her consent encounter. Her reflections were limited and she walked away towards the nurse's station. As we walked, I asked her how she was holding up. She deflected the question and focused instead on her progress learning the system of working on the floor. "I'm trying to be fast," she said, "but I'm still learning". Again, I sensed my own position was influencing my interactions with Dr. Deepah. Her answers sounded more like responses to an evaluation than to my curiosity.

Dr. Deepah indicated that she felt that she learned a great deal in her fourth year of medical school and now she was emulating the processes she learned there. She said, "There's really a standard model for writing a lot of these notes. If you use the standard model, you can't go wrong". What I take away from this statement was that her early socialization into medicine began, of course, in medical school, where "performing" the role of the doctor was learning to fill out paperwork and write notes in a standardized way. Here, when she needed a touchstone to figure out if she was performing well, she fell back on these previous measures of competency. Her reflections did not conceptualize a clear place for the new learning she was undertaking.

Later that same morning, Dr. Deepah, Dr. Pryde, and I went in search of Dr. Thomas, a hospitalist physician, to see and work with Dr. Thomas' patients. A

hospitalist is a physician whose primary day-to-day workload involves treating patients in the hospital setting. In many hospitals, including Suburban, residents are assigned to help manage the patients of hospitalist physicians. In addition to the patients directly assigned to family medicine, the residents assist with these other physicians' patients. The hospitalist is the physician ultimately responsible for their patients' care, but it is the residents who often assisted. In this case, Dr. Pryde and Dr. Deepah were helping manage three such patients for Dr. Thomas.

Dr. Pryde explained to both Dr. Deepah and myself that she knew where to find Dr. Thomas, and that meeting up with him was often much more effective than trying to "talk through his patients" by phone. Dr. Pryde explained that she typically tried to see his patients side-by-side with him – to rotate on those patients together, as an opportunity to learn from Dr. Thomas. Understanding his schedule, his rhythm, was a skill Dr. Pryde had nurtured and tried to pass on to Dr. Deepah. This approach was presented as Dr. Pryde's idea, something she had done in her time as an intern.

As we walked through the wards, Dr. Pryde explained to me that Dr. Thomas was an internal medicine physician who preferred to admit his patients with family medicine. She explained how he used to admit his patients with whichever primary care inpatient service had an available bed, but after becoming increasingly dissatisfied with how internal medicine was treating his patients, he made the formal request with the admitting office to admit solely with family medicine. Dr. Pryde cited internal medicine's disease-focused treatment of patients and a lack of strong personal connections among physicians of other specialties. Dr. Thomas valued the patient-centered approach of family medicine. It was not stated how his colleagues in internal medicine felt about this

choice, but the family medicine residents regarded him as one of their own. As Dr. Pryde finished speaking, she saw Dr. Thomas and we moved to meet up with him.

Impeccably well-dressed, Dr. Thomas favored expensive suits and bold colored ties. He eschewed the classic symbol of the physician, the white coat attempting perhaps to minimize the symbolism and authority the coat conveyed. I came to find that his “doctoriness” was conveyed more in his general appearance, dispositions and actions than the symbol of the white coat. Dr. Thomas was a Caucasian man in his forties. His hair was perfectly groomed, dark and combed back away from his face. He carried himself with a deep confidence and on first impression; I assumed he was aloof or otherwise distant. This early impression would prove to be wrong. Dr. Thomas was engaging and friendly, forthright though perhaps a bit intense. He shared strong relationships with his patients, but also telling, with Dr. Pryde and other residents of family medicine. Forming relationships was a priority Dr. Thomas shared with family medicine, as it is supposed to be for all family medicine physicians.

Dr. Thomas greeted us quickly and then moved to get to work. With little preamble, he turned and began walking down the hall towards a patient’s room in another part of the hospital. His authority and status were evident in the working dynamic. Without pause, he asserted his place as the attending and more-senior physician as he strode through the hospital floors. Dr. Pryde however, did exhibit her own sense of hierarchy and power. At Dr. Pryde’s behest, Dr. Deepah remained behind and began work on a patient note. It was unclear to me exactly why this arrangement was made, especially since Dr. Pryde was supposed to be teaching Dr. Deepah directly. Regardless, the two more-senior physicians left on rounds, leaving me torn on whom to

follow. I ultimately chose to follow Dr. Thomas and Dr. Pryde, hoping to see the learning Dr. Thomas provided to various levels of family medicine residents over time.

Without realizing it, I found myself walking just behind the two physicians. Dr. Thomas quickly noticed, stopped, and said, "Come walk with us." He took me by the arm, bringing forward and in line with the group. He was very curious about my research and what I was doing. I told him I was looking to understand how residents learn to become autonomous doctors and he quipped, indicating Dr. Pryde, "Well, you're following the wrong resident. She isn't learning anything new. She has all the knowledge." This was a strong compliment to pay to a second-year resident; one that left me questioning if I should double back for Dr. Deepah. Why was she no longer with the group? Was she missing out on educational opportunities? Secondly, this compliment contradicted the notion that, as a resident, Dr. Pryde was still learning and gathering knowledge. It was telling that this attending expressed being satisfied that Dr. Pryde could perform her role as doctor in such a way. The only work I observed Dr. Pryde perform, directly related to Dr. Thomas's patients, was reporting to him on patient progress and treatment plans. Certainly, there would be more to her apparent competency than just maintaining and carrying out his treatment plans. In reflecting back, these sentiments warranted further probing though I failed to do so at the time. Regardless, I remained skeptical as to whether this compliment was appropriate, given the long path still in front of Dr. Pryde.

We arrived at the first patient's room. To me, she seemed older than Dr. Thomas was, perhaps in her sixties. She was Caucasian, thin, with curly white hair, and appeared eager to hear what the doctors would tell her. This patient was particularly

weak and almost unable to speak – having had her vocal cords damaged by cancer. He openly touched the patient’s hand as he spoke with her. He sat down next to the patient, pulling over a chair and spoke with her at eye level. He asked how she was feeling and she smiled meekly and nodded. Bodily, he demonstrated a disposition that could be considered caring, or highly paternalistic, given her inability to speak. The patient seemed engaged with Dr. Thomas, despite being unable to speak, and did not focus her attention on Dr. Pryde or myself. At the same time he spoke with her, I observed him assessing other things going on in the room around him. He checked the IV lines, the leads for her heart and breathing monitors, and her catheter. The patient watched Dr. Thomas but did not react overly much to his words.

Dr. Thomas and Dr. Pryde helped the woman sit up in bed so they could listen to her heart and breathing. Dr. Thomas apologized, “I’m going to bother you a little bit” and together the physicians helped kept the woman remain upright while Dr. Thomas finished his examination. The patient was very passive in this interaction and I question whether she felt any choice over the matter of her exam. She seemed cooperative but not deeply engaged; a recipient of the doctors’ actions without any individual power or agency displayed. She could not vocally express herself at this moment, but her body language was receptive to the physicians’ efforts.

Throughout the interaction, I thought at the time that Dr. Thomas displayed sensitivity and respect for the patient by explaining step-by-step what he was doing and checking. However, he did not explicitly receive permission from the patient to touch her or ask her sit up for the exam. At the time, I was focused heavily on studying the doctors’ interactions with one another, but upon later reflection, I was struck by how little

the patient was socially involved in this dynamic. Again, the patient acquiesced but I can only speculate that her helplessness led to her acquiescence. The power dynamic is physician-centric, with the power of the doctor to deliver care and treatment; taking for granted the patient's willingness and need. The underlying assumption seemed to be that Dr. Thomas would deliver health and the patient would accept without questioning.

Once he was done, and the patient was lying back down, all her leads and lines in proper order, we stepped out into the hallway. Both physicians began filling me in on the patient's medical condition, presuming I was confused and interested in her medically. Dr. Thomas also explained how the patient was not being given food at the time in preparation for a procedure called a paracentesis – which involved the removal of fluids building up in the abdominal cavity. Their assumption seemed to be that, as a non-physician, I would not understand the medically complexities of the interaction I had just witnessed. At the time, I accepted this approach and was eager to hear their explanations. However, what was more telling was twofold. One, they assumed my focus was on the patient's medical condition rather than the interactions between the doctors and the patient. Two, it was telling that they wished to educate even me. The disposition of teaching, conveying lessons – knowledge, skills, and values – was an ongoing process and one that had come to include at least one physician from outside family medicine; a disposition extended to even an anthropologist accompanying them on morning rounds.

Later in my analysis, I became even more interested in the patient herself and the depth of the relationship she had (or did not have) with her doctors. The physicians did not obtain the patient's permission for the exam or explore her point of view, even if

it meant her writing down her thoughts and wishes. Her literal lack of voice translated to a helplessness that the physicians did not acknowledge or redress. Further, as seen throughout my time on the inpatient service, this discussion took place away from the patient. There was little insight given to the patient regarding the physicians' findings, impressions, or overall plan for what will happen to the patient moving forward. The exam was for the physicians and the patient's health was an assumptive factor to be trusted to the doctors alone.

Dr. Pryde and I left Dr. Thomas and went to meet back up with Dr. Deepah. As we walked, I asked Dr. Pryde about her role as a teacher and Dr. Deepah's progress. She said Dr. Deepah was as good as any of the other new interns. She possessed strong attention to detail and was eager to learn. As was becoming a pattern across the habitus, Dr. Pryde's assessment of Dr. Deepah was entirely focused on the more bureaucratic aspects of medicine. It helped, Dr. Pryde said, that Dr. Deepah was already familiar with the computer system from her time rotating through Suburban Hospital as a medical student. At this point, we reconnected with Dr. Deepah and moved to another part of the hospital. Dr. Pryde reiterated to Dr. Deepah how Dr. Thomas's working patterns were important to attend to, how this had helped save Dr. Pryde considerable time managing his patients. This technique, indicative of Dr. Pryde's disposition of learning and mastering the "tricks" of working the floor, allowed for collaborative work with Dr. Thomas.

Despite the hands-on approach used to teach that morning, I was left with a lingering concern. The focus was so clearly on writing patient progress notes and managing time. The patients seemed personally absent, treated as part of a workload to

be processed through. Despite family medicine's assertion of a patient-centered disposition, were the residents in fact learning patient-centeredness or were they simply learning the bureaucracy of medical practice? What exactly was patient-centeredness to the physicians? It was discussed a great deal, but was it enacted in a way that conformed to the discourse? Patient-centeredness often became a part of the rhetoric residents mobilized to explain why family medicine was better than many specialties, appeared often as a friendly demeanor towards patients, but did not take patients' perspectives to be the central goal of the interactions I had so far observed.

At this point, the three of us had arrived at a nursing station centrally located in the hospital, located near many of the family medicine patients' beds. Whenever I had observed the inpatient team, all of the family medicine residents came to this station at some point or another during the day. Today was no different – Dr. Mueller, another second-year resident, was just leaving the station when we arrived, and Dr. Bierce, the attending, came to talk to us as we arrived. He calmly informed us that one of Dr. Mueller's patients had died less than an hour ago. This patient was a young man, in his forties, who suffered from a debilitating illness, leaving open lesions over his body.

The work continued without much pause. Other patients needed the residents, including Dr. Mueller; everyone continued working without missing a step. I found myself wondering about the impact of this type of news on the young physicians. The attending conveyed a certain disposition, one that indicated the work must go on, that these things can and will happen. I asked Dr. Pryde about losing a patient. She said, "You never get used to it. Not entirely. You learn to control your emotions and you learn to take care of yourself at home". Her approach was to call her mother and "cry it out".

Seeing Dr. Mueller a few minutes later, I could sense a sort of numbness in her demeanor. I was curious but my positionality as a researcher left me feeling uncomfortable; who was I to ask about this kind of sensitive topic? I wish now that I had remembered my place as an anthropologist and asked Dr. Mueller about the loss.

The disposition conveyed by attending physicians and other more-senior residents was to press on. An idea transmitted to the residents was that other patients could not wait while a physician grieves. Dr. Pryde even added, "Other patients need me". Perhaps this philosophy reinforced the focus on bureaucracy and learning the technical aspects of doctoring, to distance oneself from patients who may die. Treating patients as part of a workload allowed for this emotional distance. How do the family physicians manage to balance their work with patients or, in some cases even their extreme dedication, with the distance necessary to keep going in the face of loss? Distancing oneself from the very patients to whom they claimed to be dedicated seems to run counter to family medicine's object. From these observations and comments, I learned that I need to think more about emotional balance in residency education.

Dr. Pryde's own experiences of being a risky hire, one with a lot to prove, came out later in the morning when the inpatient team met for table rounds. As each intern presented the patients he or she was responsible for, the team asked questions to get clarity and make sure a full report was made and understood by the entire team. Dr. Deepah found herself fielding tough questions from a number of her inpatient teammates about one of her patients. The chief and attending challenged her on a number of things – decisions, diagnosis, and treatment plan. The team was not cruel or aggressive, but pointed and firm. Though Dr. Deepah did not seem visibly flustered, Dr.

Pryde stepped in and covered for Dr. Deepah, filling in the gaps in the patient report. Having been there herself, as I witnessed numerous times, Dr. Pryde was able to demonstrate her commitment to those in her charge, to demonstrate a gentle way of teaching, to give the same chances she was afforded to this new intern. She mobilized her cultural capital and asserted her competency, displaying a sense of power to protect her mentee from the barrage of questions.

Not to over-psychologize the process, but possibly by defending Dr. Deepah, Dr. Pryde was able to stand up for herself at this moment in a way she could not a year ago. Dr. Pryde had accumulated consider capital – cultural, social, and symbolic. She was able to manage her patients and accurately diagnose and treat a wide range of diseases. She had earned her place as a second-year resident by virtue of her promotion, gaining confidence along the way. She was willing to put that capital on the line, to point it out to her colleagues, in a way to dovetailed with the stated values of the program; to preserve a “safe place to learn”. However, the treatment – the rapid fire style of questioning – had been threatening to a less-developed Dr. Pryde and she stepped in to protect Dr. Deepah from that same feeling. In orientation, the faculty and senior residents stressed the safety of the learning environment. In acting as she did, Dr. Pryde did her part to maintain that sense of safety for Dr. Deepah.

In closing, observing Dr. Deepah and Dr. Pryde this morning and over time provided an example of the educational dynamic I witnessed throughout the residency program. Through these interactions, I learned a great deal about the apprenticeship model used to train and socialize new interns. I sometimes had to stop and recall that Dr. Pryde was only part way through her own journey. For example, one time she

expressed to me her apprehension about her first 24-hour on-call shift starting the next day. First time events occurred repeatedly throughout their training – first patients, first on-call shift, first dying patient, first bad evaluation, first successes, first failures. Yet, those that have gone before the current interns, such as Dr. Pryde, were expected to share their learned techniques and knowledge, to demonstrate the proper behaviors and procedures, to those immediately behind them in the educational trajectory. So while having progressed further along the educational trajectory, there were still things for Dr. Pryde to learn and experience.

Finally, this mentoring conformed to the disposition put forward by Dr. Turner and others of “being the doctor” – to step up and take ownership of the work at hand. Privately, Dr. Pryde commented to me how the interns needed a push to get over their nervousness. She enjoyed the opportunity to teach and nudge the new interns into the role she herself was so familiar with was rewarding – the new interns needed these experiences, needed to “be the doctor”, in order to progress in the program. The issue remained however of the focus placed on the bureaucracy and technical paperwork and medical charting demonstrated during these learning episodes, and a distinct lack of focus on patients themselves. I continue forward to other examples in order to uncover more-obvious evidence of patient-centered healing discourses and practices, leading to the making of healers in Suburban Family Medicine.

Becoming colleagues

The next case study involved a single prolonged interaction between an advanced resident and faculty member. The resident, Dr. Levine, was transitioning to greater degrees of autonomy and levels of collegiality with the faculty member, Dr.

Sharma. This case study illustrates a later stage of the socialization process ahead of advanced residents' graduation and board-certification. Again, I start by richly describing each physician before turning to describe the observed interactions in detail.

Dr. Sharma

As an attending physician, less than ten years post residency, Dr. Sharma had a direct and gregarious personality and a tendency towards fashion consciousness. She was thin, of average height, with long black hair stylishly worn, and of Indian descent. She had a no-nonsense air tempered by a warm smile and outgoing personality. Having come from India for residency – as she puts it from a “different social, cultural background” – she had to get used to the “some of the ways here”. Her residency involved a dual enculturation – both into American culture and family medicine residency training. She struggled with her accent, explaining that speaking English was not a problem; speaking it the “American way” was. She learned how to make herself clear and understandable, asserting that “if people don't understand you, they don't trust you.” Learning how to exist in the context of an American family medicine residency was a struggle, one she took seriously from minor hurdles like learning to use the pager system to larger issues like the transition to living in the United States. The enculturation process made her first year of residency challenging, but it was also fun and memorable in her words. She claimed there was always a lot of work, including adjustment to American life, and no time to think about anything else. Dr. Sharma came to residency in the United States as a newlywed; her husband's career leading to the move. She considered herself lucky to have not had children during the three years of training, but rather could focus on her own professional development without the added

responsibilities. Interestingly, her husband did not appear in her narrative beyond the opening story of her residency, and I never learned whether or not she had children. She did not offer the information, and I failed to ask her specifically.

One particular life complexity occurred during her residency training that greatly impacted her personal understanding of the values of family medicine. Her parents came from overseas for a prolonged visit late in her residency. Her father and mother both had a number of chronic health issues. During their visit, Dr. Sharma spent time with her parents, addressing a number of their health concerns and attempting a lot of preventative care that she had learned about through residency. She describes her efforts as experiencing the American medical system from the “other side”. This experience via her parents’ health-seeking made it easier for Dr. Sharma to empathize with other patients she was taking care of.

My ability to be doing those things for other people is a lot stronger because I do the same for my own family. I feel I am a lot more genuine because whatever I am telling them to do... I do those things for my own parents... it’s just not something I read in a book or something someone told me to do... I do it for my family. I do it for my patients (Interview: November 28, 2012).

She had come to understand firsthand the impact she could have. This molded, in her assessment, the approach she took to patients from then on.

From observing and speaking with Dr. Sharma, I learned that she carried a commitment to patients as well as to the training of residents, born of the experiences of treating her own family members. “Being an effective physician. Or an effective teacher. We can never be effective in doing something unless we are trusted... unless we have a friendly relationship.” This statement summarizes Dr. Sharma’s approach to medicine and medical education – and at the time, I took her statement at face value. However,

as I worked with Dr. Sharma over time, I came to question more about how she operationalized her underlying philosophy in actual practice, as will be addressed below and more-extensively in Chapter 8.

Dr. Sharma showed considerable thought regarding her responsibility as a faculty mentor. She preferred to work with residents as directly as possible, lamenting how the residency program was not set up for more direct educational interactions with attending physicians, particularly in precepting:

You know, the saddest part about the residents learning, they can never actually do patient care with us. We supervise them from the outside. How do you role-model yourself after somebody? For the residents, they all work with us sort of in a parallel way and then our paths cross and then we teach them and then they go on their way. They never really see how we work. Are all the values we are teaching them, are we doing those when we're actually seeing patients? (Interview: November 28, 2012).

The educational model was more often focused on program requirements and meeting patient numbers. Less focus was placed on hands-on experiences and working directly together with faculty mentors. Particularly in precepting, the residents engaged in two dialogues; one with the preceptor and one with the patient. Seldom did all three participate together. Dr. Sharma advocated residents and faculty members seeing patients together more often in order to cultivate the kind of values she learned in the process of helping her parents.

Dr. Sharma succinctly expressed what has become my own concern: how exactly did the program assess the taking on of family medicine's values in its residents? The institutional-style structure of evaluations, counting patients, generating checklists of specific learning experiences, and meeting certain procedural numbers (e.g. number of babies delivered, etc.) may have prevented the sort of experiential and

organic learning that leads to becoming a “good” family medicine doctor. Those advocating the values of family medicine stress moving beyond the blood tests and prescriptions to the holistic “story” of a patient’s experiences and feelings. Yet, the training environment was often in direct contradiction to this, with its short patient visits, expected patient numbers, and focus on the details of “getting through the day”. A patient-centered healing discourse was evident in Dr. Sharma’s comments, with a focus on getting know patients and carefully conveying family medicine values to residents. Whether this teaching approach translated into healing practice remains to be seen.

Dr. Levine

Dr. Levine was a young, Caucasian woman, married to another medical resident in a different specialty at a different, local hospital. A third-year resident and one of the three administrative chiefs, Dr. Levine possessed a quiet intensity and dedication to her work. She carried herself with an independent strength, an example she set for other residents. Where other senior residents provided a friend with whom to socialize and bond, Dr. Levine guided the group through her organization, clear thinking, and calm demeanor under pressure. Hallmarks of her leadership style included never losing her composure and always working to meet or exceed attending physicians’ expectations. She had a straightforward demeanor and projected herself as a leader in her role as chief resident. She was highly determined to complete her training and take her place as a board-certified physician.

Her choice of family medicine residency began in medical school with a view towards her end goal, where she would like to work, and what lifestyle she could expect after graduating. She enjoyed all of her medical school rotations. She knew some

specialties, like surgery, might not allow her the flexibility she wanted in her career and home-work balance. It was the breadth of family medicine that cemented her decisions; a specialty that includes a “little bit of everything”. In family medicine, she appreciated being able to see a lot of different types of people, groups of patients, with many different concerns, so she didn’t have to see the same things all day, every day. Specifically, it provided her the opportunity to treat older patients. Her long-term goal was geriatrics and she was, at the time of our interview, anticipating leaving for the east coast for a geriatrics fellowship.

In order to obtain a residency position, Dr. Levine went through what was called a “couples match” – which, she said, “makes a difficult process even more difficult”. Her husband was an ophthalmology resident. She and her husband were both trying to select (and get selected by) residency programs near one another, such that they did not have to live apart. It required a lot of coordination between different departments that “usually don’t discuss [this issue] with one another”. Their top choice was in Philadelphia but her husband did not match there. Suburban Hospital was their second choice and they were both able to match.

Further, Dr. Levine expressed other concerns in her choice in residency. She was an osteopathic physician (D.O.), trained in osteopathic manual manipulation (also discussed in Chapter 6). She made her choice about where to attempt to match based on the amount of inpatient medicine Suburban Family Medicine offered. Other osteopathic programs did not offer as much inpatient and gynecological medicine as other mixed MD-DO programs like Suburban. She decided that having the ability to do the inpatient medicine was important for her career development, though she did not

make clear why inpatient medicine was important for her. In talking with other residents and faculty members, some suggested that a focus on inpatient vs. outpatient medicine was a career choice, based on preference and where a physician felt comfortable and excited about their work. Perhaps this was what Dr. Levine suggested when she referred to her “career development”; a sense of her own agency in forming the career most in keeping with her interests and principles.

A trade-off of the greater focus on inpatient medicine was a lower number of osteopathic faculty members here. She explained how this fact often made precepting a challenge for her – as DOs practice other techniques. At times finding a preceptor familiar with those techniques to help teach her had happened with less frequency than she would have liked. The other program she had considered, though having more DO faculty members, had no inpatient service of its own and a less well-developed geriatrics curriculum, with no affiliation with a nursing home or long-term care facility. She knew that the absence of these two components would have impacted her application for a geriatrics fellowship. Overall, she expressed happiness in her career thus far, and cited receiving a lot of support and strong teaching. She feels “very prepared to move on to the next step” of her career.

Finally, while training at Suburban, Dr. Levine developed many close friendships, people she felt comfortable spending time with outside of work, going to dinner with, or just talking with. This factored heavily into her enjoyment of her time in residency:

We came here not knowing anyone, and we’re leaving here now with a lot of good friends. And I remember, a lot of it came, comes I think from being interns together. You kind of have that bond where you all have been through the same sort of things. In that, you know what the other people are experiencing and you can really relate to them well. I find that my friends who aren’t in medicine, we don’t really have that shared bond or those shared experiences. So they don’t

always understand when I say that I can't go out or I can't do that kind of thing; they don't always understand why. But I feel like my friends here in the residency program really do (Interview: November 15, 2012).

This was in keeping with the program's dedication to forming supportive bonds between residents, beginning from the first day of orientation. In this case, the strategy appeared to have worked, strengthening the bonds that have supported her and led to success.

Dr. Levine seemed to thrive on the complexity in her patient's experiences and enjoy the challenge of learning about and helping patients whose conditions were less-than-straightforward. She recalled one of her favorite patients; the first patient she saw in clinic as a brand new resident. She described this patient as "a 42-year-old female who came in and she had all kinds of somatic complaints and a history of all these diagnoses." The patient had seen many different physicians in the years leading up to seeing Dr. Levine and had collected diagnoses from across many specialties. Dr. Levine immediately felt that she could help this woman make sense of the considerable medical information she had amassed and the health-seeking journey on which she had been. Three years on, Dr. Levine had seen this patient regularly, every six weeks or so and helped her sort through these complexities. Dr. Levine paraphrased the patient's feelings about the impact their relationships has had; "You know, of all the physicians I've had over the last fifteen years, you're the only one who really listened to me and I felt like cared about what I had to say".

That was a meaningful statement to Dr. Levine and pointed clearly to her playing a patient-centered healing role in this woman's life:

In medicine, it's not always about making people better. You can't fix everything, especially when there are a lot of emotional components to it that the patients don't want to face. But if you can listen to them and make the patients feel like you really care about and you care about whether or not they're getting better. Or

you care about what's going on in their lives. That really makes a difference to them. So it may not be about making the patient medically better, but making them psychologically better is a big part of it (Interview: November 15, 2012).

Dr. Levine was able to realize firsthand the benefits of the doctor-patient relationship beyond treating disease. This patient needed time to be understood rather than only treated; needed help in finding meaning in so much medical information. As a result, the doctor and patient developed a personal connection in jointly considering the health-seeking experiences that had gone on.

Dr. Levine pointed to the osteopathic philosophy – one slightly different from a more general biomedical conception of the body – that considers “the body as a unit”. To her that meant that mind, body, and soul are all present as one. The interaction between these three components was central – “if one is not healthy, then the rest of them can't be”. Other physicians, she speculated, got frustrated with patients that did not have a “medical diagnosis” to their physical concerns, but rather psychological or even underlying spiritual components. Physicians, she attested, are not “adequately trained” to fix those kinds of problems. Her philosophy took the body as a unit that must work together. If one part was not functioning well, the rest could not do what it needed to. The parallel between family medicine's idea of holism and Dr. Levine's “body as unit” is clear, as is the complex patterns of illness causation and experience that extend beyond biological disease. It is particularly intriguing to see this clear expression of family medicine's object not as an outcome of her training in family medicine, but of her training in medical school as an osteopath. Medical school, in Dr. Levine's case at least, seemed to mold her philosophy towards patients in a more-direct way than her residency training. Perhaps her point of view suggests something about the approach to

patients in allopathic training overall. These parallels warrant further research, not only between osteopathic training and family medicine, but also as to how osteopathic values translate into other specialties' residency training programs.

Family medicine's approach to patients resonated with Dr. Levine. She speculated aloud whether her deep interest in people resulted from something to which she was exposed as a child. Further, her training as a DO focused heavily on patient relationships, listening to patient concerns, and approaching patients holistically. She told me that looked for tools to empower her patients, to help them live better, to identify and deal with the problems they faced. Patients who frustrated her, those who may have tempted other physicians to give up, inspired her to consider that a medical solution was not always the right answer. Dr. Levine did not reflect on the roles of these other physicians, but it was clear that she presented herself as a "good doctor" as opposed to those physicians who may not take time with "difficult patients". She acknowledged what appears to be a disconnect between her philosophy – one in keeping with family medicine's object – and the wider worlds of medicine:

It may not be medicine as the general population thinks of it, but I think that healing comes in all different forms. And if you can make a person feel better even for the fifteen minutes that they're sitting in your office then you've made a difference in their lives (Interview: November 15, 2012).

Dr. Levine touched on an important distinction in terms of healing versus curing. I will Whether her rhetoric conformed with her practice will be better addressed below.

Dr. Levine's perspective was also informed by her current status as an advanced resident nearing graduation from this training program. As a third-year resident, planning for the next stage in her career, she reflected on leaving the program and what that meant for her, her colleagues, and her patients. "In medicine, you're always moving

on,” Dr. Levine knew that she would not have her much longer with her patients here. This was a curious perspective to have when compared with the “cradle to grave” philosophy of family medicine. Her perspective, I contend, comes from the structure of medical education, including residency training, with a definitive end. Not every resident is hired into their department upon graduation, and Dr. Levine already had plans to move away. In some ways, these newly made family medicine doctors will leave residency without really learning what doctor-patient relationships are like. The residents will move into new careers and have to exercise notions of lifelong care with patients then, as opposed to the three-year window of residency training.

A year ago, Dr. Levine started preparing the patient from the opening story for this ending of her residency training. Perhaps this way of approaching things empowered the patient to keep searching for a physician she could work with. Dr. Levine told me that here were a handful of her other patients she had told she would be leaving soon. She felt that many of these patients were afraid; they had had bad relationships with physicians before. Dr. Levine expressed wanting to empower those patients not to accept the physician they were handed. I now find myself considering the impact these patients had on Dr. Levine and her development. These important patient relationships would provide insights into what it is like to live with complex medical conditions and uncertainty around health. How her patients faced the adversities in their life could impart important lessons to Dr. Levine, towards a personal understanding of lifelong care and the patient “as a unit”. Further, with her interest in geriatric medicine, she would benefit greatly from her relationships with older patients during residency.

Regardless, Dr. Levine did not comment on the impact her patients had on her, rather only the impact she presumed to have on them.

Dr. Levine admitted that the end of patient-physician relationships was not something that “gets talked about” in medical education generally, or residency training specifically. Medical students rotate through multiple hospitals and offices during their third and fourth years of school. Residents rotate month to month and after three years, leave the program entirely. There was a subtle component to the habitus of residency training – awareness that none of the relationships will last forever. Moving on comes with the territory of residency:

You have to trust that there’s going to be someone there who’s going to take care of your patients in the future. I trust my colleagues... they’re going to care for the patient – maybe not the exact same way I will – but they’re going to take care of their medical needs. They’re not going to leave them out hanging (Interview: November 15, 2012).

Two issues stand out in this quote. First was the reference to colleagues attending to medical needs of her patients. She seemed to suggest that her colleagues might not approach her patients with the same mind-body-soul holism as to which she was accustomed. This was a surprising thing to say, as one would think that other family medicine residents would share that kind of approach to patient care as well. Was Dr. Levine’s approach to healing, one closer than others to family medicine’s object, emblematic more of her D.O. education than her residency training? Or does Dr. Levine bring certain assumptions about the superiority of her own training or way of doctoring that differed from the other residents in her cohort? Second was a sort of circumstantial artificiality in the training environment. The residency educational program was time limited. Family medicine dedicates itself to a “cradle-to-grave” philosophy of patient

care, to form longitudinal relationships. Yet, at the end of three years, residents leave, often never seeing those patients again and starting over somewhere else with new patients. Did this fact lead to a sort of artificiality impact relationship-building? Both are important topics for future research.

Towards collegiality

One indication of the outcome of three years of clinical training was the way in which the expectations of the mentor-mentee relationship eased in favor of collegiality. This transition was exemplified in the precepting interactions I witnessed between Dr. Sharma and Dr. Levine. By chance, late in my time at Suburban Hospital, I encountered these physicians working alone together. Both had put forward clear ideas about the place of healing interactions with their patients and I was curious to see these two working together. Regarding the professional socialization of residents, the interactions between these physicians illustrate an important change in the dynamic between novice and teacher – an informal, symbolic conveyance of capital wherein the novice is socially-recognized by her mentor as a full-fledged family medicine physician.

It was a quiet morning in clinic; only the two physicians were in the office. Both doctors worked at computers, checking medical records and writing prescriptions. One of three nurses would periodically come into the precepting room to tell one physician or the other that a new patient had arrived. The rhythm was calm and efficient. Appointments ran on time and the schedule for the day was relatively light. From numerous observations and discussions with residents and faculty members, I had come to understand that residents with only six months left of training were allowed a great deal more autonomy and fewer expectations in precepting. The late-stage third-

year resident was effectively acting as a board-certified physician. Precepting still occurred, but often after the patient had already been treated and left the clinic. Precepting interactions were also very brief and sometimes done in rapid succession, one patient after another, at the end of the clinic session.

For example, a patient came in with suspected mononucleosis, which a check of her tests, Dr. Levine confirmed the diagnosis and settled on a course of action. Dr. Sharma inquired about the patient while also working on her own patient records. Precepting for this patient amount to:

Levine: I'm giving her 45 doses of Pregnazone.
 Sharma: For what?
 Levine: Mono.
 Sharma: Ok.

This "checking in" style was often the norm with advanced residents. From my observations, Dr. Levine did not discuss this plan with her patient. Given her rhetoric above, in looking back now, the lack of patient involvement again becomes apparent.

Overall, the dynamic led to a calm rhythmic clinic day, as compared to the lengthy, hectic clinic sessions I observed at other times, with other residents. As a late third-year resident, Dr. Levine had developed a more-collegial relationship with Dr. Sharma, simply working side-by-side on their respective patient visits. There was only this small trace remaining of the normative precepting relationship. I observed Dr. Levine precepting all of her patients with Dr. Sharma in this way. Further, there were instances where the dialogue less-resembled precepting and was more akin to just colleagues discussing appropriate approaches to patient needs.

The light patient schedule was helpful to further developing my understanding these patterned interactions I had been witnessing over time during my fieldwork. The

ease of precepting and light workload provided opportunities to question both physicians about their work, to hear and share stories, and to observe closely the interactions between the doctors. The physicians revealed more about their approach to engaging with patients' concerns around the broader social components of health and illness. For example, an elementary school student with a peculiar rash came into the clinic. In speaking with the student, Dr. Levine discovered her teacher was pregnant. She asserted to me that she always asked people with rashes if they were routinely around pregnant women. Levine decided to run more tests on the rash to determine what it was. She explained that parvovirus is a significant risk for pregnant women and was indicated by the rash. Ultimately, she decided to wait for the test results to come back before contacting the student's school – she said she did not want to scare the teacher unnecessarily. This sensitivity to the broader interactions between health and social milieu was encouraging and pointed to the kind of holism family medicine values.

Treating children in general required another level of awareness and added complications. For example, Dr. Sharma and Dr. Levine discussed the role of parents and a child's need for privacy in adolescence, and children in general needing to feel confident enough to talk to the physician. Dr. Sharma asserted that residents regularly had to discuss sex, peer pressure, stress, safety, normal development, menstruation, and other health behaviors with patients of all ages, including teenagers. As Dr. Levine told me, "Parents don't feel comfortable. Discussing [these things] is what we do." Dr. Levine saw herself as coming to act in ways that went beyond the direct diagnosis and treatment of disease. Family medicine sees itself as addressing concerns beyond the

immediate disease and treatment, and in this way both physicians illustrated how broader concerns fall within their scope of practice.

Dr. Levine had come to a point in her development where she could more-readily address the broader social and personal patient issues that can impact health and wellness. As a further example, one family expressed their financial concerns to Dr. Levine. This issue emerged when Dr. Levine had encouraged changes to their diet. The family expressed concerns about the cost of eating healthy, did not have the money to afford medications, and had trouble securing transportation to the clinic. The ideal family medicine physician, in Dr. Levine's assessment, attempts to hear these concerns all the time, and attempts when possible to connect patients to community resources, to serve as a counselor and guide. Dr. Levine did not however relate exactly how, or if, she helped these patients work through these concerns. It did appear however that she moved to become more engaged with the patients' broader socioeconomic needs, needs that would impact their health and treatment. Dr. Levine saw the patterning between her attempts to treat disease, and the patient's illness experiences of living with and managing this disease through difficult financial circumstances.

In the end, what stands out about Dr. Levine's approach to patients is an understanding of the need "really make a difference" in the lives of her patients. She spoke at length about her philosophy towards healing and expressed noble ideas about the role of the family medicine doctors in curing patients of their ills. Her training as a DO perhaps inspired her rhetoric more than her family medicine training, though her thoughts were in keeping with family medicine's object. However, the case for her patient-centeredness was weakened as she came to behave more stereotypically,

making decisions for rather than with her patients, or positioning herself as an advocate for patient's needs while assuming what those needs were. Early in my analysis, I found myself convinced that her healing disposition was in keeping with her philosophy, but on closer examination, she tended to focus on what she could do for patients without much collaborative consultation, and without much humility around what patients teach her. Dr. Levine's patient relationships, despite her words, remained often unilineal.

Precepting had reinforced this patient-physician dynamic; cementing patterns established early in training. Later in the clinic session, with my prompting, both physicians reflected on the precepting process with advanced residents. Dr. Sharma asserted the degree of oversight depended heavily on the resident. Some needed more attention, needed "watching". In particular, "residents that don't think they need precepting are the ones you watch and watch and be careful of". She would spend more time trying to understand how this type of resident reached their diagnoses, settled on a treatment plans, and whether they adequately investigated the broader social framework ordering the patients' lives. The tacit message was one I had seen repeated throughout the habitus; family physicians should know how to diagnosis and treat, and take broader social and personal concerns into account. However, these concerns were not spoken of as a negotiation, except when patients resisted recommendations. The doctor offers a plan, the patient trusts it is the right one, or powerlessly says nothing and perhaps adheres to his or her own notions of treatment without telling the doctor.

Dr. Sharma's assessment of precepting reminded me of how dependent the professional socialization process is on these mentoring roles. Both doctors asserted a clear commitment to family medicine's values, and displayed or related behaviors that

showed a commitment to patient healing. However, if the values of family medicine are not embodied in the behaviors and mentoring of faculty members, what might be the outcome on social reproduction of family medicine doctors? Given the mentors' power to expect and enforce certain behaviors, the educational process may move away from family medicine's object. This movement away from family medicine's object may help explain the dissonance between Dr. Levine's words and behaviors. I return to this idea in Chapter 8.

Dr. Levine echoed ideas similar to Dr. Sharma's, though from her own perspective. Certain preceptors, she said, wanted all the patient information for themselves, to be assured they understand firsthand what was going on with each patient. After all, the resident's performance, including mistakes, rested on the board-certification of the preceptor – i.e. the faculty member was held accountable. Other preceptors, like Dr. Sharma, wanted to get to the point where she could trust the resident, that they had done the work and asked the right questions. Ultimately, by demonstrating an aptitude at making responsible, accurate decisions regarding a patient's health, treatment, and social context, residents earned more autonomy. In Dr. Levine's words, "A lot of residency is about proving you know what you're doing. Proving to the attending you know what's going on." Precepting became less a part of the working clinical day because the competency of those involved was proven to be at a greater level of proficiency. Dr. Levine had acquired the appropriate techniques, knowledge, and approaches with patients to be granted autonomy and a greater degree of collegial trust.

With the emergence of Dr. Levine's increasing competency, the relationship between the two physicians had changed. Dr. Sharma was spending time between seeing patients shopping online for a new couch. She solicited opinions from nurses as they came into the precepting room. Dr. Levine exclaimed, "Oh, I want to see!" and offered her opinion on a number of different options. Dr. Sharma seemed to take Dr. Levine's opinions to heart as they discussed the pros and cons of various couches. This brief episode spoke to Dr. Sharma's commitment to "friendly relationships" with her residents, but also to a new level of social equality that contested the earlier normative hierarchy of residency life. In this small way, Dr. Levine was operating as a colleague and friend – beyond the ability to treat patients without extensive precepting, but sharing camaraderie between peers.

As with her patients, Dr. Levine would be "moving on" soon and had done so by the time of this writing. Dr. Sharma, on the other hand, likely would not be. I find myself wondering about the social resources invested for a short window into patients by Dr. Levine and into learners for Dr. Sharma (both for only a three-year window). Residents will move on to other things, to careers in other hospital systems most likely. Dr. Levine was preparing for her geriatric fellowship on the east coast, preparing even to leave her husband behind for a time. Both resident and preceptor had a finite window in which to form the relationships upon which learning and career-development hinged. As mentors, faculty members invested a tremendous amount of energy into residents. As physicians, the residents invested a great deal in their patients, learning to form longitudinal relationships that have a definitive end date – a simulation of sorts for the kinds of relationships they would be expected to develop throughout their careers.

Going forward, I would want to study further whether this investment was draining, challenging, or perceived as worthwhile for these physicians in the long run.

When the educational process fails

One Wednesday morning in January, seven months through the academic year, I sat in the lecture room as I had many Wednesday mornings before. I was waiting for didactic lectures to begin, surrounded by residents at all points in their training. Before any faculty members were present, one of the chief residents, Dr. Tao, stood up and got everyone's attention. She said she had an announcement to make. After a brief preamble, she said, "I am sorry to have to tell you all that Dr. Ramsey will not be continuing in the program. He'll be leaving in a few months. At the end of the year. Dr. Hedges and the rest of the faculty are helping him look for a new residency program". Shock rippled around the room, with audible gasps and questions of "what?". Dr. Ramsey sat quietly and did not respond, smiling but not appearing particularly comfortable or happy. I had interviewed him a few weeks prior to today and he had made no mention of leaving. I had heard more recent rumors of a resident struggling to perform and maybe being asked to leave, but didn't expect it to happen like this. It seems the residents were in the dark as much as I was. Is this how things go when a resident is not doing well in the program? (Field note: January 16, 2013)

The announcement that Dr. Ramsey was leaving was startling to those who heard it that day; me included. The announcement led me to wonder what happened, and what would happen, to Dr. Ramsey. It also caused me to speculate about how the program handled matters when the training process falters. These were unusual circumstances. The case of Dr. Ramsey provided the opportunity, albeit with a heavy

heart, for me to investigate further the process of becoming family medicine doctors by looking at what happens when the process did not go according to plan. While much of what had come before has been normative in its character, or focused on the positive examples of residency training and professional socialization, Dr. Ramsey's story serves as a "negative example" that sheds new light on the overall process.

It is important to note that there were limitations on my investigation of Dr. Ramsey's departure. No one would speak to me directly about the incident, a telling indicator of the abnormality and seriousness of the event, as well as an insight into my positionality in the setting. I had to piece together the story from what I could learn. I began by looking back through my field notes, to find observations of what could have led to Dr. Ramsey's departure. Further, I tailored some of my remaining investigations and interviews to uncover details and determine how the department would handle the matter. Beginning with the interview I conducted with Dr. Ramsey, approximately two months before the announcement of his departure, I will examine his performance, capital, and demonstrated dispositions. I then detail the findings from my interview with the program director, Dr. Hedges, conducted a few days after this announcement. I include her sense of the educational process to provide context for Dr. Ramsey's circumstances. Finally, I will discuss how a failure in the educational process was not a comfortable topic for anyone involved, and resulted in a retreat from the common disposition of openness.

Dr. Ramsey

Dr. Ramsey was an African-American man in his late 20s who, at the time of our interview, was just over halfway through his second year of residency training. He

expressed a dedication to the values of family medicine, citing repeatedly his interest in helping and forming lasting relationships with his patients. He was married with young children and was dependent on his position in the department to provide for his family. He cited a time, earlier in his life, while living with his physician uncle in Chicago, as inspiring his desire to become a family medicine doctor. He saw his uncle helping people when he visited his uncle at work. He heard stories of his uncle “healing people” and how much patients appreciated the work his uncle did. At a time, he had considered becoming a civil engineer like his father, but in Dr. Ramsey’s words, “it all seemed so meaningless”. Inspired by his uncle’s example, Dr. Ramsey completed medical school and was hired by Suburban Hospital in 2010.

Dr. Ramsey began the story of his time in residency with his impressions of the reality of the American medical system. He expressed that residency had “definitely opened” his eyes to how the medical system “really runs”. He had earlier possessed a sense of optimism about medicine and “making a difference in the world” which was quickly replaced with the feeling that he was “just a cog” and his impact was not significant. His decision to go into medicine was predicated on “making a difference” and his early experiences had more in common with the reality he had hoped to avoid by leaving the path to an engineering career. The following quote summarized his position and hinted towards some of the challenges he experienced:

When you first come out of medical school, you come thinking that you’ve got all these tools and your job now is to use them to make a difference. But then you start learning about that there is somebody else who kinda overrides you. And it’s mostly the insurance company or red tape or protocol. It’s- it can be frustrating at times to try to do things for a patient and have somebody who’s never seen that patient or doesn’t know the dynamics of what’s going on, to tell you that you can do something or that you can’t do something... The fact that we were so trained to let patients talk and listen and try to help but you come into residency and it’s

like you don't have time for that. You're trying to herd everybody through to get through to the next patient, to the next patient, so you don't fall behind. So you kind of feel like... you kind of question: how much can you care? Because in one aspect you want to make sure, you want to help people. But the other aspect is do I really want to open Pandora's Box when I'm so far behind. And that's the biggest adjustment, I think, for me. That's what my story has been. Trying to deal with my idealism that came right out of medical school and how the healthcare system works in the United States (Interview: November 15, 2012).

This dissonance between the expected disposition of helping people and the realities of the current American medical system caused distress for Dr. Ramsey. He experienced this tension acutely and, as I will show, did not adjust well to it. His comments dovetailed with the program's expectations and acute focus on time management versus his perceived dedication to taking the time patients needed. The impact of insurance requirements is potentially one reason I observed other moments where family medicine's object did not come to fore in patient-physician interactions.

When asked to reflect upon his experiences as a resident to date, his story gravitated to the challenges he perceived. The reality he faced challenged his idealism, yet at the time of the interview he seemed eager to find a way to make it work. When asked what motivated him to become a family medicine physician, Ramsey recounted:

Well... the main thing I felt was that I wanted to have that relationship with my patients. I didn't want to just see them, shoo them off, and not know what's going on with them. I feel like- I felt like, you know, a patient will listen to you more if they know you and trust you. And I think that that trust you get to build over time, with seeing them over and over again. Then it gets to the point where, with your knowledge you can always give them good advice and they'll be more likely to take it. I want to be that one man army. I want to see kids. See adults. Deliver babies. See old people. I didn't want to just limit myself to a certain thing. And I felt like I would get that variety with family medicine also... So I felt like that would make a bigger difference in people's lives then just curing a cold or doing something else. You get that chance as a family physician to talk to them, know what they're going through, and help them with their struggles. And that's what I wanted to be (Interview: November 15, 2012).

His idealism and sentiments were in line with the broader values of family medicine and patient-centered approaches to healing. He also subtly shifted to referring to these desires in the past tense, as if these were no longer possible for him. He expressed the conflicts he faced as a choice, rather than a negotiation between multiple demands. He described a situation where the demands of the medical system and the values of family medicine were incompatible. Dr. Ramsey either saw patients and let the visits take as long as needed to or risked feeling like “I didn’t do enough” or that “I missed something”.

At the time I spoke to him, he was still attempting to improve his performance and find balance. He would ask himself “what can I do differently?” and sought ways to manage his time better. In particular, he struggled with patients that would come in with a list of problems, the “Pandora’s box” he mentioned earlier. He said that he received acknowledgement from his preceptors that this balance was a difficult one to find and maintain. His attending physicians would suggest, “pick one thing that is important to you and pick one that is important to the patient” and ask the patient to come back another day to address the other issues. In the end however, this approach did not appear to work. He lamented:

...it still feels like sometimes you don’t have enough time, as much time as you wish you did. But that’s just the way it is. I think you just have to accept it. I don’t think there’s a way to go about fixing it or... I don’t think there’s an actual solution. I think you just accept it. As long as the system stays the way it is, that’s just how it’s gonna be. And you just got to accept it... it’s definitely not easy (Interview: November 15, 2012).

From his description, the values of family medicine – to listen, to be holistic – were odds with this time requirement. It seemed Dr. Ramsey was beginning to surrender to the bounding circumstances of the social structure.

Dr. Ramsey expressed his sense that he was making progress, which he recognized in the moments that his preceptors agreed with his diagnosis and plan. There were clinic sessions, he recalled, when he was on schedule and able to provide for his patients in a way that made him feel like he was doing well, “especially when you’ve got the time and you know what’s going on”. More often, he considered time to be a constant issue he struggled to manage. Later in the interview, when asked to identify what had been the most challenging thing to learn as a resident, he cited “going fast enough” and how this contested efforts to meet patients’ expectations:

Because you got to figure out a way to listen to your patient, still have them acknowledge that you are listening to them, and still come up with a plan, still precept, and get them out in fifteen minutes. They have to know you care. They have to know that you’re not just cutting them off (Interview: November 15, 2012).

Dr. Ramsey expressed a sense that by the middle of his second year, he was frustrated and experienced a sense of futility in learning to balance the demands of his patients against the realities of the required fifteen-minute office visits. Time management also challenged Dr. Ramsey on the inpatient service. In reflecting back on my field notes and observations, I noted that often he was behind schedule, that table rounds were often delayed because he had not completed his work. However, he was not the only resident I observed getting behind schedule and causing a delay. Nor did he cause the most in my observations of inpatient sessions.

Perhaps what becomes most telling – the point at which Dr. Ramsey departed from the stories I heard from other residents – was how he went about handling these challenges. He explained how he regularly turned to faculty mentors for advice. In our discussion and my observations, he appeared not to rely on his fellow residents. Nearly

every resident I interviewed cited the camaraderie and support of his or her fellow residents in managing the stress of learning to become doctors. Dr. Ramsey cited how those most important in his life were not in medicine, specifically his family and outside friends. He felt however that these important people did not understand what he was going through. Further, he recalled speaking to his uncle, who was a licensed physician, though the advice he received did not seem to help him. He did not mention explicitly any bonds with his fellow Suburban Hospital residents. I was left wondering if he somehow did not bond with his colleagues in the ways I observed during orientation.

In the end, how Dr. Ramsey summarized his experiences in residency and conceptualized the learning process in a particular way, expressing his difficulties more so than other residents to whom I spoke:

Residency is a beast. You really have to push yourself. It's not like undergrad. It's not like med school. It's tough, but residency is a whole different beast. At least for me, all together. It's ok to kind of go and you read and you take an exam. That's fine. But what you're trying to do all that stuff and then you're actually responsible for patients. And you're actually trying to do the leg work of getting things together and figuring out stuff. It's kind of- you know some people are just better than others. I think that's probably what it means; it's just a different thing. You're responsible for everything. Everything you sign is on your butt. It's not- you don't have somebody- you do have people to back you up, but only to a certain extent...

I don't think you ever come out of the fire totally, but for residency, yes, when you graduate, you're done. But then you have to deal with a whole new things that come with being an attending, so it never really ends. Just specifically speaking for residency, I think it's the last day when you finish your residency program and you get board-certified, that's when you're out of the fire, I think (Interview: November 15, 2012).

Dr. Ramsey's sense of residency life was filled with metaphors of fighting a battle and of working "in the trenches". He appeared not to be taking on the role in a way that would help him succeed. Finally, his disposition towards the work was in contrast to the dispositions demonstrated by others, particularly those more "successful" residents.

Whether his attitude was an artifact of his struggles or contributed to his difficulties is difficult to determine.

It is imperative to consider the role of race in Dr. Ramsey's situation. As with much of Dr. Ramsey's story, my thoughts on race remain speculative as no one commented directly on race as a contributing factor to his dismissal. The social facts however led to some important speculative questioning. First, his idealism led him to spend considerable time with his patients, an approach very much in keeping with family medicine's object. This idealism however led to problems in time management. When he struggled in time management, he was criticized for it. However, he was not the only resident who struggled in this way. Yet, these residents were not dismissed from the program. Why would some residents receive extra guidance and effort from program leadership, until improvements were made, and Dr. Ramsey presumably did not? Was he somehow positioned as an outsider, an "other", that did not warrant as much effort towards his successful completion of residency? Further, did assumptions about his positionality help explain the insensitive way he was publically outed as leaving the program? In general, I contend that Dr. Ramsey's situation may have been the result, at least in part, of a series of microaggressions based on his race that led those in the hierarchy to view him differently from other learners.

Dr. Ramsey was certainly not the only resident to have difficulties. I was left concerned that something about Dr. Ramsey's positionality contributed to his dismissal. When compared to Dr. Pryde's learning difficulties, and the efforts the program afforded her, it seems Dr. Ramsey's difficulties were conceptualized differently by program leadership. When Dr. Ramsey stepped out of the normative pattern of progress, despite

not being the only one, the program did not seem willing to go to the same lengths to help him as they did for Dr. Pryde and other struggling residents. Further, residents like Dr. Levine were presented in a positive light for the considerable time and effort given to her patients, while Dr. Ramsey seems almost vilified for it. Dr. Ramsey's idealism was undermined, given his comparisons with his uncle's example, and the feelings of being a "cog" in the healthcare system. His idealism, one shared with many of the physicians I spoke to, became a hindrance to his progress in the program.

Further, other African-American residents were not observed experiencing the challenges that Dr. Ramsey did, so the treatment they received from mentors remained generally positive. His status as an African-American may be one reason for this. Dr. Ramsey's comments suggest his frustration over his treatment as a resident in general, reflective perhaps of the feelings he was having all along regarding his treatment at the hands of his mentors and peers. Overall, Dr. Ramsey's discourse showed a commitment to family medicine and a struggle to meet expectations. Was he pushed to the outside by the program, on a subconscious level or otherwise, because he was African-American? If he were performing well, like other "good" residents," then he presumably would have remained in the program. What did the program mentors think when they saw him struggle versus other residents? Something about him resulted in different treatment and it is troubling to think this difference was race. Finally, the impact on residency training and later medical practice is clear. There are larger implications of losing an African-American resident in a community that serves a large percentage of African-American patients. The program already had few physicians that "looked like" their patients. It would seem incumbent upon the program to preserve diversity, as

suggested by Dr. Turner in Chapter 5, then to treat one resident differently than other struggling residents based on the color of his skin. Again, this is speculative, but remains a troubling possibility.

Dr. Hedges

Dr. Hedges was a middle-aged Caucasian woman who has served as program director of the family medicine residency over the last 10 years. She was also a graduate of the Suburban Family Medicine residency program, having worked directly under the prior program director, Dr. Wen, and served as a faculty member for a number of years before taking on the directorship. Her interest in family medicine began in college, where she developed a keen interest in working with patients of all ages. This dedication to the entire lifespan led her to turn down an offer to take over her father's pediatrics practice; she knew already, as she told the story, that treating only children would not be enough for her. She had a strong dedication to helping people, which she felt was the "pat answer" for why people go into family medicine. Her statement reflected how ubiquitous this sentiment was among the residents and faculty I interviewed. Most, if not all, of those interviewed had cited "helping people" or "being a people person" as a reason, and prerequisite, for becoming a family medicine physician.

As program director, Dr. Hedges was able to provide insight into the inner workings of the residency program, including the program values that guide physician training. Dr. Hedges had a clear approach to teaching, communicating expectations clearly (as shown in Chapter 5), and was very willing to give her time and energy to residents (and to me as our interview lasted nearly two hours). Dr. Hedges championed the emic concept of "learning by doing," using it to frame the discussion of the broad

educational processes. This led to a key question of our interview: “what exactly are residents supposed to learn while in training?” Dr. Hedges acknowledged the enormity of my question, as well as the expectations on the resident. She reintroduced the idea that the intent of resident education was to create “lifelong learners”, to teach residents to remain students of medicine, even after graduation. Specifically, she says:

And a big part of what I see as needing to teach is “how to learn” because the actual facts that residents learn in three years- first of all, there is no way that a resident can learn in three years all the information that a family physician needs to know. Doesn't happen. Even if they did, that information becomes obsolete- and I can't remember the exact statistics- but it's like within seven years all of that information turns over... It's that fast within medicine and it might be even faster than that. Which means then that even if someone did learn it all in three years, it's going change so much that it's far more important to learn how to learn than it is about exactly what is learned (Interview: February 25, 2013).

So the program recognized that residents could be overwhelmed by the impossibility of having so much to learn. Dr. Hedges did say however that certain diseases were commonly seen in family medicine. Mastery of the diagnosis and appropriate treatment of these diseases was expected: “...there are some fundamental, basic, core pieces of knowledge that we expect our residents to really be able to know.”

Many of these basics have been described in the preceding chapters – e.g. diabetic management, heart disease, the common cold – and mastery of these diseases came to symbolize for residents that they were progressing in the program. Dr. Hedges commented, “And I expect that people are going to know common things. They're going to be really comfortable with that within a year or two.” However, a great deal of less-common medical problems the residents face in their learning, much of which Dr. Hedges claimed was constantly evolving. To cope with this fact, Dr. Hedges' focused on the skill of “how to learn” which would ideally allow the resident to “build upon that

framework to start making judgments about the more uncommon things” and to know how to access new information when it is needed. She explained that a resident should be able to:

Identify what it is that I know. What I don't know. What I need to know. Where I can get that information. And how fast do I have to do it?... Those become the most critical pieces to learn and again it becomes less about knowing a very specific fact than it is knowing where to get the information when that information is needed (Interview: February 25, 2013).

Embodying such a disposition meant the resident was expected to remain ever the student. He or she must acquire the techniques and values that allow him or her to find information when needed and to recognize there will always be gaps in one's personal medical and broader knowledge; to be a learner across their life course.

This led me to question where Dr. Ramsey fit into the continuum of learning and acquiring competency. Perhaps not everyone was capable of this lifelong style of learning, where mastery was something to be constantly maintained and never finished. Did the program screen for this capacity ahead of time or was it something taught? However, what about the program's failings in regards to Dr. Ramsey? There are many different ways to learn. Perhaps more could have been done to understand residents' different learning styles and adapt the program better to match these. Further, the hiring process presumably targeted applicants with particular characteristics. I asked Dr. Hedges to identify the traits the program looked for in an applicant. She outlined a number of key traits:

So first of all is academic record. Someone who has had some academic success where they're not going to be at risk for failing for the boards, or not being able to be professionally licensed...

Number two... I look for a commitment to family medicine... What we spend time on when they come in to interview is getting a sense of how did they come to choose family medicine, what is their commitment to family medicine?

We sometimes use a question: 'If you weren't going into family medicine, what would it be?' Because that kind of thing becomes revealing about who- what's their underlying values?

So part of what I'm looking for... is some of that underlying value of really enjoying patient care, really enjoying the connection, enjoying the preventive aspects, enjoying the continuity and long-term relationships, because that's a big part of what we can do. It's enjoying the breadth of the specialty...

The additional thing is I'm looking for a level of emotional intelligence. Maturity. For someone who's going to be able to fit in. And is going to be able to be responsible for their own education. If they don't have that... If someone's never going to gain that insight, if they're not going to be able to have that interpersonal connection with other people (Interview: February 25, 2013).

These traits illustrated a picture of the family medicine physician – a commitment to patient wellbeing and longitudinal relationships at the core, bookended by technical medicine knowledge. However, it also suggested that willingness to entangle with patients was sought prior to hiring, also reflected in Dr. Levine's experiences as a D.O. in medical school. What do these hiring priorities suggest about the making of healers when the building blocks of patient-centered healing practices are couched as prerequisites for employment? What about Dr. Ramsey, who placed family medicine's object ahead of time management? Dr. Ramsey exhibited many of the traits Dr. Hedges looked for, though in the end these were not the traits that mattered the program's measurement of his success. I endeavor now to address these questions and describe how those involved understood and found meaning in Dr. Ramsey's departure.

Dismissal and fallout

Piecing together the story of Dr. Ramsey's dismissal, I asked Dr. Hedges to describe how the program assisted residents who falter in learning and need assistance to get back on track. She outlined the approach used to address learning problems:

We very much rely on the advisor to help. So we really expect every resident and advisor to have an educational plan. For most residents, it fits into the whole general curriculum and it's not so much outside of the norm. And yet an

additional emphasis for an individual resident may be something the advisor and resident may do. So we ask our advisors to write up with their resident, or it's really more the opposite now, we have the resident write-up with the advisor, an educational plan. (Interview: February 25, 2013).

Simply put, the advisor and the resident were ideally in frequent communication, and hopefully addressed any issues that arose early, developing a plan to overcome them. Plans were made and implemented that were designed to help residents succeed. These plans were apparently successful as the vast majority of residents eventually graduated and passed the board exams, per my conversation with Dr. Hedges.

However, there were instances when there was, as Dr. Hedges put it, "something outside of the norm" when a resident "has needs that go beyond just what the resident and the advisor can do on their own". Dr. Hedges said, in these instances, the advisor brings the issue to a wider audience:

When we have bigger concerns, and sometimes the big concern... then we have a whole intervention policy... We ask that the issue go to three other faculty members. And really, in my thinking, is to help identify what the issues are, to be able to review it together, to identify potential solutions and then we bring in the resident. Because the resident's perspective is *incredibly* important. So we get the resident's perspective and educational plan- once we've identified issues, a plan is developed between the resident and faculty members who've sought to understand what the issues are and who know what resources we have available to be able to address whatever it might be (Interview: February 25, 2013).

This disposition dovetailed with the apprenticeship approach, in that the physicians assumed that while the advisor may not be able to help the struggling resident, someone in the department had the resources necessary to help. If not, there were other outside resources into which to tap. For example, I was told of residents who struggled with English as a second language, who received additional language learning help in the form of outside coursework. Programs of reading and studying may be implemented for additional medical knowledge. Dr. Pryde received help in

developing better study habits and overcoming her learning disability. Assisting residents with time management and patient communication techniques did not arise in the discussions I had.

Dr. Hedge's explanation of the program's remediation plan begged the question: did it always work? She explained:

No. [Long silent pause] Just because there are current issues. So I need to talk about the past. We've had times that have not always worked well. Where we've identified problems... We try to give the resident as clear expectations as we possibly can about what it is they need to do to show progress, to be able to meet the expectations, and be able to meet the progress. It's happened that there's times when a resident just doesn't progress. And that's painful... But then there have been the times that I've said "This isn't working"... I get to that point of saying I refuse to graduate you, because you do not have the skill. And I owe it to you and to the public to not graduate you (Interview: February 25, 2013).

It was unclear exactly how far the program was willing to go to help a struggling resident learn; where the line was exactly that would lead Dr. Hedges to conclude the process "isn't working". However, her response revealed something about the respect with which the program treated its residents. She was unwilling to speak in specifics, protecting the resident in question. However, this left me with a problem: I assumed it's no coincidence that Dr. Ramsey was leaving the program at the same time that I spoke to Dr. Hedges about related issues. While there may have been another resident that was in the process of being dismissed, I did not hear of it.

Regardless, there were points at which Dr. Hedges had to decide that a resident was no longer progressing, would likely not progress, and to dismiss him or her. She struggled with this decision and lamented that sometimes the program may have waited too long. Further, there were ramifications for the entire program:

Part of our philosophy is that when we've chosen a resident we put our resources in and try to help them to be as successful as we possibly can. It's just that

sometimes when we put what we feel is every available resource in and it still doesn't work, that's painful. And sometimes- one of my frustrations is that, I think, sometimes we've been- I don't know if I'd call it slow- It's either that we're slow in identifying it or we're almost too nice in trying to continue to work with someone. Because I think there's a point when we don't always take definitive, final action early enough. It's really hard to know. Because there's been some people who've come through. And where for a little while it looked like: I don't know if this person is going to make it or not. We set this up, let's see if they can do it. We think we've done everything that we can do to help give them a supportive learning environment. Now it's up to that individual. And we've had some who've come through and some who I've then been very proud to graduate sometime later. We've had some who've come through that I've not been so proud, but they've met at least the minimum. And that happens, too. Every program director will tell you that (Interview: February 25, 2013).

It is clear that the commitment to residents was strong and the program worked to help them to a degree that, at times, may seem beyond a reasonable point. The decision-making process, of when to dismiss a resident, remained unclear, as Dr. Hedges would not go into details.

At this point, I assumed that the above approach was taken with Dr. Ramsey and at some point it was determined not to be working. During his interview, Dr. Ramsey cited the help he received from faculty members and how he continued to struggle. There were clues as to where Dr. Ramsey's situation may have differed. He exhibited many of the traits that Dr. Hedges said were sought in new residents. He had a commitment to family medicine's values and to his patients. He never commented on learning challenges, only problems with time management. Again, something about Dr. Ramsey's situation set him apart from other struggling residents. His positionality as resident with high ideals and a clear awareness of his own struggles clearly mirrors Dr. Pryde's story, yet she was progressing. Dr. Ramsey's positionality as an African-American remains the only ostensible difference that could help explain his dismissal. Again, these remain a speculative, but critical, set of assumptions on my part.

Beyond the speculation, Dr. Hedges cited that there were times when a resident must be let go and residents did occasionally leave the program. Assuming she was referring to Dr. Ramsey, a number of things become clearer. First, the disposition of “being the doctor” took on a particular veneer when comparing Dr. Ramsey’s behavior and Dr. Hedges’ explanations. His notion of what it meant to be a family medicine doctor stemmed from his uncle’s example and his own idealism. He exercised his own sense of agency in dedicating himself thusly, and as a result felt frustrations and powerlessness in the lack of recognition of his progress. In other words, Dr. Ramsey chose not to highlight the technical skills Dr. Hedges did. “Being the doctor” meant different things to each of them. Second, whether Dr. Hedges was referring to Dr. Ramsey or another resident, eventually the problems a resident experienced – an inability to meet the expectations of capital accumulation and transitions towards autonomy and becoming a family medicine physician – resulted in his or her dismissal.

In the end, the resident failed to take on the dispositions in the expected way, to accumulate the cultural capacity that led to symbolic recognition of progress. What then is the program’s response to residents like Dr. Ramsey? After months and years of training (if one includes medical school) what future career prospects does the resident have? I asked Dr. Hedges, “And then what?”:

We’re committed to all of our residents, so the “and then what” is a big question for us too... If a resident doesn’t progress we aren’t just leaving that resident out to hang, but we really help that resident figure out something about the “what next”. If it didn’t work here, what kind of environment could work? Whether it’s another specialty, or whether it’s just another environment, or a different residency program. Does it need to be something that’s a little smaller or something where it’s more pre-scripted, as far as what it is that they have to do (Interview: February 25, 2013).

Ideally, the program attempted to find a new home for the resident, where their career can continue to unfold. Cynically, I wonder whether Suburban Hospital is just shifting the responsibility for a potentially-ineffective physician to a new environment where he or she may slip through and still graduate, putting the public at risk. Alternatively, Suburban Family Medicine was certainly ineffective in reaching this learner and helping make him a family medicine doctor. Perhaps the fit between mentors and trainee was ineffective, and Dr. Ramsey may have more luck in another setting. However, Dr. Ramsey was more than halfway through his three years of training. Would other programs need, or even be willing, to hire Dr. Ramsey? Regardless, the failures here were much more than simply Dr. Ramsey's inability to progress in the setting. The program itself failed him, pushed him to the outside, and eventually left him behind.

Dr. Hedges reflected on this eventuality, though in an indirect way. She commented on giving credit for the work already done before a resident moves on to a new program. She expressed concerns about technical medical skills and knowledge and the issue of permanent licensing:

What I have to look at is what are we giving credit for or not. And we also look at it from the licensing stand point. In Michigan, a resident cannot get a permanent license unless they've had two-years of training. There are other states where it's one year of training. So those become critical times – do I think that this resident can actually go out- will I allow them to leave- and at what point, because, how much does it scare me that they are going to go get a permanent license based on their [current] skill level? (Interview: February 25, 2013).

Dr. Hedges, and the entire training program, found themselves experiencing a unique tension when it came to dismissing residents. On one hand, they had made a commitment to the residents – in a sense like “raising a child” or “being married”, as Dr. Turner reflected to me in another context. On the other hand was a commitment to

training competent physicians who will do no harm. Dr. Ramsey however may be able to obtain a permanent license, but without completing residency, it remained unclear what his future employment opportunities would be. However, was the perceived risk of harm real or a response to the interruption in the normative training trajectory and power dynamic? Does Dr. Ramsey represent more of a risk to the power of those aiming to reproduce a particular type of family medicine doctor, as opposed to any real risk to patients? What good might he potentially do by sticking to his ideals and persevering? In an ideal setting, these issues could have been explored more deeply and certainly warrant a more thorough and thoughtful investigation in the future.

Dr. Hedges explained that a resident leaving “has huge ripple effects throughout the whole program”. The educational process, in this case, was not working and this placed strain on other residents and faculty to cover for a struggling resident. In addition, when a resident left, entire schedules had to be adjusted to cover the inpatient service or overnight shifts, adding additional work for others. Further, a released resident could continue to be a problem elsewhere or even seek a permanent license, meaning their incomplete skillset was being utilized to treat patients. Dr. Hedges summarizes the predicament:

So it's both things where I feel a strong commitment to the resident and to give them every possibility of giving them a learning environment where they can learn. On the other hand, if they aren't going to make it, I want to declare that as early as possible. Partly because it increases the chances of that resident getting into a different residency, which maybe that's a better match for them, as far as that learning environment. Partly because of that permanent license issue that if I don't think they really have the skills, I don't want... to give them the credit for that, then they don't have the credit for that (permanent license). Which is a level of power that I'm not sure I appreciate (Interview: February 25, 2013).

Regardless of this explanation, I was left to assume that a careful process of decision-making was utilized in Dr. Ramsey's case. Given that Dr. Hedges would not comment directly on the current situation, and could not provide a clear sense of when to dismiss, the decision-making process was still not clear. Further examining Dr. Hedges' decision in Dr. Ramsey's case was clouded by her unwillingness to discuss specific details. Further, the shocked response from the assembled residents, when Dr. Tao announced Dr. Ramsey's leaving, was testament to a potential impact on resident morale, the severing of ties of camaraderie, and the end of the shared experiences that were central to the habitus.

Complex issues of morality come to fore when more closely examining the outcome of Dr. Ramsey's departure. First, it was unclear if anyone in the program continued to support him or if, once the decision to dismiss was made, he was no longer considered a part of group. From the residents' reactions to the public announcement of his dismissal, I contend that not everyone understood why he was being asked to leave. However, being labeled a "failure" may have had some interesting consequences. If the residents were dedicated to maintaining their progress and staying on the right side of their mentors' assessments, Dr. Ramsey may have been further pushed away from the group. Distancing themselves from him would be towards preserving their own status as "good residents". Ideas of what makes a good resident and residents who are not good become troubling in this light. Further, how did Dr. Ramsey progress as far as he did, only to fail now? Dr. Hedges claimed to be committed to identifying problems early and making her decision to dismiss in a timely way. Again, I must emphasize the details about his performance and the program director's decision remain murky, but the entire

situation reflects something unusual about the residency program. While everything unfolds along expected lines, the educational process works. Struggling residents are treated in different ways, ways that may reflect latent stereotypes and assumptions based on character traits and race rather than failings on the part of the program.

Another factor may have contributed to the decision to dismiss Dr. Ramsey. “Reputations” were common in the setting; one resident may be labeled as “strong”, another as “a problem”. During my observations and interviews, I explored resident reputations, including how they developed and if they changed over time. I found that these labels came most often during the moments when the new interns were beginning to make a name for themselves. They were accumulating their first bits of cultural capital to translate into a symbolic role in the department. Dr. Turner’s repeated assertion to “embody the role”, to take on the role of physician, to internalize the displayed dispositions as quickly and thoroughly as possible, was key to developing the “right” symbolic capital – a positive reputation. Assuming the role of the only person responsible for a patient’s care, even though it was not true at the time, was the avenue towards assuming the role more thoroughly; the ultimate “fake it until you make it”. They would, Dr. Turner asserted, perform better and meet expectations sooner. To act more confident than one may have felt, the theory went, allowed confidence to grow in reality. Avoiding a negative reputation may not have been easy however.

While Dr. Hedges did not comment specifically on any one resident, Dr. Ramsey did recall his impression of the reputations residents may acquire:

It’s the truth. How you start is pretty much how people label you until you’re done. Whether you get better or not. They say that’s not the case, but it’s the case. Plain and simple. So if you don’t make a good impression in the beginning, you’re always going to have that label. Whether you’re the smartest or the

hardest working or the too hard working or not hard working enough. Fast. Not fast. And the label never goes away, so, it never goes away (Interview: November 15, 2012).

However, Dr. Ramsey's summary does not completely explain what goes into the making of these reputations. If being fast is all that matters, what is the program really teaching about family medicine's object? Alternatively, did Dr. Ramsey fixate on speed and the criticisms he experienced to explain away other failings that he did not express to me? Going forward, the role of reputations in making family medicine doctors, taking on dispositions, and achieving competency are important issues to explore further.

The notions that labels never go away suggests the possibility that Dr. Ramsey may have made progress but was unable to escape early opinions about his performance. However, other residents who acquired negative reputations still succeeded. I recall interviewing Dr. Varma, a graduating senior resident who had a reputation of being intense, sometimes hard to work with, and claimed to struggle to succeed in the early months of her residency. She was, by the end of my time at Suburban, a board-certified attending physician with a new reputation among the residents with whom she now worked in Suburban Hospital family medicine: that she was still intense, expected good communication and a strong work ethic, and could be intimidating. Her reputation of being a "problem resident" translated into competency. She had become an intimidating though a thoroughly skilled and competent attending.

Intriguingly, there was little mention of developing communication or relationship skills as a measure of progress. There was a bias towards measurable outcomes and number of patients seen. Do the technical aspects of medicine, those basic skills that may or may not physically harm patients, take priority, as suggested by Dr. Hedges'

focus on licensing and credit? Further, if patient interaction was at the heart of the healing, why did Dr. Ramsey's commitment not help him succeed? Regardless, in the end, Dr. Ramsey was marked as failing to display the proper cultural capital and technical competency, in the expected way, to remain in the program. His errors of being behind schedule and having a difficult time precepting were described as the key things that led to his dismissal.

In the end, from Dr. Hedges' explanation, a resident was never asked to leave without considerable attempts to help and careful consideration of the ramifications. However, her decision-making process in Dr. Ramsey's case suggested some troubling contradictions. The disposition of having a safe learning environment continued even if that learning environment turned out to be the wrong one; the program attempted to find a new home for the resident. However, the transparency I normally witnessed became anything but transparent in the complex case of Dr. Ramsey's departure. What can be said with certainty was that residents may not always succeed and that the departure of a resident was a challenging process not undertaken lightly, given the impact on the resident, the program, and the physicians left behind.

Getting back to the issue of thinking about whether healers are being made, one explanation is that this case study revealed more about a failure in the making of curative doctors than in the making of healers. Technical practices, and the error of not mastering them, were the focus of program leadership. These techniques were more objectively measurable with assessments of specific skills and techniques, suggested by Dr. Hedges' repeated focus and the evaluation system utilized by the residency program. The dissonance I observed elsewhere, between healing discourses and

behaviors, took on new meaning in light of the symbolic importance the program placed on learning to diagnosis and treat specific diseases, to see requisite numbers of patients, and learn to manage time and patients efficiently. Becoming a lifelong learner reinforced a focus towards medical knowledge and seemed to take patient engagement for granted; something to be selected for in the hiring process rather than developed over time. Dr. Ramsey's dedication to his patients was not enough to overcome other concerns brought by leadership, despite being blind to their own contributions to his failure. Further, he was not the only resident to struggle. Differential ways that residents were treated as successful learners, practitioners and healers require further thought and discussion.

Discussion

Taken together, these cases exemplify a range of different types of experiences I observed during my fieldwork. Further, they speak to important factors in the making of healers: the end result of the training processes, the way learners made meaning around the learning they engaged in, the place of power in training, and local conceptualizations of healing and the impact these have on patients. I address each of these in turn to illustrate how these case studies help address the aims of this project.

First, the processes I observed map well on to the steps taken in making healers cross-culturally (Womack 2009). Recognition of a potential apprentice's innate ability was seen in Dr. Pryde's story, the initial stage in Womack's model. The residency program took a chance on her, despite having some learning difficulties. The academic abilities of a potential family medicine resident are a chief component of screening for

interviews during the hiring process. Dr. Hedges listed medical ability and exam scores as among the first things she looks at when selecting candidates for interviews.

Next, there is often a “call to the field” that brings an apprentice to a particular healing tradition. All of the physicians I spoke to for these case studies cited a “calling” to family medicine, to the treatment of all ages and all medical conditions, to forming relationships with patients, as the reason for coming to the specialty. They had a resonance with the values and rhetoric of family medicine, and a desire to learn family medicine’s approach, before applying for residency programs. Dr. Hedges took this a step further in that she actively sought potential residents who expressed dedication to family medicine and to their relationships with patients, rather than a more-general interest in getting into a residency program.

Finally, it is during the socially-recognized and structured process of “becoming” is where the making of doctors is most clearly seen. The early moments of the Dr. Deepah’s apprenticeship showed how new residents learn skills from those around them such that they can perform their work autonomously. Dr. Pryde’s acquired the cultural and symbolic capital to not only convey information and demonstrate appropriate behaviors to Dr. Deepah, but to have that information and behavior emulated by Dr. Deepah because it’s relevant and appropriate. Further, Dr. Pryde was able to measure her own progress, both in realizing how much she had to offer Dr. Deepah but also in the effective working relationships she demonstrated with the hospitalist, Dr. Thomas. Likewise, Dr. Levine enjoyed considerable autonomy, having come to point of being socially-recognized and legitimized by Dr. Sharma. The end

result is a process by which residents move towards greater competency, greater autonomy, and finally social recognition of their status as family medicine physicians.

However, the case studies also revealed a great deal about the contextual ways in which learning was locally defined. Particularly, the case with Dr. Pryde and Dr. Deepah showed how the reproduction of the program's habitus occurred through mentoring and meeting the program's expectations. Dr. Pryde had become what the program set out for her to become: a skilled technician who could effectively manage the institution's systems for EMRs, ordering tests, and managing the inpatient workflow. The program had taken a chance on her, and she took the expectations placed upon her with considerable dedication, to prove herself worthy of her hiring. She had taken on the disposition of "ownership" and conveyed the seriousness of the work to Dr. Deepah.

Interestingly, Dr. Deepah herself did not conceive of the things she was being taught as learning. Instead, learning was to master skills at recognizing disease, providing accurate diagnoses, and formulate appropriate treatment plans. The majority of the time spent with Dr. Pryde involved hands-on instruction in structural techniques necessary to perform these diagnostic and disease-centric tasks. Dr. Deepah had to learn the system in order to perform medically. In fact, as a reminder, her time spent on the floor often involved "reading up on patients". What exactly did this activity do for her except to prepare her to understand the disease and treatment for those patients? She was learning skills, akin to Sinclair's (1997) focus on the basic medical habitus, in order to perform the technical practices expected of her.

Perceptions of power dynamics and agency, between and among the residents, help explain this lack of engagement with family medicine's object. Dr. Pryde

commented that her role was not to teach medical knowledge, but to convey “little words of wisdom” that would help Dr. Deepah achieve and meet the expectations of her attending physicians and senior residents. Dr. Pryde had learned a great deal in her first year around managing patient notes and computer records, reporting to seniors and performing patient stories in rounds. She conveyed these as important learning moments for Dr. Deepah. The various forms of capital conveyed suggested management of workflow and how to interact with supervisors took priority. Further, the mentors like Dr. Pryde held the power to evaluate those under their charge. Other markers of progress were bestowed through evaluations and reports. Residents’ awareness of being evaluated and wanting to make progress in the program leveraged influence over the residents’ behaviors. Neither however placed focus on patients as experiencing members of a medical relationship in the pursuit of health and healing.

The way Dr. Levine precepted revealed her autonomy and competency; the symbolic capital she had acquired was demonstrated through her approach to patient management. As a result, a shift in the mentor-mentee power dynamic occurred in the relationship between Dr. Levine and Dr. Sharma; a shift emblematic of the progress residents were making in the program. Because Dr. Levine had developed socially-recognized competency in her evaluation, diagnosis, and treatment of patients, Dr. Sharma conveyed trust and the willingness to allowed Dr. Levine to precept only occasionally, and then very briefly. By demonstrating an aptitude for making responsible decisions regarding patients, Dr. Levine had earned autonomy from Dr. Sharma’s careful oversight and was given broader approval by program faculty.

On the other hand, Dr. Sharma's approach, however careful in its mentoring, reinforced the normative expectations of the program. The tacit message was one of compliance; meet the expectations consistently and oversight will lessen. Both doctors asserted a clear commitment to family medicine's values, and displayed or related behaviors that showed a commitment to patient healing. However, if the values of family medicine were somehow not embodied in the behaviors and mentoring of faculty members, and they possessed the power to expect and enforce appropriate behaviors from the mentees, the impact on social reproduction would be a movement away from family medicine's object. Paternal attitudes towards patients would mean the preceptor and (eventually) the resident could decide whether progress was made, rather than through engaging with patient's own self-assessment.

Dr. Thomas' story was an interesting case to shed light on the place and role of family medicine in American medicine. He seemed critical of internal medicine's focus on disease process and disease treatment, and wanted more; a holistic approach he could more-readily find with family medicine. Though warm and initially encouraging, the encounters with Dr. Thomas were still paternal in their approach to patients. In the case of the mute woman, there was no engagement sought from the patient, she was merely informed about what was happening; her permission was not elicited. The physicians found no reasons to explore a better way to communicate with her. When we left the room, the default position the physicians took was to explain to me the medical issues this woman was experiencing. They chose to educate me in their understanding of the patient's concerns, yet nothing was said of how the patient herself felt or understood what was happening to her; a disposition more in keeping with family medicine's object.

Finally, the keen focus placed on learning the systems involved in enacting biomedical practices – and the rhetoric of a dedication to patient-centeredness – came to the fore with the case of Dr. Ramsey. The notion of health as a return to a prior state – to fix problems akin to repairing a machine – obscured the family medicine physicians' opportunities to engage with their object (Baer, Singer, and Susser 1997; Metzl 2010; Klein 2010). While Dr. Ramsey demonstrated the family medicine disposition of patient-focused care and a deep commitment to treating the whole patient, he struggled with the expected behaviors around time management and developing treatment plans. He attempted to exercise power he did not have in pursuit of priorities that did not meet the expectations of the program, despite being more congruent with family medicine's object and values. He was on his way philosophically to the example Dr. Levine provided, but failed to meet training program expectations, or did not have the adequate capital (perhaps of any kind) to practice medicine that way. Where Dr. Levine was praised for her dedication to patients and attempted to embody more-closely family medicine's object, Dr. Ramsey's attempts to do so were not positively received.

Alternatively, perhaps the program failed to see how Dr. Ramsey was so alike other struggling residents. Dr. Pryde's successes were not recognized in Dr. Ramsey's efforts. Regardless of my speculations above around microaggressions of race, something set Dr. Ramsey apart from other residents that contributed to his dismissal. The patient Dr. Ramsey wanted to focus on was lost in the haze of regulations and institutional systems; his own agency and commitment to ideals challenged by the normative social structure in which he worked. Dr. Ramsey had the makings of the kind of family medicine physician whose behaviors might conform to the rhetorical ways in

which family medicine discourses describes this kind of specialist. Yet, he was dismissed from the program. Whether the story gathered from Dr. Hedges is accurate or something else contributed to Dr. Ramsey being labeled an outsider remains unclear.

Ultimately, the examples of Dr. Pryde, Dr. Levine, and Dr. Ramsey – and their respective interactions with physician mentors – speak volumes about the power dynamics at play in the making of healers in family medicine. There were physicians in the setting that established how medicine should be practiced. These mentors had the authority to mark progress symbolically in residents who conformed to expectations. The authority of these mentors stemmed from the history of family medicine and its place in the larger scope of American biomedicine. The residents were stuck in a sense, to speak discursively about the superior ways in which family medicine goes about its practice, but forced to conform to the structures of biomedical patient management, steeped in insurance requirements and training milestones. Family medicine's object was pushed to the background; something to focus on second in favor of direct diagnosis and treatment. Further, history influenced the behavior and expectations of mentors, which in turn influenced the expectations placed on residents. To resist this normative structuring led residents to be labeled as "problematic" or "struggling," with eventual remediation used to address the problems. Advanced residents mirrored this structure, placing expectations on less-senior residents to conform to the ways they had learned. To exercise one's own agency became a delicate undertaking, one that even Dr. Levine, upon closer examination, did not entirely embody.

What do the observed behaviors mean for the patients and the place of family medicine's object? In most cases, the place of the patients was as an object of the

physicians' attention, or rather the patient's disease was. The patient was not a collaborator in meaning-making and establishment of understanding. Local idioms like "patient-centeredness" would suggest more entanglement, but instead was enacted in episodes of being friendly with patients. In the end, these educational moments seemed to be less about conveying new cultural capital or asserting competency around the diagnosis and treatment of disease. Instead, these interactions (with the exception of Dr. Ramsey) illustrate the rewards of accumulated capital, the new status enjoyed by an advanced resident, and the final stages of professional socialization.

The program leadership embraced family medicine's values discursively. Dr. Hedges referenced educational milestones repeatedly as the means by which residents were evaluated and skills assessed. These included "seeing common things commonly" and steps towards becoming lifelong learners. She focused on the impetus to learn by doing, repeating her insistence from the first days of orientation. However, the criterion of being "patient-centered" came second to the applicant's academic record. Is this then to suggest that what makes a good family medicine physician, what passes for a dedication to family medicine's object, to patient-centered values and holistic practice, must be present and fully formed *before* training in family medicine begins?

Dr. Levine expressed the clearest idiom of healing of any physician I spoke to and she was able to balance her approach with the biomedical requirements of the learning modalities. She defined healing as finding a way for patients to feel better whether or not their bodily symptoms and disease were improving. She sought to empower her patients to seek the kinds of physician relationships that worked for them, that addressed their needs and helped them feel better regardless of the diagnosis and

treatment. She was suggesting that healing was subjective, that with her treatment “how one gives them sometimes matters more than what one gives” (Canguilhem 2012: 54). That treating the cause of and resolving a disease may at times be impossible, but healing occurs through providing information and understanding, such that the patient can attempt understand, make mean, and find a new sense of the normal.

Dr. Levine was touching on an important distinction in terms of healing versus curing that I brought up earlier in the initial literature review. She expressed a desire to connect with a patient, understand their worldview and social milieu, and engage with a patient’s own goals and understandings for their health. Dr. Levine displayed a disposition born of her personal history and her training to see the problems of the body and people’s lives as multifaceted and complex. Importantly, she was willing to not retreat from that complexity. She had a dedication to relationships with her patients, to listening, and to making patients feel better with and without medications.

Perhaps Dr. Levine’s D.O. training was sufficient for her to take on her own idiom of healing; to think and act in these terms. On the other hand, Dr. Sharma’s experiences suggested a major shift in residency, after helping her parents secure treatment while in the United States. Her experiences with her parents changed her approach to her patients in general. Dr. Sharma conveyed how her early experiences of medicine were more “mechanical” and it took her family and the need to treat her father directly that led her to a broader definition of healing practices. This experience made her more “genuine” and made her a “good” family medicine doctor.

However, those like Dr. Levine, Dr. Thomas, and Dr. Ramsey described and attempted to display more obvious patient-centered behaviors. Delving deeper, we saw

how even these physicians presented complex behavioral engagements with family medicine's object. Dr. Levine still made decisions exercising her paternal ideas about what was best for patients. She conceptualized patient engagement as understanding, without allowing her own positionality and experiences into the dynamic; to allow her patients to affect her. Dr. Thomas was still the physician in charge of his patients. His outward demeanor was encouraging, but his patient was powerless to refuse his touch or examination. Finally, Dr. Ramsey's dedication to patient-centeredness, to take the time necessary to speak to and help his patients, was met with criticisms. He was told to choose one thing to focus on and ask the patient to return for another visit. This approach does not acknowledge patient's needs or the burden this request would place on them. Dr. Ramsey was unsatisfied and the program ultimately unsatisfied with him. There is certainly plenty of blame to go around, but ultimately the movement away from patient-centeredness in practice, away from patient entanglements, was clear.

As a result, the discourse around what family medicine's values and key behaviors was often empty, without clear definition, and left family medicine's sense of identity as a specialty in question. What exactly was "patient-centered" or "holism" or "a good family medicine doctor"? What did Dr. Pryde mean exactly when she claimed family medicine was better than other specialties by being "more dedicated to the patient"? The discourse around family medicine as a distinct, superior type of biomedical practice was present, yet a deeper engagement with the values was not seen. The educational model encouraged patient engagement but did not often role-model exactly how to achieve this. When patient engagement was displayed, it was often paternalistic, repositioning the patient as object of inquiry at the very moment the

physicians could engage more deeply and assess the patient's expectations and subjectivity of their illness experiences. The rhetoric of healing relationships was in stark contrast to the embodied behaviors. The behaviors I observed did not map on to the stated values of family medicine.

In the end, the discourse and behaviors I observed suggested the physicians often had the best of intentions. They wanted to do the right thing by their patients and demonstrate in action how they valued family medicine's object. My data showed the challenges and complexities inherent in this process, the pressures residents and mentors faced, and the dissonance that crept in. The educational processes mirrored these intentions but often focused on more measurable outcomes. There is considerable hope for improving the educational process in the future. My findings and discussion shed light on what would need to be recognized and changed to bring practice and dispositions more in line with the values of specialty. I turn now to a series of more-intensive patient-physician interactions to further address this tension between discourse and practice, taking a final look at the making of healers in action.

CHAPTER 8

BEDSIDE ROUNDS

From my earlier background as a behavioral scientist as well as my reading of the literature, I was aware of the importance of bedside rounds as a teaching exercise. Flexner (1910), Verghese, et al. (2011), Balmer, et al. (2010), and other medical educators assert that bedside rounds are a critical locus of learning and becoming competent physicians. To this end, I explored the use of bedside rounds at Suburban Family Medicine. In these inpatient contexts, physicians and patients were seen interacting directly, where the activities of clinical care were practiced at the patient's bedside (Gonzalo, et al. 2010). Consequently, I anticipated that I would see family medicine's object more overtly displayed. I sought to observe patient-physician entanglements that may better illustrate the local healing idiom and practices. Exploring bedside rounds therefore became an appropriate and fruitful place in which to observe healing and the making of healers in practice.

The bedside rounds I have chosen also illustrate changes in my thinking overtime regarding healing and family medicine. I first present a set of bedside moments that reflect my earlier thinking, coming to realize that the values of family medicine were not being clearly demonstrated. Then I will show how my thinking evolved on this topic through a lengthier case study example at the end that better demonstrates the stated values of family medicine. I give more space to this key ethnographic encounter because I find it is highly emblematic of a local healing idiom and attendant practices. However, I conclude that when compared to the stated values of family medicine even this encounter looked very different than expected.

Learning at the bedside

Bedside rounds were patient-physician interactions that took place at the bedside, which involved discussions and clinical care directly with the patient. In Suburban Family Medicine, the specific term “bedside rounds” was not used as often as the phrases “going to see the patient” or “an interesting case”. Since I did not ask directly about this, the reason for this difference remains unclear. I suspect the phrase was simply a colloquialism. In practice, I observed no clear difference between bedside rounds as defined in the literature and the activities I observed at Suburban. What I did ask about specifically – and becomes more intriguing – is the rationale used to choose patients for bedside rounds. Overall, the driving motivator of choosing particular patients for a team visit in Suburban Family Medicine was whether or not the patient’s disease, symptoms, treatment, diagnosis, or illness experience contained “something teachable”. The attending faculty members often spoke of “teaching pearls” – educational moments orchestrated to convey a lesson or idea to the residents with which they were working.

Decisions around which patients to visit happened through discussions during table rounds, which happened every day in the late morning, as described in Chapter 6. Attending physicians or senior residents would suggest patients to see at the bedside, based on the discussions the team would have about all their patients. If a particular patient’s diagnosis or behavior proved difficult for an intern to understand and resulted in a discussion among the team members, the attending physician would suggest that patient as someone from whom the residents could learn. I did not observe any lengthy debates on this decision-making process and I never observed anyone disagree with going to see a particular patient. If the patient sparked a conversation, because of their

symptoms, treatments plans, or personal interactions with the residents, the physicians would visit with the patient at the bedside.

The bedside rounds I observed fell into three broad categories: hands-on observations of patients' signs and symptoms, patients with whom interactions are strained or challenging, or patients whose story may especially help the doctors understand the illness experiences of the patient themselves or similar patients in the future. I now provide examples of each of these categories and describe how these encounters helped socialize residents and explore notions around healing.

Hands-on observations of a patient

The greatest number of beside rounds I observed involved visiting patients with an “unusual” or “interesting” symptom or physical presentation of a disease. In keeping with standards established following the Flexner Report (1910), the tacit intent here was that nothing learned in books or case studies can substitute for the learning that takes place in seeing a specific patient with a particular presentation of a disease or symptom. In general, unusual cases were chosen for bedside rounds above more routine medical presentations. In hindsight, I should have explored the choices more carefully. I did note that these were often medical conditions that the attending had experience with, but were new or uncommon for the residents on the team. I presume that it was the uncommon presentations that would take a physician off guard later in their careers, when working alone, and exposure to a range of signs, symptoms, and diseases would aid the resident by broadening their repertoire of disease knowledge.

The team I followed in this case included Dr. Pryde, described in Chapter 5, who was still an intern at this point in my fieldwork and the resident immediately responsible

for the patient we were about to visit. The senior resident was Dr. Monroe, a friendly, soft-spoken African-American woman in her late 20s, looking forward to graduation in a few months. The attending was Dr. Sloan, a middle-aged Caucasian woman, conservatively dressed, with medium-length, brown hair. This was the only encounter I had with Dr. Sloan during my fourteen months of field work; our respective schedules never again overlapping. However, in spite of our just meeting, she seemed unconcerned about my presence. She said that she remembered the consent process from a few months previously, and quickly moved on with a simple “welcome aboard”.

During morning table rounds, Dr. Pryde described a patient that had been admitted following an exacerbation of his diabetes. Though diabetic concerns were a common reason for admission to family medicine, his particular signs and symptoms were somewhat unusual and new for the team. In this case, the patient’s stomach was severely distended and soft. The stated goal was to visit and observe the patient’s condition, and literally to feel his stomach hands-on, such that the residents could be shown what to feel for in these circumstances. Shortly after table rounds, the group dispersed and Dr. Sloan, Dr. Monroe, Dr. Pryde and I went to see this particular patient.

The patient was a largely built, somewhat overweight, white, middle-aged man with graying hair. He was sitting upright in bed and no one else was in the room with him. The television was off and the room was quiet. He turned to look at the doctors when we entered but did not say hello. He kept looking at the physicians, appearing interested in why the physicians were there, but said nothing. The attending physician greeted him warmly but his response was a short “good morning”. She began by asking the patient what brought him to the hospital. He explained that a recent surgery,

combined with his diabetes, resulted in this bloated appearance in his stomach. The group listened to the patient's brief story of what brought him to hospital, which was delivered in a quiet, direct way. While speaking, he looked occasionally at Dr. Sloan, but more often straight ahead. He did not look at the other doctors or me.

Dr. Sloan said, "This must be very difficult for you". She smiled and touched his arm as she said this. The residents stood quietly watching the patient and Dr. Sloan, but said nothing. The patient seemed unchanged by Dr. Sloan's gesture. The impression I was left with was one of passive acceptance, acquiescing to the doctors' presence but not engaged in the exchange. The discussion quickly moved to the group's goal. Dr. Sloan told the patient the team was there to look at his stomach, but did not explain that she was there to teach. No distinction was made for the patient between medical practice of treating his stomach and the educational demonstration that was about to happen. The goal was not necessarily to help the patient better understand his disease or illness experience, but for the residents to learn something about his condition. Once her sympathies were expressed for the patient, Dr. Sloan moved to examine his stomach. She asked if it was "okay" to do so, and the patient provided his consent with a simple nod. To me, he was not in a position to disagree. His demeanor seemed to accept what was happening. I was unsure if he was comfortable with what was about to happen and it was unclear if he expected something more from the encounter.

Despite the pedagogical goal of having every resident learn directly from this patient, presumably by touching his stomach and learning what to look for, Dr. Sloan explained to the patient, "We're not going to have everyone mash on your belly". The patient remained a passive participant as Dr. Sloan "palpated" his stomach. He

consented but did not engage the group and did not react in any obvious way to what was happening. Likewise, the residents were focused on his stomach, not on any other aspects of the patient; there was no longer any conversation. In fact, the patient himself disappeared in a sense; only his stomach remained as an object of interest.

As I later wrote up this interaction, I noted that this was entirely an exam of a set of physical symptoms. Dr. Sloan explained to the residents what she was looking for, as she demonstrated the manual technique of pushing on various parts of the man's stomach. The goal, she explained, was to palpate the various abdominal organs and assess their size. Of particular interest was the liver, as an enlarged liver can be a marker of disease progress in diabetes. The residents observed intently and seemed to take in Dr. Sloan's words. However, once again, the patient said nothing, asked no questions; he was no longer involved in the process. I wondered whether he felt that he lacked agency to actively participate or whether he did not care to do so, or both. Once complete, Dr. Sloan thanked the man for his time and permission to examine him. The residents muttered their thanks as well as we walked back out into the hallway. The patient himself said nothing. He offered a weak smile and nodded as the team left.

Once back in the hallway, Dr. Sloan motioned for Dr. Pryde to close the door leading back into the patient's room. After encounters at the bedside, I frequently witnessed the team discuss diagnoses and treatment plans with the patient removed from the conversation, only to be brought in once the diagnosis and plan were already decided. In analyzing this encounter, I came to realize that this situation – discussing the patient without his or her participation – was another example of how family medicine's values and practices as I observed them did not align in the educational

process. The message being sent here was that the patient was less important than the sign or symptom being observed. This patient's stomach became the locus of the team's attention. Patient-centeredness would have suggested more direct interactions with the patient. They would inquire about his experiences and feelings around his distended stomach, address his concerns and expectations for health, and assure him that the team was working to help him. Without demonstrating a patient-centered approach, residents would have trouble learning to engage with patients. Further, as this was a solely educational moment, explaining that fact to the patient would be keeping with the communication values of family medicine; he was given no indication that this encounter was for the team's benefit.

The conversation in the hallway involved a debate over the pros and cons of short-acting versus long-acting insulin. Here Dr. Sloan pointed out a broader consideration for which to choose. The patient's social circumstances – where and with whom they live – might have helped the team decide. If the central value of patient-centeredness was to be achieved, these circumstances would have to be assessed with the patient at a later time. They had had an opportunity to have this discussion with the patient, assess immediately his social circumstances. Instead, Dr. Sloan simply explained that long-acting insulin was less expensive and normally administered less-frequently and therefore easier to manage for a person dependent on others for help. Whether these social factors were the patients' concerns was not assessed at this time.

Dr. Sloan explained, "Not everything has to do with medicine" but at times broader social concerns of the patient must be assessed and taken into consideration. To which Dr. Monroe responded, "We're not always thinking about that". In analyzing

this encounter, it was clear that the educational habitus was leading residents to think first and foremost about diagnosis and treatment. The residents were more concerned with the most appropriate, physically efficacious treatment, to restore the physical health of the patient, regardless of whether a patient could afford or administer the treatment. Further, the residents had not discussed, nor were they led by Dr. Sloan, the patient's social context with the patient himself. To do so would suggest a clearer focus on family medicine's holistic values, more clearly defining what was meant by "patient-centered". Dr. Sloan suggested this communication was important but the expectation was left at that; no one was explicitly asked to gather a better understanding of the patient's circumstances. Dr. Sloan unfortunately demonstrated to the residents that they need not overly worry about the patient themselves during these encounters, though she would remind the learners of the patient's social context after the fact.

Assessing the overall quality of this educational moment, I also feel that the explicit goals of bedside session were not entirely met. The stated values of the family medicine training includes hands-on "learning by doing" – which did not exactly occur, since the residents did not themselves palpate any organs – and to embody the value of involving the patient in their own care – which most certainly did not happen. Despite Dr. Sloan's concerns about feasibility of self-administered treatments, the interaction I observed was at odds with the espoused healing discourses and practices encoded in family medicine's values, including the underlying goal of bedside rounds described by family medicine researchers and educators (e.g. Verghese, Gonzalo – see Chapter 1).

Throughout my time at Suburban, I witnessed numerous bedside rounds that closely resembled the encounter I have described here. The patient's body became the

setting for cultural capital exchange, yet did not engender the sort of patient-centered behaviors I had expected to observe. Examining patients at the bedside was often an exercise of “showing” residents what to look for, and much less about showing residents how to interact with patients beyond ignoring or removing them from the discussion. Patients were often involved only to garner permission to examine and I observed little of residents explaining diagnoses and treatment plans. I found that residents would often return later to explain to a patient what was going to happen next, but only once decisions were made and treatments underway. A paternal, “doctor knows best” approach became the norm. These encounters did not engage the patient on the patient’s terms, but rather provided training in the technical portion of medicine for residents eager to gain the necessary capital to move towards technical competency. The patient-centeredness of family medicine’s values I thought to find remained elusive.

Challenging patient interactions

Other bedside rounds I observed did entail considerably more dialogue and direct interaction with patients. I continued to examine these encounters for direct demonstration of family medicine’s values and object. What I observed however revealed additional concerns about the nature of many patient interactions. These encounters involved conversations where tensions arose between patients and doctors on the inpatient service. From the physicians’ point of view, as expressed in their private reflections with one another, patients would make demands that the physicians were not willing to agree with. The ways in which residents were taught by faculty attendings to approach these “challenging patients” is the focus of this section. In such encounters, I sought to find reconciliation and efforts towards healing by incorporating the patients’

concerns; that the physicians would approach these challenges as moments that would better demonstrate family medicine's object. Instead, the physicians often galvanized against the patient. I will now describe two such encounters, witnessed approximately six months into my time at Suburban Hospital.

The first bedside rounds of this category involved a middle-aged white woman suffering from extreme pain related to an ongoing disease. When I joined the team, they were on their way to meet with the patient. Her pain that had led to her initial hospitalization was resolved to the physicians' satisfaction, leading the team to discharge her. In their assessment, her immediate medical concerns had been resolved and it was deemed safe by the team for her to go home. From the way the team discussed her discharge plans, the patient was likewise eager to leave. One resident even said the patient getting dressed and packing her belongings. At the nurse's station, down the hallway from the patient's room, the team stopped before going to see the patient, to discuss one lingering concern.

Despite her preparations and eagerness, the patient was refusing to leave the hospital once she had learned that she would not be prescribed pain medications. Further, the patient specifically requested a prescription for Dilaudid, a very powerful and addictive painkiller. Gathered in the nurse's station, the residents – the chief Dr. Clark, the co-chief Dr. Floyd, and three interns – strategized how to approach the woman and convince her to leave without the pain medications. Dr. Clark was a woman who had emigrated from Ghana to the United States a few years prior to residency. She was tall, thin, with a warm but intensely-focused demeanor. Dr. Floyd was a young, Asian-American woman, of average height and weight. She was often intense in her

approach to work, and quick to comment about problems she observed in the work she and others did. I now present how the residents talked amongst themselves about this patient, without the attending physician present, and describe how that conversation changed when the attending arrived. This becomes an important moment to attend to when considering the role-modeling faculty members are expected to provide.

The discussion among the residents quickly turned from explaining the patient's request for pain medication and into expressions of frustration. The co-chief, Dr. Floyd, was incensed by this patient's demands. Dr. Floyd commented, "I'm not a dealer. I won't be blackmailed." She asserted to the team that she wanted to treat all patients with objectivity and fairness, to find consistent ways to decide when to give such powerful drugs. Dr. Clark stated that giving in to a patient's demands would essentially be passing the problem on to someone else. The tone from both the residents was accusatory, with sentiments about "fueling addiction" and leaving it up to other physicians to say no to her. The interns on the team did not contribute to this dialogue. The senior residents were clearly angered by the patient explicitly asking for not only pain medications, but also a specific drug with which she had previous experience. Dr. Toa mentioned having encountered this patient before. She had been admitted multiple times to family medicine's inpatient service, always with similar demands.

"Getting rid" (Mizrahi 1986) of her by succumbing to her demands went against the dedication these residents felt towards the patient, yet challenged the power dynamic between resident and patient. Further, the residents were adamant in "standing up" for their principles; but to which principles they were referring. The principles of family medicine would suggest that a physician should endeavor to understand a

patient's illness experiences and attempt to reconcile conflict in the interest of mutual benefit and cooperation. The principles the residents referred to were more in keeping with the authoritarian, physician-in-charge paternalism that characterizes some types of biomedicine more broadly.

It is important to remember that these statements were made among the residents alone, without the attending physician. On this day, Dr. Sharma was the attending. She was the preceptor described in Chapter 7, interacting with Dr. Levine. Her demeanor was often very friendly with residents and patients alike. After the dialogue among the residents, they left to meet up with Dr. Sharma before going to see the patient, intent on enlisting Dr. Sharma's aid in "dealing with" this demanding patient.

We found Dr. Sharma near the patient's room, but when we went to meet with the patient, she was not there. Instead, she was in a final physical rehabilitation session in another part of the hospital. These sessions were held in a clinic area away from the family medicine's inpatient service and so the team went to find her there. The patient was engaged in the session when we arrived and, as a result, I was not able to consent her before the physicians went to speak with her. I waited in the hallway with the chief resident, Dr. Clark. Though I was unable to observe the direct interaction, this moment afforded me the opportunity to ask Dr. Clark about this patient and her thoughts on demands for pain medications.

Dr. Clark explained to that the patient was "very rude, but knows her body. She knows what she wants, what she thinks she needs in order to treat her pain." The patient told the team as much, claiming that the doctors did not know her body as she did and did not know what she was going through. It seemed the truth of this statement,

from the patient's perspective, became irrelevant to the doctors when the patient's demands began. Dr. Clark was not able to articulate "why this patients upsets me so much". "Pain", Dr. Clark explained, "is so subjective. It's hard to tell if a patient is just trying to get medications out of the doctor and when they really legitimately need them." She asserted, "I'll refer out patients who need chronic pain management" rather than dealing with them herself. Further, patients would often see different doctors or go to different hospitals, essentially "doctor shopping", to get the drugs they needed.

Perhaps, Dr. Clark was troubled by woman's expertise over her own body as compared to the physician's expertise in medical signs and symptoms. Dr. Clark conveyed some understanding of the challenge of pain for the patient, but quickly resisted the challenge of working through pain issues with a patient. She recognized the inherent problem in this patient-physician dynamic around pain, but was not fully trained in how to work through it with the patient directly. Her family medicine education did not help her finish the job of reconciling disagreements around pain management. Ideally, this integration of patient's perspective and wishes would be something attending physicians would embody and demonstrate for the residents, in keeping with family medicine's object and dedication to patient-centeredness.

The team returned to the hallway where Dr. Clark and I waited. The conversation with the patient had lasted only a few minutes and the team's frustrations appeared to abate. From what I could tell, Dr. Sharma had taken full control of the situation and ensured that the patient would be discharged without pain medications. I was not able to ascertain the details of how they finally made her leave. Dr. Tao suggested that the patient was threatened with having security forcibly remove her. Regardless, the

challenge to physician authority was clear and clearly dealt with in an authoritative manner. I was deeply troubled by this encounter. Why did the team fail to engage the patient and hear her story, access her illness experience more directly, and find a better solution? Are there better solutions or was this a problem larger than communication skills can address? Regardless, the values of family medicine evaporated when challenged by a patient's demands. A more patient-centered healing approach could have addressed potential addiction or otherwise found a compromise. I was further struck by the attending physician's attitude in this encounter. The attending had flexed her power and authority to enforce the doctors' wishes and had the patient removed. I would later come to find out that Dr. Sharma had a reputation "being stern when necessary". Her approach was valued and her reputation signaled to residents that a more authoritative, physician-in-charge approach was sometimes preferred.

Later that morning, I witnessed a discussion about a second patient that continued in a similar vein. Again the conversation among the physicians was far more candid and telling than any interaction with the patient directly. For context, the patient was a middle-aged white male suffering from a myriad of ailments, resulting in a range of severe physical symptoms and pain. It was difficult for me to parcel out which symptoms corresponded to which disease. From what I overheard as the physicians walked back towards the inpatient service, this man had become aggressive and argumentative regarding the management of his symptoms. The patient was less concerned about the medical approach to treating his disease because he felt the symptoms took priority and were not being well addressed. The physicians felt otherwise. The physicians had explained repeatedly to the patient that treatment of the

disease was paramount and the symptoms would resolve themselves. The physicians told the patient that they had done everything they could to ease his symptoms as he waited for his health to improve.

This argument had been ongoing over the course of a week, when Dr. Sharma took over from Dr. Douglas as attending physician. At the point when I observed this conversation, Dr. Sharma had already had one conversation with the patient. Dr. Sharma detailed how she had a long discussion with this patient the previous afternoon that ended in something of a stand-off. The attending physician detailed for the residents how she and the patient were staring at one another, neither talking, neither willing to back down – until the patient finally looked away and conceded the point; that he needed to treat his disease to help his symptoms, to accept what the physicians wanted to do. Dr. Sharma commented that she had “won the stand-off”.

Having related the details and outcome of this interaction, I will discuss what to make of it in relationship to the values of family medicine and the taking on of healing practices by residents. In the physicians’ conception, what the patient needed to do was give up his stubborn position and allow the doctors to do their job. From the physicians’ discussion, I surmised that the patient had a very detailed plan on what best to do to help with his particular symptoms, a plan the physicians disagreed with. Dr. Sharma asserted that she eventually won him over by reframing the problem – to focus on the disease such that the symptoms will be resolved through treatment of the underlying cause. The tension here between physician and patient was strained, yet from the physicians’ perspectives Dr. Sharma had appropriately resolved the dispute. I was

troubled to find that the patient's perspective or feelings about this encounter were not a part of the discussion.

However, back in the residents' call room with Dr. Sharma, the residents did express their feelings regarding the outcome. The chief, Dr. Clark, said that Dr. Sharma "didn't give him room. She was the boss. She established authority and drove the point home." Dr. Floyd said, "I for one feel so much better." A medical student commented that Dr. Sharma did in a few minutes what Dr. Turner had struggled with for days. One of the interns commented how Dr. Turner, the week prior, had said – "Wait until Dr. Sharma gets here. She'll be able to handle this patient better than I can." This was very telling language, suggesting again that power dynamics inhibited the realization of family medicine's value of patient-centeredness and partnership. Dr. Sharma's approach to patients was a tool that was used upon patients that did not readily submit to more congenial approaches, particularly those who threatened physician authority.

Within a few moments, the conversation segued from the conflict with this particular patient to a general discussion of why patients do not listen to their doctors. The assumption again reflected the power dynamics involved; that the patient should and must listen to and conform to the expectations of the doctor – a very biomedical approach to patient care. However, the conversation took an interesting turn. Dr. Sharma posited that one reason patients do not listen to physicians was because physicians have not listened to them and heard what the patients were saying. She defined these kinds of conflicts in a patient as the fault of the doctor; that "I haven't done enough, haven't listened enough, in order for the patient to be compliant." This

sentiment was, in words at least, in keeping with family medicine's values. Yet completely at odds with the behaviors Dr. Sharma had demonstrated moments before.

Reflecting back on this encounter, I troubled by this contradiction between the words this attending used and the behaviors she demonstrated for the residents. The two patient encounters clearly conveyed messages about hierarchical power and the ability to force patients into compliance through "pulling rank". These ideas were rooted in the history of biomedicine with a long-held tradition of physicians being in charge and expecting patients to do what the physician said. This dynamic was not something I expected to see in family medicine's approach to education and medical care, given the literature and observed discourse around patient-centeredness and healing.

Despite her rhetoric, Dr. Sharma demonstrated an outward disposition that did not conform to the values of family medicine, one that spoke to "how you handle patients who won't listen to you". The act of speaking *to* patients, rather than speaking *with* them, left the patient out of those interactions. The conflict focused the residents and attending physicians onto the technical strengths of their profession – that they knew how to diagnose and treat and the patients did not. Further, these encounters sent the message to new learners that this behavior was permissible. The message that was sent to the residents was not a healing one; that patient wishes and the patients themselves need not be taken into account when those wishes contradict the physicians' assessment of best practice.

Practice theory helps us to make sense of this contradiction. Habitus has generally been characterized as largely unconscious; that values and ideas become deeply encoded and subtly impact behavior. However, as shown, a great deal of

discourse occurred in the educational model, where ideas and expectations were verbally laid out and explained, and those expected to take on particular dispositions discussed the work they were performing. The central premise of education in the field was role-modeling and the presumption of imitation fueled by the prestige of the attending physician. Words however did not hold the same symbolic capital, same authoritative mentoring power, as the actions the residents witnessed. However, this suggested a potent impact of the dissonance – if the values of family medicine are only spoken and less-seldom enacted, the object of family medicine referenced but not deeply engaged with, then how will residents understand and take on dispositions consist with family medicine’s object without clear demonstration? Further, healing that incorporates patient illness experiences into treatment plans, which strives to enable patients find a new sense of normalcy, cannot be reliably realized unless role-modeled by those mentors charged with making family medicine physicians.

Gathering the patient’s story

Family medicine values speak overtly to the importance of a patient-centered approach to medicine, though as illustrated above the behaviors I observed were often authoritative. However, there were instances that were more balanced between patients and physicians. What follows is an account of a patient interaction that more-closely demonstrated behaviors that conformed to the values and dispositions of family medicine; a time when things appeared to go right. The encounter was orchestrated by the attending physician to elicit the patient’s perspective and explore her involvement in her own care. The goal was to hear a particular patient’s story – one providing a strong rationale for not wanting treatment. The encounter also demonstrates variation between

attending physicians in their approaches to patients. The attending physician in this case attempted to role-model listening to and working to understand patient concerns. Her demonstrated behavior differed considerably from Dr. Sharma's behavior.

A number of important players were involved in this meeting. The inpatient team at this time consisted of three interns, a second-year co-chief, a third year resident, and the attending that initiated the bedside rounds. Dr. Mueller was an intern during this encounter. She was mentioned briefly in Chapter 7, as a second-year resident whose patient's had died. She was a white woman in her late twenties or early thirties, with a quiet demeanor, whom I had not interacted with as much as some of the others. Dr. Reynolds was a white male, also in his late twenties or early thirties, with a dry wit, with whom I also had limited previous encounters. He was close friends with Dr. Pryde. Finally, there was Dr. Kirkman, similar in age to both Dr. Mueller and Dr. Reynolds; a warm, personable, though somewhat quiet white woman. The co-chief was Dr. Floyd and the chief was Dr. Clark, both of whom were described above.

Dr. Tandon was the attending during these rounds. She is an Indian-American woman, having immigrated to the United States as an adolescent. She had a warm, engaging personality and I encountered her repeatedly throughout my months at Suburban Family Medicine. Of all the faculty physicians, she was among those who seemed most dedicated to incorporating patients' stories and illness experiences. On various occasions I observed her encouraging residents to demonstrate understanding and careful communication with their patients, and anticipated these bedside rounds would follow suite. Dr. Tandon had set up this meeting between a patient and her team to provide an opportunity for that patient to describe her difficulties. The stated goal was

to help the residents better understand the patient's circumstances and to hear the patient's story in her own words.

The patient in this encounter was Anne. Anne was an African-American woman in her early thirties. She was very thin, frail in appearance, and wearing pajamas beneath the traditional hospital gown. When I went to meet and consent her for this study, she seemed guarded but agreeable. Anne was HIV+ and nearing the end of her life. She was diagnosed with AIDS, her disease having progressed to the point of threatening her life. The bedside rounds were designed to give Anne the opportunity to voice her concerns and to provide the residents a structured setting in which to listen to Anne's illness experience. In particular, Anne was unable to follow the doctors' treatment plans and was here to explain why. From Dr. Tandon's explanation, the question driving the meeting was: what do physicians do when they can no longer cure? This was not a particularly patient-centered question. I began to have concerns about this bedside session.

Before the meeting, while seated around the table in the residents' call room, Dr. Tandon provided context for the encounter. She reminded the group of how Anne had refused treatment for her disease and explained that she had other priorities. Dr. Tandon explained that the team would be hearing Anne's story and hoped that the residents could learn something about their limitations, to find other ways to help when medical practices were no longer an option. She urged the residents on her team to empathize with Anne's position, even prior the meeting. Dr. Tandon said,

How many of us can look death in the face, walk towards death, and not flinch? She's not concerned with herself but with her family. She's struggling with her own way to exit from the stage of life without leaving a lot of problems for the family (Field note: March 1, 2012).

The residents listened silently to Dr. Tandon's words. Empathy was a value Dr. Tandon wished to impart. Some shifted uncomfortably in their seats. Others seemed less than totally engaged with what was going to happen and glanced around the room rather than meet Dr. Tandon's gaze. None responded to her words.

Dr. Tandon urged the group to accept Anne's decision and instead to try to understand Anne's reasoning and experiences. Dr. Tandon related that Anne wanted to save enough money to off-set funeral costs; the co-pays and prescriptions had drained Anne's financial resources. Anne often obtained medications from friends and family members to treat her pain, fearful of being labeled a "drug seeker". She acquired marijuana from a friend to help treat her pain. Some members of the team nodded their heads in agreement that such measures were understandable in Anne's circumstances.

Dr. Tandon reminded the group that this was the second time Anne had been admitted to the family medicine inpatient service. Dr. Tandon, Dr. Clark, and Dr. Floyd all remembered her from her prior admission a few months previous. Dr. Tandon explained that little curatively was done for her at that time, but rather the team had encouraged and helped Anne strategize a way to confide her status to her teenage son. Dr. Tandon explained that Anne felt it was important that someone in her family know, that her son deserved to understand his time with his mom was running out, but needed help and support to open up to her son. In disclosing to her son, Dr. Tandon felt Anne experienced relief from the "mental anguish" she had been experiencing.

Sometime later, after table rounds and before lunch, the team met with Anne in person. These bedside rounds turned out not to be at the bedside at all, but in the staff lunch room down the hall. Dr. Tandon explained that Anne preferred to meet us there –

she did not want to have a conversation with other people around. For Anne some of the issues included that she shared a room with another patient, and her own family members kept coming and going, some of which were unaware of her medical condition. While it was not stated and I did not explicitly ask, I wondered whether meeting in a conference room also helped Anne feel less like a “hospital patient” than if the meeting took place with her in bed, to attempt level the power differences.

The group of residents and I sat in the lunch room, around a large table, while Dr. Tandon went to get Anne. The residents were quiet. Some kept busy with their patient notes or other work. Others simply waited. I personally felt tense, wondering what this encounter would hold. In a few minutes, Dr. Tandon came in with Anne in a wheelchair. As mentioned earlier, she was frail and very thin, appearing much older than her mid-30s. She was wrapped in a blanket and dressed in her hospital gown and pajamas. Dr. Tandon pushed Anne’s chair up to the table and took a seat to her left. I was seated nearby at Anne’s right. The residents were arrayed along both sides of the table, their eyes fixed on Anne.

Dr. Tandon made introductions and explained again why Anne had been asked to speak to the group. She wanted the residents to hear Anne’s story, to use her experiences to better understand why patients accept or reject their recommendations – how patients decide what recommendations to listen to and what not to. Dr. Tandon wanted the residents to hear Anne’s story of her challenges with HIV medications, her experiences of being sick, and the reality of having a terminal illness at a young age. Finally, she said she hoped Anne would learn something too – a little bit about the physicians’ point of view, such that “everyone wins”. I was struck by this sentiment;

Anne would receive little in the way of “winning” with her life ending soon. Perhaps commendable in attempting to keep the discourse patient-centered, Dr. Tandon’s final rationale suggested how physician-centered this encounter would be. Finally, Dr. Tandon turned the floor over to Anne by asking her to tell her story about having HIV and explain why it was difficult for her to take her medications.

Anne began her explanation by telling the physicians that her medications were never a priority and further that she did not prioritize herself very highly; the other people in her life came first. She was very busy with her family, taking care of her children, and maintaining the relationship with her boyfriend. She confessed that her boyfriend would often treat her “like a maid”; he was very controlling and demanded a lot out of her. She said she did not have the time to take the medications.

Anne went on to describe how depression was a factor. She questioned how she acquired the disease and as a “good girl” she didn’t deserve to have HIV. She explained how she thought HIV would go away on its own and that she was often in denial about having it at all. She ended by reiterating how busy she always was, before being hospitalized, making it hard to focus on anything besides the people in her life. She said she never made time to focus on her own health. She worked around responsibility to herself by citing her responsibilities to the people in her life; referencing a broader American cultural value about being too busy to care for herself.

Throughout Anne’s story, Dr. Tandon modeled a bodily disposition of empathy, leaning in towards the patient and closely attending to her words. The residents watched Anne, but their faces were passive and they leaned back in their seats away from Anne. It was unclear to me whether the residents were uncomfortable or

disinterested. Near the end of the conversation, Dr. Tandon summarized the purpose of meeting with a direct question, “How could we as doctors have been better partners in your care? What could we have done differently that would have allowed you to be healthier, to take your medications?” Dr. Tandon was looking for the pathway to help Anne curatively – perhaps the team missed something – rather than finding a way to engage Anne in her experiences. Either way, she attempted to elicit Anne’s thoughts.

Anne thought for a moment and slowly looked at the doctors in turn. Her response was telling, “Nothing. There was nothing you could have done. I wouldn’t have let you help me. I didn’t want to be a bother to anybody and I was embarrassed. So I wouldn’t have let you help me.” I watched the residents for their response to Anne’s statement. The residents were silent. They simply looked at Anne. A couple of the interns glanced quickly at one another, confused looks on their faces. The more-senior residents remained passive, focused on Anne but showing no outward response.

I still find myself deeply affected by Anne’s closing words. When I first heard them, it was an emotional moment. My heart went out to Anne. I felt it commendable that Dr. Tandon brought Anne’s story to the residents. Reflecting back in my analysis, I now see the interaction differently. The inpatient team backed Anne into a corner. She ultimately confessed that there was nothing the doctors could have done. She was beyond their help and therefore what was happening to her was not their fault. Was this interaction really about Anne and her story, or about the doctors’ need to validate what disease-centered approach they had taken with Anne and assign blame?

Dr. Tandon thanked Anne for her time and her words and brought the meeting to an end. She stood and wheeled Anne from the room. The residents quietly thanked

Anne and she thanked the doctors for listening. To me, the ending left the room feeling tenser than before the meeting. No one however said a word and the group members stood up and left.

A few minutes later, the entire group, including Dr. Tandon, reconvened in the residents' call room. The group then seemed much more willing to discuss what had just happened. Away from the patient herself, they began reflecting on Anne's words and puzzling over the challenge she represented. Dr. Tandon took this opportunity to engage the residents directly and help them learn from this encounter. She attempted to reframe the residents' role in Anne's story in a way they might better understand. She asked, "Given what Anne said, what could we have done? How could you manage this patient who wasn't compliant? What other ideas can we use?" Rather than wait for the residents to respond, she explained her thoughts on the matter.

First, she suggested expressing to Anne that "it's a privilege help her" – to make her feel valued, to validate her perspective, and to acknowledge the anger, resentment, and denial she's experienced around her illness. The sentiment dovetailed well with an illness-centered approach to medical practice. The interaction was an opportunity to approach Anne's health circumstances in a more humanistic, healing way – to discuss Anne's actual issues and circumstances. The team could address the conflicts at home and the fact her children needed her, to urge her to agree to measures that may improve her health and extend her life. However, it may have been more validating to hear her concerns and incorporate them into their approach to her; practice acceptance over trying to find a way to force compliance.

During her first admission, what the physicians did for Anne was much more emotional and interpersonal, and less disease-centered – a striking difference from many of the encounters I have related in this and previous chapters. In Dr. Tandon’s assessment, the most helpful part of both of Anne’s hospital admissions had been the relief she experienced, in part from the assistance the doctors provided in unburdening herself of her secret and this time in listening to her story. This relief also iterated more-closely with family medicine’s stated values around healing practices. Further, Dr. Tandon was advocating the practices residents should be taking on beyond diagnosis and treatment of disease; to attend to and respect patients’ illness experiences.

Dr. Tandon also addressed the relative powerlessness the physicians experienced as a result of Anne being unwilling to take her medications. She acknowledged the disposition physicians usually operate within for treatment – one of using biomedical practices to cure disease. She went on to reframe the situation with Anne when the normative approach was no longer appropriate: “You do the best you can. I’m not trying to even talk too much with her about her HIV. She has heart problems as well.” Not to mention the social problems Anne was encountering at home.

At this moment, I became more personally involved. I wanted to further explore how the team felt hearing the message from the patient that could accomplish nothing curative. I asked:

Being doctors, my understanding is that you are expected to be able to provide care and healing for a patient, and that you expect that of yourselves, to be able to do something and here you’re told directly by a patient that there’s nothing you can do – What is that like? How do you react to that? (Field note: March 1, 2012).

The chief resident, Dr. Clark, was the first to respond. She said, “It’s very frustrating. Ultimately the choice is with the patients. I can only do so much but it’s up to the patient

to decide if they're going to take the medication or not." Dr. Floyd, a second-year resident at the time, immediately added, "Well, we still have to try." She relayed a quote regarding doctors she had heard years ago which had stayed with her, "We cure sometimes. We treat often. But we care always."

This sentiment was strongly in keeping with family medicine's values and healing practices more generally, and reflected how these ideas were referenced verbally in the field. However, the residents still struggled to embody and take on these ideals, positioned as they were against the power- and history-driven impetus to biomedically diagnose and treat. The exchange with Anne exemplified the duality of medicine for these residents. On one hand, they followed the courses of diagnosis and treatment they were taught in medical school, reinforced in residency training. Yet they then denied responsibility if the patient did not follow suit; a technocratic and paternalistic approach. Yet they were reminded of their mandate to care always and to provide what they can for the patient, not to give up. This was a tension between curing and caring, and whether on some level caring was equitable with curing – whether healing involved more than treatment – to help a patient navigate through their illness.

Dr. Floyd went on to explain how she had what she called "a noncompliant patient" who frequently came to see her but did not follow her recommendations. This dynamic made Dr. Floyd feel "ineffective," that she was failing to help this patient. Dr. Tandon stepped in with a recommendation, to ask the patient directly, "What do you get out of coming to see me? What is it that you're hoping we can accomplish together? Why aren't you doing what I'm asking you to do?" The tone of voice with which Dr. Tandon expressed these questions was sincere. She went on and explained how this

approach has been very fruitful for her, that patients may be seeking different benefits from seeing a doctor than the doctors' expectation of diagnosis and treatment. There may be some unseen benefit. This is something of a leap of faith away from the normative pattern of doctor-patient working relationship, something the residents were not exactly ready for, given their reactions thus far. Dr. Tandon summarized the common response she receives; she paraphrased, was "As my doctor I know you care about me. I'm not ready to take these medications, but I know that you will be here when I am ready". Dr. Tandon attempted to demonstrate potential outcomes of healing behaviors, ones that were applicable in Anne's case. The residents were engaged more so in the rhetoric of healing, rather than changing their behaviors with patients.

Dr. Tandon attempted to demonstrate a central value of family medicine. Her approach went beyond a technical approach to medicine – beyond "take these medications so you can live" – but strove to understand the patient's perspective. She encouraged the residents to attempt to understand the patient. Dr. Tandon reminded the residents that family medicine was not focused on "one organ system" but on the whole person and the doctor were in a "privileged place" to make an impact on the patient's broader lived experience. She encouraged a longitudinal view of patient care, to address complex issues over multiple encounters – in either the hospital or the clinic – to "walk through the journey, take the journey with the patient. Whatever it is that they're experiencing, whatever it is they're going through, express to the patient that you are in it together, that you're going through it with them". The encounter lent symbolic importance to the practice of hearing a patient's concerns and moving beyond symptoms and treatment.

The relationship with the patient was a core goal of family medicine's values. Dr. Tandon summarized the final lesson in regards to Anne – the trick was to find the “patient's motivation”. What will motivate them to take care of themselves, to be ready to follow a treatment plan? She felt that the best approach, as a physician, was to bring Anne to better understand her illness, to manage her other health concerns, and to help her address the complex issues she was experiencing at home. However, Anne was having the actual lived experience and knew her illness as an insider. The physicians did not need to help Anne understand her illness, rather the other way around. The doctors could help her understand her trajectory and what may happen with her disease. The idea of helping Anne was good, if misguided. The physicians seemed unaware of the inverted dynamic and how it reinforced medical authority in a way contrary to family medicine's values and object.

The problems in this encounter became more apparent the longer I spent pouring over my field notes and the anthropology literature on biomedicine. A great deal was accomplished in this bedside rounds encounter, but I am troubled what was not accomplished. This exchange demonstrated how the residents and attending were sometimes on the path to healing and sometimes not. The attending physician desired to learn and was earnest about seeking out patients' thoughts on their collaborative relationships. The residents discursively claimed similar goals but their behaviors suggested otherwise. In the end, the approach I observed remained highly focused on the physician, focused on issues of effectiveness and medical efficacy, about what patient behaviors could have changed to better assure medically successful treatment. To subjunctivize for a moment; such an encounter would appear much differently were

a physician start by telling the patient that he or she wanted to better understand the patient's viewpoint. Instead of placing focus on the explanation for non-compliance, they could focus on the patient's perspective and what they hoped to achieve together?

The entire encounter, on later reflection, appeared more of an accounting for Anne's decision not to take her medications, not to comply, then about her life and illness experiences. The patient was essentially being held to account for her actions under the pretense of helping the residents to understand her circumstances. In other words, the issue here became one of medical compliance versus medical adherence (Brodwin 2010; Dorflinger and Auerbach 2013; Hunt, et al. 1989; Trostle 1988). A truly medical adherence driven approach is more in keeping with family medicine's values, wherein the patient and physician are partners and negotiate mutually-agreeable treatment plans.

Further, why was this debriefing done away from Anne? Like the conversations related elsewhere in this chapter, these encounters seemed to end when the patient's immediate usefulness had ended. The learning and debates took place away from the patient. Yet Dr. Tandon urged that Anne would benefit from this encounter as well, perhaps learn something from the doctors. What exactly did Anne learn? Was it ever expressed to her how important her story was or what the residents may have gained from her telling it? So while the embodied behavior of hearing patients' stories was better related in Dr. Tandon's approach, the tacit value remains: the patient was secondary to the learning of the residents. The residents deflected away from Anne's story to relate other encounters.

In specialties, like palliative care, where care is often non-curatively oriented, Anne's story may have been more-easily grappled with. A more-narrow focus on curative practices is more in keeping with biomedicine more-broadly, suggesting less emphasis was placed in the habitus on patient-centered practices. Efficacy was measured by evidence of physical recovery, or at least that the residents did something hands-on for the patient. Listening only became an option when curative options were no longer available. Less often was assisting a patient in coping, understanding, or finding acceptance a measure of efficacy.

Problems aside, Dr. Tandon was able to demonstrate a way of reframing the problems, expectations, and normative behaviors of both doctors and patients, to show the residents an alternative way to make meaning in their work. However, I saw hesitancy in the residents towards taking on this approach. Did they find the approach to be meaningful and appropriate? How do the residents absorb this kind of lesson? My field notes bear no other instances that approach patient-centered healing practices more closely than Anne's encounter with the residents. This was one good, albeit problematic, encounter. Could more have been done to place these family medicine residents more firmly on the path to following their own values; to move beyond healing rhetoric to clearer healing in practice?

Discussion

In studying the bedside encounters explored in this chapter, I witnessed a complex array of unexpected things. These included a heavy focus on a disease-centered, biomedical approach, direct patient-physician interpersonal conflict, a level of discomfort with hearing and incorporating patient concerns, and reliance on

authoritative approaches to medicine. The role-modeled behaviors were inconsistent with family medicine's values and object. Residents seemed to struggle to engage directly with patients. However, I found some instances of deeper engagement as the physicians' attempted to reflect on their experiences and reach new understandings of their patients.

In revisiting these encounters, a number of important educational issues emerge. First, the place of patients in these encounters was highly problematic and often they seemed almost removed from the encounter entirely. This removal happened either through a narrow focus on disease or symptoms or through holding key meaningful discussions away from the patients themselves; both suggestive of a misplaced focus away from family medicine's object of patient-centeredness. Second, when patients were more directly involved, the discourse and behaviors often turned paternalistic and authoritarian. The physicians too often moved towards dispositions and goals that focused more on their own agendas than those of the patient. As a result, the mentors provided limited ways and tools to engage more thoroughly with the patients. Thus, the learning moments did not always engage with patients productively or family medicine's values in a deep, critical way. I will address each of these issues as they relate to healing, power, and the professional socialization of the residents.

Repeatedly, we see that patients were treated as objects of inquiry, as an exemplar for learning about disease symptoms and treatment regimens. While this was a teaching hospital, wherein the patients were made aware that learning activities take place, the values of family medicine – communication, patient-centeredness, and relationship building – would suggest more could have been done to engage the patient

directly. The patient with the distended stomach disappeared as a person as the residents observed their attending physician push on his stomach. Dr. Sloan did teach an important diagnostic technique, one the residents might use repeatedly in their careers. However, the team did not elicit his perspective on his experiences beyond brief comments about the difficulty of his situation. This encounter became an exercise in developing the residents' understanding of the patient's disease. The patient became an "interesting case", taken as prima facie valid for their instructional needs and educational value in diagnosis without context for the patient.

Challenging patient encounters resulted in a tension between the patients' sense of their own agency and the dependency on the physicians that often comes in seeking treatment for sickness. These ideas are mentioned in the wider literature too (e.g., see Moncrieff 2014; Bosk 2003). The physician works to "return" the patient to a state prior to disease, while the patient has other hopes and goals. Thus there was a discrepancy between what the patient hopes to receive from the doctor and what the doctors attributed as "progress" and "treatment" (Canguilhem 2012: 53). When these discrepancies occurred, as was seen with Dr. Sharma, patients were frequently managed paternalistically. The physicians exercised authoritative power to attempt to control patients rather than engage in collaborative communication towards improved understanding.

The patient encounters involving Dr. Sharma most clearly illustrated this power dynamic. With the patient who wanted better symptom management, the physicians' approach suggested that what the patient needed to do was give up his "stubborn position" and allow the doctors to do their job. From the physicians' discussion, I

surmised that the patient had a very detailed plan on what was best to do to address his particular symptoms, a plan with which the physicians disagreed. Dr. Sharma asserted that she eventually won him over by reframing the problem – to focus on the disease such that the symptoms will be resolved through treatment of the underlying cause. However, she described staring at him until he relented. The interaction here between physician and patient was strained, yet from the physicians' perspectives Dr. Sharma had appropriately resolved the dispute. I was troubled to find that the patient's perspective about this encounter were not a part of the physicians' discussion, nor were reflections on Dr. Sharma's intense management approach. Both patient encounters involving Dr. Sharma clearly conveyed messages about hierarchical power and a doctor's ability to force patients into compliance through "pulling rank". While these ideas are rooted in the history of biomedicine with a long-held tradition of physicians being in charge and expecting patients to comply, this dynamic was not something I expected to see so widely demonstrated in family medicine's approach to education and medical care.

Reflecting back on this encounter, I was troubled by this contradiction between the words Dr. Sharma used and the behaviors she demonstrated for the residents. Despite her patient-centered rhetoric seen here and in Chapter 7, Dr. Sharma demonstrated an outward disposition that did not conform to the values of family medicine, one that spoke to "how you handle patients who won't listen to you". The act of speaking *to* patients, rather than speaking *with* them, left the patient out of those interactions. The conflict focused the residents and attending physicians onto the technical strengths of their profession – that they knew how to diagnose and treat and

the patients did not. Further, these encounters sent the message to new learners that this behavior was permissible. The message sent to the residents was not a healing one. Instead, it was that patients' wishes and the patients themselves need not be taken into account when those wishes contradict the physicians' assessment of best practice.

Practice theory helps us to make sense of this contradiction. Habitus has generally been characterized as largely unconscious; that values and ideas become deeply encoded and subtly influence behavior. However, as shown, a great deal can be learned from discourse that occurred in the educational habitus, where ideas and expectations were verbally laid out and explained, and residents expected to take on particular dispositions discussed the work they were performing. The central premise of education in the field was role-modeling and the presumption of imitation fueled by the prestige of the attending physician. Words however did not hold the same symbolic capital, same authoritative mentoring power, as the actions the residents witnessed.

Seen in another light, the conflicts between Dr. Sharma and her patients were essentially about "getting rid" of patients. Terry Mizrahi (1986) speaks about an important dichotomy in patients from the perspective of resident physicians, the ideal versus the despised. This split, according to Mizrahi, causes physicians to attempt to "get rid of" patients who were labeled as self-abusing with drugs or alcohol, system abusers who manipulated the house staff into "getting their way", or difficult, demanding, suspicious, hostile, or otherwise "disrespectful" (ibid: 77-8) patients. Both of Dr. Sharma's cases were in some senses "despised" by the physicians and efforts were made towards their removal.

Pain management served as a symbol of this critical patient-physician power dynamic. The discourse around this woman's request, about "fueling addiction" and being a drug pusher, being "blackmailed", certainly suggested that the physicians were no longer considering the patient, but focused on their own power and claims to medical expertise. This perspective on patients was something Mizrahi (1986) points out as essentially "blaming the patient" for any challenging dynamic in a patient encounter. The values of family medicine, their patient-centered object, disappeared when challenged. The discourse became a paternalistic exercise in showing to each other that they had done the right thing. That this discourse occurred while the attending was not present was equally troubling in that the residents were embodying this approach to challenging patients and had begun taking on the disposition as previously demonstrated.

In most cases, there was little concern for the patient as an experiencing, social individual – only the disease seemed to matter and its resolution would prove the physicians correct. Kleinman (1980, 1988, 1995) states that without attention to the personal and social experiences, the techniques and practices of Western physicians, while often curative, are not entirely healing in nature. Canguilhem (2012) points out an underlying difference between physicians and patients in terms of the goals of health, treatment, and healing. Each hopes to have his expectations met. The doctor's success is in fixing the body. The patient's success is in reestablishing his place and relationship in the social milieu, to understand and find meaning around the disease (Geroulanos and Meyers 2012). So therefore, in the encounters I observed, healing came to focus on treatment of disease, not the broader sociocultural and personal concerns of patients.

I now return to the case of Anne. Here, I had expected to see family medicine's object most clearly demonstrated. The dynamics I have outlined above were still apparent, though in more subtle ways. As someone nearing the end of her life, Anne was both depressed and dying from AIDS. How might her treatment have been handled differently if she had been admitted via different specialties: infectious disease, palliative care, psychiatry? Should not family medicine, with its own patient-centered values and object, have had something more to offer a patient like Anne?

Dr. Tandon felt that the best approach, as a physician, was to bring Anne to better understand her illness, to manage her other health concerns, and to help her address the complex issues she was experiencing at home. However, Anne was having the actual lived experience and knew her illness as an insider. The physicians did not need to help Anne understand her illness, rather the other way around. The doctors could help her understand her trajectory and what may happen with her disease. The idea of helping Anne was good, if misguided. The physicians seemed unaware of the inverted dynamic and how it reinforced medical authority in a way contrary to family medicine's values and object.

What then could the team of physicians do for her? The attending physician elected to choose her as a "learning pearl," to bring Anne before the inpatient residents and have her present her story. Medicine has begun to see storytelling as "not only valuable diagnostically but therapeutic in itself" and in this case a potential alternative when curing fails (Alcabes 2015: 81). However, the team did not seek to understand Anne's account, but rather address their own powerlessness and own motivations. By asking her why she did not take her medications, the physicians were calling her to

account for her actions. They were displaying a sort of paternalism that acknowledged her choice but called her to explain herself. As a result, I feel that what the physicians did was contradictory to patient-centered family medicine. Anne's sense of agency, sense of peace in her own decision, was pushed aside in favor of the physicians' perspectives.

Something was accomplished in this bedside rounds encounter, but I am troubled by what was not accomplished. This exchange demonstrated how the residents and attending physicians experienced complex negotiations around healing idioms when it came to their patients expressed desires. The attending physician began by expressing interest in Anne's own story, but proved to be still largely driven by questions of compliance and what the doctors could have done to sway Anne's decision-making in favor of their interests. In the end, the approach I observed remained highly focused on the physician, focused on issues of effectiveness and medical efficacy, about what patient behaviors could have changed to better assure medically successful treatment. To subjunctivize for a moment; such an encounter would appear much differently were a physician start by telling the patient that he or she wanted to better understand the patient's viewpoint. Instead of placing focus on the explanation for non-compliance, they could focus on the patient's perspective first and what they could possibly achieve together.

Thus, the entire encounter, on later reflection, appeared to be more of an accounting for Anne's decision not to take her medications, than better understanding her life and illness experiences. In other words, the issue here became one of medical compliance versus medical adherence and the goal of helping the residents to

understand her circumstances became a pretense. An approach driven by a model of medical adherence would be more in keeping with family medicine's values, wherein the patient and physician are partners and negotiate mutually agreeable treatment plans.

Again, following Canguilhem, healing is a discursive entanglement between patient and physician, intended to explore the patient's subjective experience and engagement in her social milieu and attempt to help the patient restore a sense of normalcy, even in the face of failing to cure. Yet there was no discourse, per se, with Anne. She provided her brief accounting and left. There was little back and forth, merely Dr. Tandon's questioning to provide evidence to the residents, not just of Anne's social experiences and decision-making processes, but also for the discourse that would occur when Anne left. In order to manage their own powerlessness, they pushed Anne into a corner that forced her to account for her decisions.

As with the conversations related elsewhere in this chapter, the meeting with Anne seemed to end when her immediate usefulness had ended to the physicians. The learning and debates took place away from the patient. Yet Dr. Tandon urged that Anne would benefit from this encounter as well, perhaps learn something from the doctors. What exactly did Anne learn? Was it ever expressed to her how important her story was or what the residents may have gained from her telling it? In specialties like palliative care, where care is often non-curatively oriented, it may have been easier to grapple with Anne's story. Instead, the residents moved away from Anne's story to relate other encounters and expressing their frustrations. The information obtained was used to vent frustrations about other patients.

Anne's case suggests what Luhrmann refers to as "complex empathy" (2000). Simple empathy involves caring for a patient through treating the basic disease, feeling empathy for the patient's experience while moving towards treatment. The doctor is the technician, feeling a "moral urgency in removing this blight from the earth" (ibid: 277). The empathy, Luhrmann claims, is simple because the problem is simple. The case with Anne was not simple. She was dying. She had not taken the medications that may have prolonged her life. A complex empathy would have better addressed and incorporated these facts. The physicians did not demonstrate the empathy needed to accept these facts, to see the decisions and the disease as part of the whole person. In Luhrmann's words, describing a patient with severe depression, "to empathize with him is to empathize with his self-destructiveness as well as his despair" (ibid). Simply empathy works only when the disease is circumscribed and eventually will go away. Complex empathy becomes a deeper challenge and requires finding other ways to be the healer.

Further, the ethics of helping patients near the end of life call into focus other notions of healing and wholeness. I take this to mean, in Anne's case, that the part of healing may involve helping a dying patient engage with their social milieu and perhaps help a patient face death with dignity (Boyd 2000). Just listening to what she had to say about her lived experience of realizing that she was reaching the end of her life held value but required humility to realize that biomedicine may not have an easy answer to give here. Instead, the team spent time away from Anne discussing their powerlessness and feelings of ineffectiveness. Dr. Floyd's words – "we cure sometimes. We treat often. But we care always." – ring as a rhetoric; empty words without clear definition. The team could not cure Anne. They attempted to treat Anne. Dr. Tandon talked about not finding

Anne's "motivation". They still attempted to sway Anne to their goals, to their paternal sense of what was in Anne's best interests. They did not acknowledge Anne's agency to make her own decision. They fixated on the loss of her previous state and their inability to restore it. They sought acknowledgement that they had "done everything possible" and therefore had made no technical errors as doctors (Bosk 2003: 170). How do the residents absorb this kind of lesson? Could more have been done to model a patient centered approach and place these family medicine residents more firmly on the path to following their own values; to move beyond healing rhetoric to clearer healing practice?

In closing, the story the physicians told themselves was at odds with their practices. The rhetoric used by faculty members and residents showed that the ethos of family medicine was used to rationalize the behaviors I observed. Disturbingly too, the residents often appeared disinterested in what was happening in these circumstances. Had they been taught to have the view that there was always more important work waiting? What does that learning outcome have to do with trying to become a healer in family medicine? The role-modeling I observed, and the taking on by residents of the demonstrated dispositions, left me with concerns regarding the sort of healer being made. I have shown that the observed practices were most often curative and/or technical in nature and did not involve healing entanglements with patients. An approach to healing that embraced and incorporated patients' social milieu and sense of normative experiences into the treatment of disease did not mostly occur. The paternal, authoritarian model of curative care was not in keeping with what family medicine says about itself and its values.

I remain troubled by these encounters. The values of family medicine – “patient-centered”, “holism”, or “understanding the patient” – became signifiers that were not consistently seen in my observations. They were empty in the sense that whatever situation the team encounter, the rules of behavior could change. “More ideal” patients could be interacted with quickly and effectively without fuss, and the “despised” patients moved to discharge as quickly as possible (Bosk 2003). Most critically, the role-modeling from attending physicians, charged with establishing the standards to which residents should aspire, sent a clear message that this sort of treatment towards patients was normal and expected. The physicians found ways to excuse their behavior, shifting blame onto things like time management issues, patient behaviors, or their own inexperience. Further, the faculty members showed the residents just how to do some of these things. In closing, I turn now to my conclusion, and summarizing my exploration into the making of physicians in family medicine, the particular definitions of healing, and the local engagements with family medicine’s object. Despite some of the serious problems encountered here, I remain hopeful that something good can come from this critique offered – to be useful for thinking about family medicine residency training going forward.

CHAPTER 9

CONCLUSION

This dissertation set out to identify and describe healing and the making of healers in the context of an American family medicine residency training program. In doing so, I came to understand the challenges inherent in conceptualizing healing, socializing residents into their new professional role, and the complexities involved in engaging with family medicine's object. As shown, scholars in anthropology, history, and medical education have studied cross-cultural notions of disease etiologies and how these mold medical practice (Foster 1976; Kleinman 1980; Good 2005; Lock 1984; Press 1980). They have also investigated how historical and cultural contexts impact medicine (Ludmerer 2015; Janzen 1978), and cross-cultural differences in practices marked as healing (Foster 1976; Glick 1967; Good 1977; DelVecchio-Good 2013; Luhrmann 2013). Scholars in anthropology have refuted notions that Western medicine is somehow unique as compared to medical practices elsewhere (Sinclair 1997; Davis-Floyd and St. John 1998; Konner 1987; Luhrmann 2000; DelVecchio-Good 1995). Further, there are particular ways people in different cultural contexts move through the process of becoming healers (Rivers 1924; Levi-Strauss 1963; Evans-Pritchard 1937; Womack 2009). I began from the premise that the contextual nature of ethnomedicine means that the practices used to identify, understand, and treat disease are culturally-constituted and molded. These would be influenced by local patient and healer expectations, contestations of power, and larger social institutions.

What made American family medicine such an interesting case to think about is how it shares practices with other biomedical specialties, yet family physicians consider

their specialty to be different than other specialties. I have demonstrated how, in some ways, family medicine is surprisingly firmly rooted in biomedical practice here. Steeped in history and molded by broader institutions, family medicine is a product of a broader biomedical world, one which it simultaneously fits into and resists. At Suburban Family Medicine, the “noise” of all the technical practices and related cultural capital too often obscured the more holistic, patient-centered values of family medicine. In the tradition of studying healers, all of what I saw enabled me to explore the ways in which residents come to understand and embody the values, techniques, and knowledge of family medicine. What did I learn about how residents work towards becoming healers and something new in this family medicine residency training program?

Conclusions on the making of healers at Suburban Family Medicine

To answer the question above, I must think more about how the local conceptualization of healing in Suburban’s residency program fits into to the broader cross-cultural literature on healing. During my fieldwork at Suburban, I saw many instances in which healing was discussed and definitions of healing directly negotiated in particular moments of learning and patient interactions. Tapping into their specialty’s particular historical and cultural context, the physicians often verbally expressed deep caring about family medicine’s object. This sentiment was demonstrated by the near constant discourse I observed around established values like “patient-centeredness,” “holism,” and a “cradle-to-grave” philosophy of healthcare delivery. Faculty and senior residents also demonstrated a verbal dedication to teaching these ideas. Residents frequently cited the ideals of family medicine as the central reason for choosing the specialty. What I saw in education and practice though did not yet show them becoming

family medicine doctors who fully embodied the values and object of this specialty. Why was that the case?

At this point, I must return to literature introduced in Chapter 1, where the question is posed of whether it is even possible to have healers in biomedicine. From early on, Kleinman's (1980, 1995) position was that doctors in biomedicine may be incapable of healing. He postulates that without a focus on patient illness experiences, Western practitioners may be ignoring broader sociocultural factors of health. Further, Canguilhem (2012) argues for a critical difference between patient-centered healing and curing; the former necessitates the subjective accounting from the patient to determine efficacy, as compared to the latter that more often relies on objective medical testing and bodily outcomes. I must now further reflect on how these ideas go with the local medical practices I observed and whether healing can happen here.

Very often, I saw medical education practices that resulted in producing technicians of the body. Too often such practices being validated by the educators encouraged residents to be most engaged with treating disease over more deeply engaging with patients. This approach, to cure first and attend to the patient's state of being second, is at odds with family medicine's values and ideas about healing (Jagosh 2011; Shahady 1993; Stephens 1982). The success of the healer is supposed to be based on his or her patients' sense of their own new normal following their illness experiences (Canguilhem 2012). Yet the way healing was framed and validated through demonstrations by and the expectations of the faculty showed that the treatment of disease was more often more highly valued than patients' illness experiences. This leads one back to the original question of whether healing in biomedicine is feasible

when framed in curative terms. The residents became professional biomedical physicians. They were able to discuss issues of a patient-centered nature, but took actions predominately featuring curative measures. The observed dissonance between healing discourse and healing practices was the main subject of each my findings' chapter discussions. There I show over and over again how a healing approach was constantly spoken about but ways of diagnosis, treatment and doctor-patient interaction reflected something quite different.

I found that physicians at Suburban Family Medicine used, swapped, and exchanged definitions of healing throughout different patient and learning encounters, sometimes in a matter of moments. As a result, healing became an open space wherein meaning was individually- and collectively-made and contested. In turn, these idioms and rhetoric around healing, family medicine's object, and residency program values directly shaped medical practices, expectations, and dispositions. I return to a quote from Dr. Levine:

It may not be medicine as the general population thinks of it, but I think that healing comes in all different forms. And if you can make a person feel better even for the fifteen minutes that they're sitting in your office then you've made a difference in their lives (Interview: November 15, 2102).

The open nature of what healing could be is reflected in her quote. How physicians engaged with defining and practicing family medicine healing within and across the training habitus needs to be further considered.

From orientation on, program leaders laid out expectations for the work ahead, framing doctoring in a way that was bound up in the day-to-day work of managing bureaucracy and patients, often in that order. This trend continued in the program's training as the new residents more completely took on their roles as residents, shaping

their approach with patients. As seen in Chapter 6, the chief resident, Dr. Tao, spent considerable time explaining admissions, patient charts, and how the interns were to perform the bureaucratic tasks necessary to diagnosis and treat patients. Dr. Bonowitz and Dr. Pryde both spent considerable time with their mentees explaining computer systems, test ordering, and obtaining consents from patients, though without instruction on how to engage with patients directly. Dispositions like “embodying the role” and “being the doctor” were, in these cases, operationalized in explaining and demonstrating techniques needed to successfully navigate the bureaucratic social system of medicine, rather than focusing on interpersonal practices with patients. Resisting this system was not well-tolerated, as evidenced by how residents were taught to think about working to quickly discharge patients, particularly the most “difficult” patients on the inpatient service. These findings were jarring to me – as they were not what I was necessarily expecting to see given family medicine’s stated values and object.

In thinking about larger structures overall, I also observed how the particular structures of time management requirements and insurance regulations greatly shaped the medical practices of the physicians. The time required to nurture family medicine’s object – the relationship with the patient – was challenged by the requirements of fifteen-minute office visits and high patient turnover. “There’s never enough time” was a common lament from residents struggling to balance complex patient concerns, paperwork and other bureaucratic requirements, precepting, and a full schedule of other patients waiting to be seen. Residents could be weeded out, and even careers halted, if residents were not perceived to be learning these lessons of time and patient management adequately and quickly enough. For example, Dr. Johar and Dr. Ramsey

struggled with time management challenging their ability to achieve competency and prove their ability as physicians. While all the factors that went into Dr. Ramsey's dismissal were not fully made clear, his inability to keep pace and prioritize certain valued aspects of efficient medical practice were highlighted as contributing factors.

Most often, healing practices were defined by discourses that emphasized medical techniques towards the recognition, diagnosis, and treatment of disease symptoms within a patient's body. Canguilhem warns that contemporary medicine was founded on "the progressive dissociation of disease and the sick person", resulting in an approach to patients that "characterize the sick person by the disease" (2012: 35). This sensibility was most clearly illustrated in the precepting negotiations outlined in Chapter 6. Consider Dr. Rana's patient who contested the physician's ideas about exercise. Likewise, recall Dr. Johar's patient who was only concerned with a sinus infection while Dr. Johar had many issues she wanted to address with her patient. Both instances illustrate a focus on performing curative and preventative medical practices rather than negotiating more holistic health-related goals with the patient him or herself. Though both were deeply concerned about their patients, they still did not approach these issues in a patient-centered way. By focusing on the form of doctoring that had been role-modeled for them, the residents were less successful than they might have been as healers. What good is a deep caring for patients if the resident did not get closer to the patient's own ideas about health? What is actually achieved without arriving at mutually-negotiated and agreed upon goals? In keeping with family medicine's object, residents would be better able to embody family medicine's values if training included patient negotiations and related goal setting from the outset.

To further illustrate the ways the doctors moved away from family medicine's object, recall the behaviors role-modeled by Dr. Sharma in Chapter 8. Her disposition was one where physicians know best how to restore health with or without the patient's agreement. The patients who contested Dr. Sharma's diagnoses or requested pain medication as a condition to leave the hospital were managed aggressively. Her significant symbolic capital meant residents and other faculty physicians viewed her approach as one to emulate. What does this example say about the training of healers in family medicine when the specialty's values and object are minimized in these situations?

Further, I saw other attending physicians like Dr. Thomas, Dr. Douglas, or Dr. Sloan display paternal behaviors towards patients while educating the residents. To illustrate, Dr. Douglas was eager for Dr. Sharma's intervention with challenging patients on the inpatient service. Dr. Sloan failed to explain to her patient the intent of her bedside rounds. Dr. Thomas did not negotiate alternative methods of communication with his patient who could not speak. All of these attending physicians were committed to the educational goal of producing good family medicine doctors; yet these instances show that more needs to be done to better consistently convey and model what healing practices in family medicine could and should look like.

The daily rhetoric I observed mobilized a particular image of family medicine, where residents and faculty members posited family medicine as more caring, more nurturing, and more effective than other specialties. Residents were especially eager to espouse family medicine's superior approach, that family medicine "does it better". In one-on-one interviews, they frequently conveyed these sentiments that they had been

taught and believed. In Chapter 6, for example, Dr. Pryde asserted that those who chose to become family doctors are “just more dedicated to the patient”. In Chapter 7, Dr. Levine placed emphasis on family medicine’s holism, balancing patient’s broader social concerns with her medical practices, and the idea that “healing comes in all different forms”. In most cases, as shown through their interviews, residents discursively cited family medicine’s dedication to patients as the key motivator for choosing the specialty.

Yet, the varied definitions of healing directly affected medical practice, therapeutic efficacy, and outcomes for patients. For example, I return to one of Dr. Rana’s patients, the middle-aged man who had ideas regarding exercise and weight loss that were different from the doctors. The physicians expressed more concern about enforcing their own interpretation and claims to knowledge about appropriate levels of physical activity than understanding or incorporating the patient’s point of view. The patient’s position was pushed aside; he was considered unaware of the medical facts. What would have happened instead if his ideas had been better explored and validated through acknowledging his different claim to knowledge? That the patient would eventually agree to the doctors’ plan seemed taken for granted. Can this ever be seen a form of family medicine healing?

Further, recall Dr. Sloan’s patient with the distended stomach. Dr. Sloan approached bedside rounds in a manner that positioned the patient as an object of learning. Though Dr. Sloan expressed a basic level of empathy, her approach was focused more on her pedagogy than the patient’s feelings or situation. The residents were visiting the patient, not to understand his experiences, but to learn. The patient

was not told this explicitly and received no insight into the physicians' findings. Conversations about this man's condition happened in the hallway, away from the patient and without his input. The expected capital and attendant disposition to take on was that the patient himself was at that moment less important than the sign or symptom being observed. The learning moment was not designed for residents to become entangled with the patient's story or help him explore his experiences.

Finally, the last encounter presented involved the HIV+ patient Anne who was dying and had decided not to take her prescribed medications. The educational experience was framed as the doctors' gaining understanding of why Anne chose not to take the medications and that it would be beneficial for all to discuss this issue together. This ethnographic example illustrates how even when certain pedagogical activities were described as also having patient-centered intentions, physician-centered issues still dominated. Despite Dr. Tandon's framing of the encounter as meant to be helpful for everyone involved, the residents reframed the conversation away from Anne and towards their own sense of frustration and failure. Anne's story led to a lengthy discussion about failure to cure and what the physicians' responsibilities are following a failure. In private reflection, the conversation quickly became more about the "noncompliant patient" and feeling "ineffective" rather than reflections on Anne's agency, lived experiences and possible healing process in late life. Dr. Tandon's message, that walking the path with the patient was something to do when curative measures fail, placed family medicine's values into a secondary role, something to do after biomedical treatment fall short. The rich potential learning about healing in Anne's story was overshadowed by the residents own concerns over their competency. This example

which I thought would be most promising turned out to be particularly troubling in considering what the state of learning about healing may be in this residency training program today. Although how the activity happened left much to be desired, Anne's story can be seen as a jumping off point for thinking about how to better train family medicine residents about healing.

Fitting my ethnographic findings into the broader literature

I conclude that the varied ways physicians in the family medicine residency training program spoke about healing, yet often engaged in contradictory biomedical practices, directly hindered the making of healers. Using practice theory, I found that the educational habitus exposed residents to the work of being doctors, to learn to diagnose and treat disease – though not necessarily to fully take on the dispositions of family medicine and mobilize healing in practice. Through “prestigious imitation” (Mauss 1973), the residents became doctors. In fact, the resident often came to act as if he or she already possessed the skills being taught (Luhmann 2000). Residents moved towards autonomy, competency, and graduation, through the accumulation and negotiation of cultural and symbolic capital. To some extent, they negotiated discursively with values of the specialty like “patient-centeredness” and “holism”. Together, these processes most often led residents towards increased competency, promotion, and eventual graduation.

Ideas about apprenticeships from the broader anthropological literature on the making of healers were found to be at work here too. In ways similar to making healers elsewhere, residents frequently cited notions of having experienced a calling to their chosen specialty and a sense that their interests and skills would be a close match to

family medicine's values. They possessed innate abilities (Womack 2009) that initially led them to family medicine, shaped how they undertook their apprenticeship in the process of "becoming", and ended their training with the social-recognition of "becoming a doctor". But was the resident made into a healer yet? I conclude that, to a certain degree, they were. Although I have shown that complexities arose around taking on family medicine's object and negotiating different definitions of healing practices towards patients, it can be said that these key steps leading to the making of healers did go on here. Many questions remain though that merit further exploration about what a successful family medicine healer actually is, how family medicine residency training can start the life-long process to becoming a seasoned healer, and what must occur to begin that process properly with newly credentialized doctors.

In some key respects, the educational patterns in Suburban Family Medicine followed patterns similar to those seen in making healers elsewhere. For example, the relevance of Levi-Strauss' story of Quesalid illustrates well the value of still making these cross-cultural comparisons. Despite Quesalid's misgivings of the healing tradition into which he was being immersed, the new healer came to take on and appreciate the efficacy of his tribe's approach to healing. Likewise, the residents in Suburban Family Medicine not only accumulated cultural and symbolic capital, but were exposed to and took on certain values encoded in the expected dispositions. The newer residents, like Quesalid, acted with a greater certainty in their own skills than they actually possessed, until these skills became a part of them. Observing mentors with the symbolic capital to expect new behaviors from them led the residents towards ways of being that conformed with local ideals of what makes a "good doctor". Like with Quesalid, the local

history of healing discourse and practice shaped the approach to healthcare delivery and led to the production of social actors of a particular type. Again, the question remains of whether this type of educational process results in the production of a doctor who can rightly be classified as a healer for the family medicine specialty. The history of family medicine illustrates this tension further, detailing how the structures of medical specialization shaped family medicine's generalist approach towards biomedical diagnosis and treatment and away from family medicine's values (Ludmerer 2015; Stein 2006).

As discussed in the broader literature, I came to see that how the learning is staged and transmitted in family medicine education may affect whether the making of healers occurs. Sinclair's (1997) distinction between a "basic" and an "advanced" medical habitus suggests that taking on and demonstrating new skills and expert knowledge occurs in a stepped way. First are the behaviors and attitudes that one was first exposed to as a medical student, and come to take on early in residency – how to write reports, how to take a history from a patient, how to present information back to a supervising physician. However, time management constraints often left residents without space in their day to reflect on the deeper place of healing in the habitus. They quickly learned what the program priorities were and how to succeed as a doctor in this high pressure environment. Later on, as Dr. Wen commented, activities like precepting began the transition towards more complex thinking, integrating patient experiences in disease profiles, and better managing the hierarchy of how physicians and teams work together. However, based on my findings, I contend now that this educational system may well be setting family medicine residents on the path to becoming healers too late

in the process. My findings show that the place of patients in the learning encounters was problematic from the outset and set up some bad habits for the residents to potentially need to “unlearn” as future healers. My findings also illustrated how patients’ needs were too often treated as secondary to physicians’ own concerns. Going forward, it would be valuable to continue to research the larger and long-term impacts of learning being staged in this way.

On a related note, Luhrmann (2000) and Messinger (2003, 2007) conclude that different specialties shape the work of making new doctors in unique ways. Luhrmann shows how psychiatric residents are focused on a particular set of diseases, techniques for treating them, and skills at communicating these treatment plans to patients. Their object, in other words, molds their approach to healing in particular ways. As with Luhrman’s study, the Suburban residents were focused on their particular set of diseases and treatment strategies. Family medicine’s object of inquiry was shaped by the “common things” seen in primary care that Dr. Hedges referenced in Chapter 7. What I make of this focus on treating everyday diseases and concerns is that the specialty’s curriculum, in placing clearer focus on their particular object, could well accommodate an earlier introduction of the concepts of what makes a family medicine healer and what such a healer looks like in practice.

In addition to when and how the residents come to engage with their specialty’s object, another dimension that merits further consideration is how the treatment that residents themselves receive during their training affects their learning processes. Messinger points out how the struggles inherent in “becoming” often leads residents to focus on their own experiences and difficulties they encounter, rather than those of their

patients. The psychiatric residents in Messinger's study came to be closed off from their patients through harsh treatment from both attendings and other patients. In numerous instances, I saw similar patterns at Suburban. While the residents at Suburban were usually treated well in their training, some saw the harshness of mentors as appropriate or necessary. When residents were debating teaching awards, harsh treatment from attending physicians was sometimes admired and framed as essential for effective learning. Accepting this harshness empowered mentors to expect demonstrated behaviors from learners. On the other hand, the harshness of Dr. Ramsey's situation remains a stark reminder of the possibility of failing to become a family medicine doctor. The question remains of whether Dr. Ramsey was in some ways moving towards becoming a family medicine healer, despite significant problems he had in meeting the practice standards of the residency training program. Therefore, to emphasize what I have said before and underscored with my data, what the mentors expect and how well those expectations incorporate family medicine's values and object truly become of critical importance here. Taken together, and echoing the literature, the educational processes I observed illustrate the important ways in which residents became family medicine doctors, though not necessarily healers.

In addition, how do power dynamics in the process of making new family medicine doctors further complicate the making of healers? The social system was, as Ortner (1984) points out, "powerfully constraining" on the actions of the new physicians. The "established order" (Bourdieu 1977), steeped in the history of family medicine as a specialty, resulted a set of practices that were themselves heavily molded by biomedical practices. Further, Rouse (2007) points to how the quest for authoritative knowledge

influences the actions of those attempting to acquire said authority. Taken together, the power faculty members carried – claims to expert knowledge, to pass or fail a resident, to bestow marks of progress and competency – motivated resident behaviors towards meeting expectations. The preceptor called on the history of medical science and the normative patterns of patient interaction to expect the residents' actions to shift into line with the expectations of the habitus. Efficacy was measured most often in the objective results of treatment regimens. Further, demonstrations from faculty attendings were normalized by virtue of the structure of evaluation and promotion. The resident progressed in the program by accepting what was taught and meeting expectations. The end result would be “good family medicine doctors” as defined at Suburban, through competency, expert knowledge, and eventual graduation.

What does this educational process summarized above and its related power dynamics look like in action? How did practice theory help me explore these key issues? First, having learned a great deal in medical school from textbooks and lectures, the residents' first transition was to more active involvement in medical practice and direct responsibility for patients. It was this segue I most clearly observed as residents began to “be the doctor”, seen in Chapter 6. Dr. Hedges explained how the goal of residency was to expose residents to the most common diseases and treatments that fall into the realm of primary care. Further, residents were expected to dress and act in particular ways that demonstrated a shared sense of what is behaviorally appropriate and establish the social recognition of their new role. In this way, the resident came to embody the appearance and attitudes of the family medicine physician while still working to acquire the capital necessary to work as one. Finally,

definitions of progress and competence were often balanced against moments wherein the residents were clearly reminded of their learner status. As described in Chapter 6, didactic lectures, while a source of cultural capital, were often problematic – repetitive or ineffective, coming too late in some cases, as the residents had already encountered patients wherein the didactic information would have been useful. Fundamentally, however, didactics reinforced the overarching disposition of “lifelong learning”.

The overall apprenticeship model, with learners working alongside mentors, was the engine by which the dispositions of the particular habitus were demonstrated and reinforced through hands-on work of medicine, with advice, coaching, and course adjustments from more advanced physicians. As the work of Konner (1987) illustrates the processes of educating residents involved ever-more intense expectations of autonomy and increased “assumption of responsibility” (Konner 1987: xiii), reflected in the changing performances of residents over time in precepting. Mentors held power through their expertise and symbolic capital, to place expectations upon their novices, and reinforced this power through the ability to convey increased symbolic capital to learners as they progressed. The goal was to be eventually able to act autonomously, without the intermediate precepting steps, and to do so competently, as defined by the requirements of the program. I showed how residents learned to interact with patients in some key ways, both precepting (Chapters 6 and 7) and on the inpatient service (Chapter 8). For example, In Chapter 7, we see residents like Dr. Levine moving away from needing supervision, having gained trust and symbolic capital, to be treated more as a colleague. Residents became professionally socialized towards expected

behaviors, and eventually competency, which was both codified in formal educational plans and the discourse around family medicine's object.

However, the educational process became particularly problematic when a guiding mentor's words and actions were not consistent. Dr. Hedges' expectations in the form of milestones and ACGME requirements put distance between the actions of the educators and the stated values of specialty. Particularly, there was a clear rhetoric around creating the best family doctors possible, without consistently engaging deeply with family medicine's values and objects. At some times, mentors' behaviors were paternalistic and overly focused on the restoration of health through biomedical techniques. For example, despite the depth and sophistication of her spoken attitudes towards healing, Dr. Sharma played a major role in the department as an enforcer of sorts to "deal with" and manage challenging patients. She relied on her status as physician to cow difficult patients into acting "better". At the same time, Dr. Sharma could be heart-warming in her approach to patients and espoused listening more to really understand patients' concerns. Dr. Sharma's positionality as a mentor, one who possessed a keen dedication to overseeing her mentees and held the authority to pass on markers of progress and competency, motivated residents towards the behaviors she (and the program) expected, despite the contradictions. As a result, the power message being sent – and the habitus the mentors were creating and recreating – urged residents to attend to the bureaucracy of medical management more than the entanglement of healing through patient understanding and co-negotiated treatment strategies.

In addition, “learning by doing” and “being the doctor” did not mean the same thing to every participant I observed. Dr. Ramsey exhibited many of the traits in Dr. Hedges’ list of hiring criteria and yet his way of “doing” and “being” did not conform to expectations of the program. However, Dr. Ramsey exercised his own agency and attempted to contest the milestones and markers of progress as defined by the program requirements towards more patient-centered healing. He experienced considerable challenges and ultimately did not achieve the expected socialization and professionalization, wherein residents like Dr. Pryde struggled and overcame her learning challenges. Further, Dr. Levine expressed ideas much like Dr. Ramsey’s, yet and was perceived on a path to greater success as a family medicine physician. She conformed better to the program’s norms and was rewarded for it, whereas Dr. Ramsey was ostracized and eventually dismissed. The rich contrasting cases of Dr. Ramsey and Dr. Levine in the residency training program are thought-provoking in terms of what they may say about power dynamics here. In the end, Dr. Ramsey represents the most obvious contestations and complexities around power in the habitus. His actions could be interpreted as an attempt to reject the normative biomedically-focused power dynamic and instead to focus on his own understanding of the ideals of family medicine. Whether his dismissal was ultimately his failing or a bias on the part of mentors remains unclear, due to lacking all of the information and context needed for a final assessment. However, the very different educational trajectories and outcomes of Dr. Levine and Dr. Ramsey show why power dynamics in the residency training program cannot be ignored. Finally, the fact that Dr. Ramsey’s difficulties were not entirely unique remains troubling and an avenue for future research.

Lateral and intragroup power relationships that emerged between residents were intriguing and also merit further exploration going forward. These could be studied by exploring how more senior residents interacted with junior ones as well as dynamics between those in the same cohort. Most clearly, more advanced residents were tasked with mentoring new interns in the daily work of inpatient medicine. Here, these new residents conveyed their own successful approaches to managing their daily work. Further, these instructional relationships often mirrored the expectations of the program towards competency of specific tasks, techniques, and organizational knowledge. This exercise showed some degree of power of the more advanced, second-year residents, reinforcing the normative expectations of the program. For example, Dr. Pryde exercised power over her mentee, Dr. Deepah, through the authority given by the program, to educate Dr. Deepah in the day-to-day work of the inpatient service. Dr. Deepah performed her work well, according to Dr. Pryde, by resisted notions of what counted as real learning. Dr. Deepah had her own ideas, ones that dovetailed with much of Dr. Hedges' notions about milestones and learning to diagnose and treat common diseases.

Residents also pushed back against the hierarchy, contesting the power dynamics within the training environment. Didactics demonstrated how residents were forced to make careful choices about their use of precious time. Further, physicians came together and occasionally displayed their unique capital, demonstrating their perceived superiority over even their faculty mentors. Specifically, I refer to Dr. Probst's display of particular osteopathic techniques in manual manipulation. Dr. Probst possessed cultural capital that she was eager to display, asserting her own

competency. Dr. Levine had achieved a comparable measure of symbolic capital as Dr. Sharma, while remaining discursively dedicated to family medicine's object. However, as I illustrated in Chapter 7, she often retained the majority of the decision-making power in her patient interactions. These examples show why both obvious as well as more subtle forms of residents contesting power would be valuable to further explore in future work.

Finally, I return to the question of whether healing is possible in biomedicine generally and family medicine specifically. The patient experiences the disease as illness (Kleinman 1980, 1988, 1997; Kleinman, et al. 1978), and must find a way to make sense of and reclaim their place in the social milieu (Canguilhem 2012). Herein, the positionality of the patient is different than the physician's and what medicine owes the patient is different than the expectation of that patient. However, when healing is framed as an "entanglement" (Alcabes 2015) between patient and physician, the social dynamic of healing changes, suggesting the importance of multiple actors, each with their own notions about the place and role of practice in the medical encounter. That the training of residents did not often engage with patients on patients' terms suggests the social and professional roles of family medicine doctors remains problematic.

In conclusion, given the way healing discourse and practice were mobilized at Suburban in the training of family medicine residents, was the making of healers achieved? I conclude that while the physicians moved at times towards healing relationships with patients, they remained so bound by biomedical structures that they could not fully take-on family medicine's object in becoming healers. The idea of "regaining" health as described in the literature on healing in biomedicine (e.g., see

Canguilhem 2012; Johnson 2014; Melazzini 2014; Street 2009; Ong, et al. 1995; Kleinman 1980, 1995) remained the primary goal of many of the doctor-patient encounters I observed. The structuring influence of the educational processes, as described above, further shaped this goal in practice. This finding is interesting because many of the physician discourses and patients' concerns I presented would lead one to think the discussion and practices around healing in family medicine would go in other directions. There were good intentions in the educational goals of the family medicine training program, but there was also significant room to grow here. In short, I still have concerns like those expressed by family physician and scholar, Howard Stein (2006), that family medicine has lost focus on its object.

In defense of these enormous educational undertakings, to become entangled in patients' experiences is not easy. Nor is it something easily taught. Some physicians may prefer to leave paternal patterns as they stand, and continue to rely on more direct biomedical approaches to patient care. I contend that while patient-centered healing was something often discussed and yet often remained unachieved, it was not an impossible endeavor as suggested by Klein (1980, 1995) and Canguilhem (2012). Instead, I conclude that it was the creation of open spaces for healing entanglements that was not as actively developed, as it should have been in this educational habitus. Encouraging and opening opportunities for the patient "to achieve a new state of equilibrium with the demands of the environment" (Canguilhem 2012: 65) would mean sharing power, learning strong communication skills, and accepting patients' perspectives. Resident physicians could be taught to engage more deeply with patients by faculty members defining and demonstrating new dispositions, expectations, and

assessments of time management. Given more time with patients, residents could be better instructed towards how to help create these more-open social spaces. These spaces would allow physicians to seek out and incorporate patient concerns and encourage patient involvement in treatment decision-making, providing the setting for patient's own sense-making around their illness experiences and redefinition of their place in their social milieu.

Changes like these would not be easy, necessitating not only adjustments to the educational modalities, but to the structuring expectations of other major stakeholders, like insurance providers. The overwhelming pressures of biomedical treatment standards, time management, and insurance systems limited the time and interactions between physicians and patients. However, I contend that greater awareness on the part of family medicine physicians of the nature and philosophy of healing for this specialty would be a good first step. The pedagogy could then become one that encourages explicit awareness, acceptance of a degree of shared power with patients, and overt novice-mentor dialogues that demonstrate healing spaces between patients and physicians. This awareness could create an explicit learning goal – a new disposition – better situating family medicine's object at the core of the physicians' practice.

I would urge family medicine programs to explore their own definitions of healing, and to see where the values of family medicine can be more overtly integrated into the education of residents. An anthropological approach to residency education highlights the problems that could be better recognized. The improvements in training that medical education is constantly looking for may benefit from a reassessment of the values

encoded in residency teaching and mentoring. The sometimes empty signifiers of patient-centeredness, healing, and holism could be better operationalized and directly wedded to the educational processes. Both curing and patient-centered healing are certainly critical, but could perhaps work more effectively together if more overtly intertwined and understood. Residents could be taught to leave open social spaces – the same open space wherein the physicians wrestled with definitions of healing – such that the patient can make sense of their health and healing for themselves. The challenge however is in investigating exactly how to accomplish such a thing; a possible avenue for further research and exploration that could well-involve medical anthropological input and participation.

Researcher positionality revisited

I feel it critical to return to the issue of researcher positionality, to examine how my own shifting thoughts and experiences influenced my findings and conclusions. Looking back at my time at Suburban Hospital, I was extremely grateful that I was permitted access to whatever I wished to observe. I was often given insight into whatever I asked about (and even many things I did not). The case of Dr. Ramsey is the only obvious place where my access was limited. The faculty physicians gave me permission to participate wherever I felt appropriate, and I was often drawn into conversations or invited to participate on rounds. Over time, I became more cognizant of my self-imposed status as a learner. In a way, they had accepted me as one of their own and I, in turn, accepted that position.

Some residents, especially Dr. Pryde and the others with whom I spent a good deal of time, joked very openly with me. I was playfully teased and told I was one of

them. Some faculty members treated me as another resident, or at least a student they could teach. With hindsight, I realize that at times I uncritically accepted the power differential this entailed. Even the hospitalist, Dr. Thomas, treated me with his disposition of an educator, informing me in detail of patients' medical history and backgrounds. Dr. Wen in particular encouraged my development and reassured me that it appeared to him that my research was going well. Something in my demeanor or these faculty members' character (or both) suggested to them that encouragement and explanation was needed. Early on, my bias towards the role of learner and guest left me to be less critical and more accepting of what I was being shown. As I attempted to rectify this bias, I tended to overcompensate and became overly critical. Following my defense, I approached my data with new perspectives and attempted to achieve a balance between critically examining what I found and carefully checking my assumptions.

Managing being an ethnographic researcher in this setting was sometimes challenging. In some cases, I felt that I was neither fully a resident nor fully a faculty member, but embodied bits of both roles. To see this conundrum, one only needs to return to Chapter 6 when I describe the ringworm episode in detail and how I felt my own power was muted by virtue of my learner's role. What I came to realize through observing the residents – and even conducting my own fieldwork – is that cultural capital is not merely piled on, layer upon layer, until a fully-formed physician is made. Perhaps, competency, a sense of power, and being the doctor (or the anthropologist) was the result of finding oneself with more and more of the answers. The process of

becoming professionally-socialized would then amount to increased confidence and conveyed symbolic capital; that one was progressing in learning and doing the work.

In closing, I will continue throughout my career to reflect on my positionality as an anthropologist, careful to balance the emic and etic perspectives therein. Given my personal background of mentoring in residency education and strong commitment to residents themselves, maintaining close ties to the anthropology of medicine will be critical to my success engaging as an anthropologist *in* medicine. This study illustrated the challenge of physicians engaging with family medicine's object in the broader context of biomedical practice. The making of healers became a complex engagement within an open space of negotiated discourses and practices. The practices of these residents were influenced by the power faculty members held over their training, competency, and social-recognition as autonomous doctors. In the end, there is need to further evaluate and develop the educational habitus towards accomplishing the goal of making family medicine physicians who successfully embody the larger values of the specialty. Medical anthropology offers a robust perspective on the medical educational process; work I will continue into the future.

Limitations and future directions

No research project answers all of the questions it uncovers through the research process. There were topics and events witnessed that inspired new questions and suggest future directions for my research. Some of these take the form of limitations to the present study, while others are entirely new avenues of inquiry. I will now outline some of the more significant topics I hope to address in my ongoing research agenda.

First, the clearest limitation of this study was my lack of direct focus on patients. As healing practices are contextual, and situated within the patient's perceptions of efficacy as well as those of the practitioners, then it stands to reason that increasing my data collection to include patient interviews and perspectives would have better fulfilled some of the objectives of my project. As I continue to question the making of healers cross-culturally, it would also be very useful to include assessments of what patients look for in a healer and what behaviors their medical practitioners should demonstrate. Further, patient insights into the encounters I recorded would have increased my understanding of the power dynamics of patient-provider interactions, the efficacy of family medicine's techniques, and provided a richer definition of healing. I have begun to explore new relevant literatures in all of these areas.

Second, as lifelong learning is a goal of the residency education at Suburban, a five to ten year follow up with the residents I observed would be useful. Further, the cradle-to-grave approach to patient care is difficult to actualize in a three-year training program. Therein, using my findings to date, I could formulate better research questions and specific aims, directed at conceptualizations of healing practices, ideas about the goals and role of family medicine in society, and the long-term impact of the values, techniques, and knowledge imparted and taken on during residency training. Further, it would be intriguing to observe the now board-certified physicians in their daily work lives, to assess the fruition of the seeds of healing planted during their training. Ultimately, I would hope to determine if, with time, the making of healers would reach completion and the former residents would come to more-closely resemble the examples set by Dr. Tandon, Dr. Thomas, or Dr. Douglas, or remain contested and

sometimes contradictory like those of Dr. Sharma or even Dr. Hedges. Revisiting Dr. Ramsey's career trajectory would further highlight the longitudinal process of making doctors and healers in family medicine.

Third, I would more explicitly explore definitions and understandings of the values of family medicine and their role in resident education. Through interviews and more-directed observations, I would attempt to identify and describe more instances of patient-centeredness and holism, a connection with family medicine's object, to ascertain whether a deeper commitment exists that is less obvious than my initial observations would suggest. Further, I would more explicitly apply the healing concept from anthropology to interviews and conversations to explore conceptualizations of the term more fully. The dissonance between discourse and practice would come into greater focus and I could test my conclusions in a more careful way.

Finally, in the short term, I wish to devote time to a more specific topic within the broader value and behavioral system observed in family medicine. Pain and pain management remain a crucial area for healthcare delivery, and yet one that frustrates and challenges physicians. Its subjective nature and resistance to straight-forward treatment left the residents at times resentful of their patients, and challenged the notions of healing as I have defined them in this study. Further investigation, on a more focused topic, would reveal instances where healing occurs or disappears as patients and physicians come into contact with one another.

Concluding thoughts

In closing, I set out to identify and describe the various social processes involved in the training of family medicine residents and the complexities around healing and the

making of healers. This project has only renewed my interest in this line of inquiry, opening many more avenues of discovery, and showed me the importance of a critical, balanced approach to such a complex social undertaking.

However, I dedicated a great deal of effort to critiques of the learning modalities as I observed them. I drew comparisons between the witnessed behaviors and stated values of the specialty, suggesting problems that may be limiting family medicine's ability to realize its own vision for itself. This should not be taken as a dismissal of the important role family medicine has to play in broader society, nor as a condemnation of the specialty as a whole. I have tremendous respect for the incredibly challenging process these physicians undertake. The three years of training are difficult and the faculty members showed continuous dedication to resident training. It is only with utmost care and a shared commitment to family medicine's values that I offer these critiques and evaluations. The doctors welcomed me into their educational and professional lives, humored my bumbling questions and struggles to understand, and ultimately accepted me as part of the team.

I have taken this stance on family medicine and its entanglement with healing practices because of the very respect I hold for the specialty. By presenting a tough critique, I hope I have offered new insights that will help move the specialty forward towards a more complete engagement with the complex philosophical underpinnings of its own values system. I hope my findings and implications find their way to fertile ground, to take seed and help change the face of residency education. In the end, this project has enlightened to me regarding the multiplicity of complex factors involved in educating doctors, the institutional structures that molded who they became, and the

meaning they attempted to find in the process. These physicians have my deepest respect for challenges they face and the important work they do. I offer my findings as a contribution to advancing the educational processes in family medicine – because of the key role that this specialty has to play.

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ABSTRACT**LEARNING ABOUT HEALING IN FAMILY MEDICINE:
MAKING DOCTORS IN AN AMERICAN
MEDICAL RESIDENCY PROGRAM**

by

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Advisor: Dr. Sherylyn Briller
Major: Anthropology
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This ethnographic study identified and described healing and the making of healers in the context of an American family medicine residency training program. The project goal was to describe the training of family medicine physicians through observation and interviews with resident and faculty physicians. The project investigated discourses and practices around healing. The aims of this study included: (1) to identify and describe the educational processes in a residency training program towards professional socialization of residents into family medicine. (2) To describe how the habitus of the residency informed the ways in which residents came to embody of the role of family medicine physicians. (3) To identify and describe definitions of and meaning-making around healing through discourses, practices, and engagement with family medicine's values. Findings showed a range of healing definitions were mobilized in the setting, with attendant discourses and practices. Comparisons were made between the observed practices and expressed values, and those similar values and

behaviors as described in family medicine literature, medical education literature, and the anthropology literature on healers and making healers cross-culturally. I conclude that while the physicians moved at times towards healing relationships with patients, they remained so bound by biomedical structures that they could not fully take-on family medicine's object and achieve the making of healers. Dispositions that forwarded the physicians' greater insights and authority regarding disease and disease treatment often overshadowed the espoused notions of understanding patients' illnesses experiences or aiding patients in making sense of their health and sickness. This conclusion suggests more could be done to help those engaged with family medicine training to better conform to their own culturally-situated values. The result would be residents and future family medicine physicians who more fully embody the tenets of family medicine and the distinct object by which it defines itself.

AUTOBIOGRAPHICAL STATEMENT

Edward J. Rohn earned his B.A. in Anthropology & Sociology at Albion College, Albion, Michigan and his M.A. in Interdisciplinary Studies at Wayne State University, Detroit, Michigan. In this dissertation work, he studied medical anthropology, specializing in the organization and the making of healers within family medicine residency education. He has presented his findings at local and national level conferences including the American Anthropological Association, the Society for Applied Anthropology, and the Society of Teachers of Family Medicine. His current work involves applying his skillset to a cross-disciplinary study of quality of life for veterans and non-veterans living with spinal cord injury. His future goal is to combine his focus on resident education and patient-provider collaboration to the study of pain and pain management for persons with spinal cord injuries. To this end, he has accepted a post-doctoral fellowship position at the University of Michigan Department of Physical Medicine and Rehabilitation.