CHAPTER 3

PUTTING IT ALL TOGETHER: THE CULTURE OF JUNIOR DOCTORS

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

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

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

Table 5. Key themes from interviews.

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

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

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

HOW TO PLAY THE GAME: POSTGRADUATE TRAINING PROGRAMS

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

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

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

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

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

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

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

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

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

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

http://www.springer.com/978-1-4020-1238-9

Medical Education and Sociology of Medical Habitus:
"It's not about the Stethoscope!"
Luke, H.
2003, XIV, 178 p. 9 illus., Hardcover
ISBN: 978-1-4020-1238-9