How can the experiences of stakeholders with doctors inform medical selection and education?

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ABSTRACT

The practice of medicine is complex and challenging. Medical practitioners require a range of capabilities to practice effectively and consistently over a long career. Selection for the capacity to develop these capabilities and education to build them are becoming increasingly important in a rapidly-changing society that demands a return on its investment in medical schools and post-registration training.

Although the range of capabilities required for trainee and graduate doctors is described in the medical student selection and education literature, the viewpoints of privileged stakeholders have generally been favoured in determining them, relative to those most affected by medical practice (and malpractice). This study attempts to address this question from a more inclusive stakeholder perspective, linking ‘capabilities’ to ‘doctor experiences’ in ways not previously reported in independently-refereed research literature. A qualitative phenomenological approach offered the most suitable paradigm for exploring the ‘doctor experience’.

A pilot study was conducted to refine the research question and to inform the main study. For the main study, a total of 107 participants were purposively recruited to represent the diversity of stakeholders in medical practice. Thirty-nine (39) one-on-one interviews were conducted with doctors (13), patients (11) and participants identified as ‘key stakeholders’ (15) because of their medical student selection and education expertise and experience. The remaining 68 stakeholders each participated in one of eight group interviews (as health professionals, medical educators, academics, health executive managers, medical students, patients or community representatives).
The interviews focused on first-person accounts of stakeholders’ experience of their interactions with medical practitioners, which were audio recorded, transcribed verbatim, anonymised and imported into computer assisted qualitative data analysis software. The analytical methodology utilised was based on Smith’s (1996) Interpretative Phenomenological Analysis (IPA).

In order to accommodate the larger-than-usual number of participants for an IPA study, Smith’s method was somewhat modified. All of the data were first analysed descriptively to identify broad categories of experience with doctors and the extent to which particular participants had provided vivid first-person accounts of those experiences. Participants whose narratives were the most deeply experiential and provided the richest accounts of particular doctor capabilities or concerning behaviours were designated ‘signature’ stakeholders for that category and their transcripts were interrogated with the full IPA methodology. This involved meaning-making and interpretation through application of the ‘hermeneutic cycle’. The analysis of these transcripts was then supported by less intensive interpretation of accounts from other stakeholders who had made sense of their experiences in similar ways.

Broadly speaking, experiences of doctors were evaluated by participants as either positive or negative. Positively evaluated experiences focused on doctor capabilities in the major domains of being ‘patient-centred’ and being a ‘good communicator’. More specifically, these emphasised ‘ensuring patient safety’, ‘showing genuine concern for patients’, ‘combining competence with caring’, ‘being a good listener’, ‘allowing sufficient time’ and ‘being respectful’.

Negatively evaluated doctor experiences focused on behaviours in the major domains of being ‘unprofessional’ and ‘compromising the safety of self and
others’. More specifically, these related to ‘being disrespectful’, ‘being arrogant’, ‘having impaired judgement’, ‘being a poor communicator’ and ‘being incompetent’.

The study’s findings were somewhat concordant with the existing literature. My participants’ positively and negatively evaluated experiences pointed to capabilities such as a patient-centredness and effective communication that had previously been identified as desirable in competency frameworks derived from the opinion of ‘privileged’ stakeholders such as ‘CanMEDS’ and the Australian Medical Council Graduate Outcome Statements. The study adds to the literature, however, in that the positively and negatively evaluated experiences of the broader range of ‘less-privileged’ stakeholders I interviewed prioritised different patterns of capabilities. They emphasised particularly patient-centredness, good communication, professionalism and practicing safely, characterising each of these domains in novel ways.

Potential limitations of the study related to the novelty of the modification to Smith’s IPA method that I developed in order to balance respect for the idiographic (distinct and detailed) accounts of my participants with the need to manage data from a larger-than-usual number of participants for a phenomenological study. The modified method appeared to serve its purpose, however, and the range of measures taken to ensure the trustworthiness of its findings is described. My experience as a health professional and medical educator may have affected my degree of ‘reflexivity’ or ability to self-examine the potential implications of these experiences for my research role. It may also have influenced how participants viewed me, particularly those who were known to me previously. A further range of measures taken to overcome this potential limitation is also described.
Implications of the study are discussed and recommendations made for future medical selection and education research and practice. These include strategies to refine the range and prioritisation of practitioner capabilities, on the basis of the experience and needs of a broader range of stakeholders, to enable doctors to practice effectively in today’s society.

The study adds to the existing body of medical selection and education research. It also gives stakeholders an opportunity to be heard, particularly those most affected by medical practice and malpractice.
STATEMENT OF ORIGINALITY

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Marise Lombard
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS** ........................................................................................................... XII

**CHAPTER 1 INTRODUCTION** ................................................................................................. 1

1.1 BACKGROUND .................................................................................................................. 1

1.2 CONTEXT ........................................................................................................................... 2

1.3 AIMS .................................................................................................................................. 3

1.4 THESIS OUTLINE ............................................................................................................ 4

**CHAPTER 2 LITERATURE REVIEW** ...................................................................................... 8

2.1 INTRODUCTION ................................................................................................................ 8

2.2 LITERATURE REVIEW METHOD .................................................................................... 9

2.3 MEDICAL STUDENT SELECTION .................................................................................... 11

2.3.1 ‘Cognitive’ predictors .................................................................................................. 13

2.3.2 ‘Non-cognitive’ predictors ......................................................................................... 15

2.3.3 ‘Mixed’ predictors ..................................................................................................... 21

2.3.4 Medical student selection challenges ......................................................................... 23

2.3.5 Medical student selection solutions ........................................................................... 29

2.4 MEDICAL EDUCATION .................................................................................................. 34

2.5 STAKEHOLDERS ............................................................................................................. 39

2.5.1 Stakeholder perspectives of the ‘good’ doctor .............................................................. 41

2.5.2 Stakeholder views of selection methods .................................................................... 44

2.5.3 Stakeholders in health care ....................................................................................... 45

2.5.4 The doctor-patient relationship .................................................................................. 47

2.5.5 Patient-centredness .................................................................................................... 51

2.5.6 Professionalism in medicine ..................................................................................... 54

2.5.7 Stakeholder experiences of doctors ........................................................................... 61

2.6 LITERATURE REVIEW SUMMARY ................................................................................... 73
CHAPTER 3  RESEARCH DESIGN ................................................................. 75

3.1  BACKGROUND .............................................................................. 75

3.2  METHODOLOGY ........................................................................... 77

3.3  METHOD ......................................................................................... 85

3.3.1  Pilot Study .................................................................................. 85

3.3.2  Main study ................................................................................ 109

3.3.3  Main study sampling and recruitment ........................................ 113

3.3.4  Main Study Data Collection ....................................................... 122

3.3.5  Main Study analytical sequence ............................................... 131

CHAPTER 4  DATA ANALYSIS – FINDINGS.............................................. 147

4.1  POSITIVELY EVALUATED DOCTOR EXPERIENCES .................... 148

4.1.1  Interpretive analysis of what ‘being patient-centred’ meant for selected participants (identified in the data-analysis structure, Table 3, section 3.3.5.2) ........................................ 148

4.1.2  Interpretive analysis of what ‘being a good communicator’ meant for selected participants (identified in the data-analysis structure, Table 3, section 3.3.5.2) ..................................................................................................................... 161

4.2  NEGATIVELY EVALUATED DOCTOR EXPERIENCES .................... 176

4.2.1  Interpretive analysis of what ‘being unprofessional’ meant for participants (identified in the data-analysis structure, Table 3, section 3.3.5.2) .............................................................. 176

4.2.2  Interpretive analysis of what ‘compromising the safety of self and others’ meant for participants (identified in the data-analysis structure, Table 3, section 3.3.5.2) ................................................................................................................................. 192

4.3  SUMMARY OF FINDINGS AND INITIAL CONCLUSIONS .......... 217

CHAPTER 5  DISCUSSION .................................................................... 221

5.1  COMPARING FINDINGS TO STAKEHOLDER-BASED LITERATURE .... 222

5.1.1  Patient-centredness ..................................................................... 222

5.1.2  Communication .......................................................................... 226
5.1.3 Professionalism ................................................................. 229
5.1.4 Safety .................................................................................. 232
5.1.5 Giving a voice to stakeholders .............................................. 234
5.2 COMPARING FINDINGS TO ‘CAPABILITY’ FRAMEWORKS ........... 236
5.2.1 ‘Domains of attributes’ for medical student selection ............. 237
5.2.2 ‘Graduate outcome statements for medicine’ ......................... 240
5.2.3 ‘Physician competency’ ....................................................... 245
5.3 METHODOLOGICAL CONSIDERATIONS AND LIMITATIONS .... 262
5.3.1 Study limitations ................................................................ 266

CHAPTER 6 SUMMARY, RECOMMENDATIONS, FUTURE RESEARCH AND CONCLUSIONS

6.1 SUMMARY ............................................................................ 279
6.2 RECOMMENDATIONS ............................................................. 283
6.2.1 Harmonise capabilities prioritised by medical schools with those of the communities they serve, particularly patients ........................................ 283
6.2.2 Reconcile priorities of medical schools and the profession to mitigate the risks of ‘unprofessional’ and ‘unsafe’ medical practice, with those of the communities they serve, particularly patients ........................................ 286
6.2.3 Strengthen the focus on diversity in medical selection and education decision-making ................................................................. 291
6.2.4 Strengthen the commitment of medical schools to workforce planning initiatives ........................................................................ 291
6.2.5 Increased recognition by medical schools of the interplay between a candidate’s temperamental capabilities and those that are mutable for long-term, effective medical practice ........................................ 292
6.3 IMPLICATIONS FOR FUTURE RESEARCH ................................. 295
6.4 CONCLUSIONS ...................................................................... 297
APPENDICES .............................................................................................................................................. 299

A – GLOSSARY OF TERMS .......................................................................................................................... 300

B - ABBREVIATIONS .................................................................................................................................. 311

C - SEMI–STRUCTURED INTERVIEW SCHEDULE (FINAL VERSION) ........................................................... 318

D - EXTRACT FROM CODING BOOK FIELD NOTES .................................................................................. 320

E – ETHICS APPROVAL FOR PILOT STUDY ............................................................................................... 324

F – ETHICS APPROVAL FOR MAIN STUDY ............................................................................................... 325

G – PARTICIPANT INFORMATION SHEET ................................................................................................ 326

REFERENCES ............................................................................................................................................... 328
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Participants recruited for semi-structured group interviews for the period 2012 to 2013</td>
<td>115</td>
</tr>
<tr>
<td>Table 2</td>
<td>Participants recruited for semi-structured individual interviews for the period 2012 to 2013</td>
<td>120</td>
</tr>
<tr>
<td>Table 3</td>
<td>Data analysis: structure of stakeholders’ positively and negatively evaluated doctor experiences</td>
<td>139</td>
</tr>
<tr>
<td>Table 4</td>
<td>Comparison of study findings to three capability frameworks</td>
<td>251</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

FIGURE 1. DESIGN AND EVALUATION OF SELECTION SYSTEMS ................................................................. 32

FIGURE 2. PROPOSED MODEL FOR A PHENOMENOLOGICAL FRAMEWORK ........................................... 82

FIGURE 3. GRAPHIC REPRESENTATION OF THIS PROJECT ........................................................................ 282
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So why do they [patients] love you?

[Question from character of ‘Dr. Roy Basch’]

I’m straight with ‘em and I make ‘em laugh at themselves … I make them feel like they’re still part of life, part of some grand nutty scheme instead of alone with their diseases … With me they feel they’re still part of the human race … Docs are no different from anyone else, they just pretend they’re different, to feel big.

[Answer from character of ‘The Fat Man’]

(Shem, 1978, p. 192)
CHAPTER 1 INTRODUCTION

1.1 BACKGROUND

The practice of medicine is complex and challenging. Medical practitioners require a range of capabilities to practice effectively and consistently over a long career. Selection for the capacity to develop these capabilities and education to build them are becoming increasingly important in a rapidly-changing society that demands a return on its investment in medical schools and post-registration training.

Unprecedented change is being brought about by the effects of globalisation; of advances in medical science and technology; of changes in population health profiles; of diminishing health care resources and financial constraints; of increased consumerism and patient empowerment; of findings of enquiries into ‘medical misadventure’ and of alarmingly increased reports of burnout, distress and suicide among doctors.

Such changes have important implications for informing future medical selection and education. Firstly, they signal a move away from ‘candidate-and-student’ centred to ‘community-and-patient-centred’ initiatives. Secondly, they challenge medical selectors and educators to replace processes that have been traditionally exclusive and privileged with more inclusive, patient and community-centred approaches. This shift in focus challenges medical selectors and educators to consider who (should be involved in decision-making); how (to reconcile the goals of candidates and universities with competing community and patient needs) and what (kinds of evidence should inform medical selection and education models)?
Whilst there is evidence of enduring attempts to address the increasing complexities of selecting and educating tomorrow’s doctors, relatively few reports have focused on the experience of those stakeholders most affected by medical practice and malpractice, particularly patients (Lombard, 2011; Paterson 2012b; Ellaway 2017). My study attempts to address this relative gap in the medical student selection and education literature, as well as in the stakeholder-based literature.

Identifying ‘what to select for in a good doctor’ or the range of capabilities required for effective medical practice, requires further attention and clarification. This ongoing project is made more complex by uncertainty about whether desirable capabilities (such as empathy, conscientiousness and communication) can be learned or the extent to which they are pre-determined as part of an individual’s inborn temperament. As a result, medical student selection may actually involve selecting candidates for their ability to acquire the range of capabilities needed for effective and enduring medical practice (Roberts, 2017; Krasner et al., 2009).

Whilst acknowledging that a major thrust of medical student selection processes over the last 15 years has been to identify the range of capabilities required for medical practice, the value of my study lies in linking these ‘capabilities’ with the doctor experiences of diverse stakeholders – a perspective that is rare in the literature.

1.2 CONTEXT

My interest in the field of medical selection and education research has evolved over the course of my career as a health professional and medical educator. These roles were instrumental in raising my awareness of the complexities
surrounding scholarly debate in this field and to identifying potential gaps in the existing literature. Coupled with my background in primary health care, nursing and midwifery, my medical education role also placed me in a strong position to recruit the diversity of stakeholders needed for the project. My focus on how stakeholder experiences with doctors could better inform the future selection and education of medical students contributed to this field of research from a different perspective.

1.3 **AIMS**

The overall aim of this project was to explore how stakeholder experiences with doctors can inform how we select and educate them, while the specific objectives for the project were defined as the research question evolved. This process began with a focus on stakeholder perspectives of the ‘good doctor’ and developed into a specific examination of how stakeholders’ experiences with doctors might better inform how we select and educate them. The fully-developed objectives of the study were:

- To explore the existing literature and identify gaps in this body of knowledge, particularly relating to the contributions of stakeholders
- To undertake a pilot study to test the interview schedule, develop my interview skills and inform the main study
- To undertake data collection for the main study by purposively sampling participants for individual and group semi-structured interviews, within ethically-approved guidelines
- To analyse the main study data utilising a phenomenological interpretive method
- To synthesise the findings of the positively and negatively evaluated doctor experiences of the study participants
- To discuss the significance of the study’s findings whilst acknowledging its limitations
- To add to the body of medical student selection and education research, disseminating my findings and recommendations through ongoing scholarly contribution and debate.

1.4 THESIS OUTLINE

The key elements of the project were as follows:

Exploration of the literature in Chapter 2 was guided by my developing research question. This question evolved from an initial intention to explore how stakeholder perceptions of ‘good doctors’ might inform medical student selection, to a focus on how their reported experiences with doctors could be analysed. An interpretive phenomenological framework was suitable for linking these ‘experiences’ to ‘capabilities’ in ways that had not previously been considered for medical student selection and education decision-making.

The first part of the literature review focuses on research attempts to better inform medical student selection and education. Figure 1, used with permission from the authors, demonstrates one such attempt (Patterson et al., 2016a, p. 52). The second part of the literature review clarifies the definition of the term ‘stakeholder’ for the project and goes on to explore prior stakeholder contributions to medical student selection and education debates. The latter exploration revealed a gap in the literature that offered a unique opportunity to recruit a greater diversity of stakeholders.

Informed by gaps identified in the literature and by the evolving research question, Chapter 3 outlines the research design for the project, including the methodological approach and the methods most suited for the pilot and main
studies. For example, Figure 2, used with permission from the authors, explains the positioning of my study in their proposed phenomenological framework (Hopkins et al., 2016, p. 21).

Tables 1 and 2 outline the recruitment of participants for the main study. These participants were valuable for the project as they shared an interest in the research topic and were from diverse backgrounds. They represented health professional practice (medicine, nursing, midwifery, rural health, alternative health and allied health), medical education, academia, health executive management, medical students, patients and community organisations. During 2012 and 2013 data collection was undertaken via individual and group interviews. An example of the final semi-structured interview schedule is captured in Appendix C.

Within a phenomenological framework, I undertook concurrent data collection and analysis, shifting the focus of my research question to more deeply explore stakeholder experiences with doctors. Ethics approval for the pilot and main studies is captured in Appendices E and F respectively and informed participant consent was sought via the example provided in Appendix G. I was guided by IPA principles and the Hopkins et al. (2016) framework (illustrated in Figure 2), to capture the ‘essence’ of this ‘doctor experience’ phenomenon from a stakeholder perspective that was both unique and powerful.

The study’s findings are discussed in Chapter 4. I referred to key sources in the literature to support initial coding of the anonymised interview transcripts, supported by field coding notes and computer assisted qualitative data analysis software. An extract from the study’s coding book field notes is included as Appendix D.
Within a phenomenological framework, an idiographic (distinct and detailed) approach was applied to progress data analysis from this initial (descriptive) phase to deeper interpretation and meaning-making of individual participant doctor experiences. Eleven ‘sub-units of meaning’ emerged within four broader ‘units of meaning’ that related to what doctors being ‘patient-centred’, ‘good communicators’ or to being ‘unprofessional’ or ‘unsafe’ meant for participants. From this inductive process, two broad phenomenological themes of the ‘positively’ and ‘negatively’ evaluated doctor experiences of participants were identified. The data analysis structure is outlined in Table 3 to facilitate discussion in the subsequent Chapter 5.

Chapter 5 discusses the study findings and includes comparisons within the data-set as well as between the project’s findings and the existing literature. While some similarities were identified (for example, stakeholder preferences for doctors being ‘patient-centred’ and ‘good communicators’), unanticipated negatively evaluated doctor experiences conveyed powerful messages that bear on future medical student selection and education. Comparisons were also made between my study findings and three capability frameworks, which are summarised in Table 4. Along with strengths that lend weight to the study, a discussion of the study’s limitations was equally important and is undertaken in this chapter.

Chapter 6 summarises the key elements of the project, which are graphically outlined in Figure 3. Recommendations are made on the basis of my findings and in the context of scholarly attempts to better inform future medical selection education. These included reforms to medical workforce planning initiatives; strategies to increase diversity and widen participation of historically under-represented groups; more community-focused social accountability initiatives as
well as strategies to address medical selection error and failure and hidden curricula effects. In the light of these recommendations I outline important implications for future medical selection and education research and practice. My conclusion re-establishes my claim to have contributed to the existing body of knowledge in this field; giving stakeholders an opportunity to be heard, particularly those most affected by medical practice and malpractice.

A glossary of terms is outlined in Appendix A and a list of abbreviations in Appendix B.
CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

I undertook the original literature search for this project in 2011, which focused on scholarly attempts to inform medical selection and education, including stakeholder-based studies. Stakeholder-led studies were under-represented in this body of research, particularly in relation to stakeholders as the end-users of medical practice. This shortfall informed my initial research question, which (albeit focused within my city of residence) was titled: *Informing medical student selection and education: what do Gold Coast stakeholders consider to be the characteristics of a ‘good’ doctor?* This question guided development of questions for the semi-structured interview schedule, which was applied in the first group interview that comprised the pilot study, conducted in the same year.

Exploration of the literature continued alongside the phenomenological research. Although the semi-structured interview schedule prompted participants to share their considered views of ‘good’ doctors to better inform medical education and selection, many were eager to share personal experiences with doctors that had contributed to those views.

The data gathered were initially shaped around a discourse of stakeholder perspectives of ‘good’ doctors that might inform medical student selection and education. As the study progressed, the data became increasingly experiential and unforeseen, particularly in relation to negatively focused doctor experiences. I adapted the study methodology accordingly and refined the research question to: *How can the experiences of stakeholders with doctors inform medical selection and education?* Adjustments were made to the
compiled literature review to take account of the evolution of the research question and study methodology as the project progressed.

2.2 LITERATURE REVIEW METHOD

The underlying aims for my literature review method were to explore what aspects of the research topic had been addressed previously, to identify the controversies and issues in the area and, most importantly, to identify gaps in the existing literature. Preliminary steps to achieving these aims included:

(a) Identifying the necessary research skills for the project. I sought guidance from qualitative research experts, accessed relevant books and articles and participated in relevant conferences, workshops and seminars.

(b) Acquiring the necessary knowledge and skills to manage computer assisted qualitative data analysis software as well as a citation management system. I consulted with experts in these fields and participated in instructional individual and group learning sessions.

(c) Acquiring the necessary knowledge and skills to access, select and evaluate scholarly contributions to the research topic. I participated in instructional group learning sessions and enlisted the support of colleagues in my institution’s library services.

I was fortunate to undertake the project while employed fulltime as a university medical educator. This gave me access to essential literature resources such as subsidised subscription to journals and software packages, computing and technical assistance, as well as a broad range of library support services. The latter facilitated access to a reputable catalogue of books, journal articles
(including journal alerts) and databases such as ‘Pubmed’, ‘Proquest’, ‘Springer’, ‘Ovid’, ‘Wiley-Blackwell’ and ‘Biomed Central’.

The literature review for this project did not follow a rigid predetermined protocol or attempt to be a formal ‘systematic review’ involving explicit inclusion and exclusion criteria. This was because the (evolving) research question and iterative methodology did not lend themselves to the tight prospective circumscription that would have been necessary for such an approach. Rather, I undertook a critical, responsive, ongoing, narrative review of all of the literature that I could find relevant to the component terms of my research question. I also gave consideration to the methodological concerns of the project, both at the outset and as they evolved over the study’s long time course.

An exhaustive initial search, including detailed mapping to explore the discursive threads referenced in each of the papers identified, led to following these discursive threads backwards toward the origins of the key ideas discussed. Subsequently, the use of automated ‘content alert’ systems, as well as assistance from vigilant human colleagues who kept my areas of interest in mind as they engaged with the literature themselves, ensured that I kept abreast of further important developments as the study unfolded. Appendix D demonstrates how my ongoing engagement with the literature informed the initial coding book field notes for organising verbatim transcripts and initial analysis of the interview data.

What follows is a review of scholarly attempts to inform medical selection and education as they connect with my research question. This includes an exploration of selection methods, associated challenges and possible solutions
for improvement. The review progresses to focus on research attempts to inform medical selection and education from a stakeholder-based perspective.

2.3 MEDICAL STUDENT SELECTION

The medical student selection literature reflects a diverse and often confusing use of terminology, particularly in relation to selection methods. Comparisons made by researchers (and reflected in the many terms and abbreviations outlined in Appendices A and B) include references to ‘objective versus subjective’; ‘academic marks or performance versus clinical performance or competence’; ‘knowledge versus affective and psychomotor skills’ and ‘quantitative versus qualitative’ approaches.

Additional studies included discussion of the use of academic or ‘cognitive’ versus personality-related or ‘non-cognitive’ predictors or variables that claimed to measure or predict the performance of candidates prior to, during and beyond medical training (Cohen-Schotanus et al., 2006; Gorman et al., 2008; McManus et al., 2003). This research is complicated by reports of some scholars who claimed to have found correlations that applied in the short-term only (Powis et al., 2004; Simpson et al., 2014).

Research that related to developing and testing selection methods as ‘entry’ requirements with only short-term predictive validity, begged the question of the value of selection methods for graduating doctors (Arulampalam et al., 2004; Hillis & Mitchell, 2008). Only a few studies touched on this important issue by exploring selection methods for ‘clerkship’ (in the United States of America), ‘internship’ (in Australia) and ‘specialist training’ (Glick, 2000; Meredith et al., 1982; Reiter et al., 2007).
A further dimension of medical student selection research focused on the choice of selection methods for undergraduate versus graduate entry programs (Elliott & Epstein, 2005; Powis et al., 2004; Rolfe et al., 2004). These studies demonstrated the complexity of medical student selection discourses and raised questions that were beyond the scope of this project. For example, where most of the research attempted to link medical student selection to academic performance outcomes, the focus of my project was to inform medical student selection from a stakeholder perspective.

A significant deficiency in the medical student selection research was that studies had lent stronger support to predictors that measured medical students’ academic performance than to those that measured outcomes for patients (Elkin et al., 2011; Hojat, 2007; Meredith et al., 1982). This criticism implied a heavy reliance on criteria valued by ‘privileged’ stakeholders to inform medical student selection at the expense of those ‘less privileged’ in the practice of medical education (patients in particular). I defined ‘privileged’ stakeholders as ‘those given exclusive authority in medical student selection and education decision-making by virtue of their higher socio-political, financial and/or academic status. ‘Less privileged’ stakeholders were defined as ‘those marginalised in medical student selection and education decision-making by virtue of lower socio-political, financial and/or academic status or as end users of medical services’. My project, therefore, attempted to address this shortfall by including stakeholders who represented ‘privileged’ as well as ‘less privileged’ viewpoints.

Medical student selection research, which has been undertaken on a broad scale over a protracted period, continues to attract widespread attention in the literature. Admissions committees are responsible for the difficult task of
selecting relatively small numbers of suitable candidates from large and highly competitive pools of applicants (Bore et al., 2009; Chen, 2013; Story & Mercer, 2005; Van Der Weyden, 2007). Within this context, the popular Bloom’s (1956) Taxonomy of Learning, which proposes ‘cognitive’, ‘affective’ and ‘psychomotor’ domains, offers a suitable framework for reviewing medical student selection methods, given the diversity and large volume of research in this field.

2.3.1 ‘Cognitive’ predictors

Selection methods that fall into the cognitive domain of the Bloom (1956) framework, are often referred to by researchers as being traditional, being grounded in the sciences and based primarily on the knowledge and academic ability of a candidate (Salvatori, 2001; Tutton & Price, 2002). Researchers claim that quantitative selection methods in this field produce data that are relatively easy to measure with strong predictive validity and reliability (at least in the short-term). For example Spooner (1990) highlights the initial importance but relatively short half-life of the predictive value of academic criteria across physicians’ total careers and emphasises that academic predictors must be complemented by other factors in the applicant’s background.

The most frequently researched ‘cognitive’ predictors are the aptitude and marks-based tests that continue to be widely used to inform medical student selection. Often referred to as metrics in the selections literature, they remain an integral part of admissions tests globally. Examples of these metrics include the Grade Point Average (GPA), derived from prior university grades, and the Graduate Australian Medical Schools Admission Test (GAMSAT) in Australia (Australian Council for Educational Research, 2014; Australian Council for Educational Research, Pywell, Hunt, Lai, & Le, 2010; Coates, 2008; Mercer,
Crotty, Alldridge, Le, & Vele, 2015); the Medical College Admissions Test (MCAT) or MCAT plus GPA in the United States of America and Canada (Dunleavy et al., 2013; Eskander et al., 2013; Monroe et al., 2013; Schwartzstein et al., 2013) and the United Kingdom Clinical Aptitude Test (UKCAT) (Cassidy, 2008; Husbands et al., 2014; James et al., 2010; Wright & Bradley, 2010).

Other metric tests include the General Cognitive Ability (GCA) test, which assesses candidates on verbal, numerical and abstract thinking skills, as well as on prerequisite knowledge for particular medical programs (Didier et al., 2006; Emery et al., 2011; Griffin et al., 2008); Mental Agility Test scoring (McManus et al., 2003, 2005; Powis et al., 2005) and the Biomedical Admissions Test (Emery et al., 2011; Ramachandran & Venkatesh, 2014).

Preference for using ‘cognitive’ predictors to inform medical student selection continues to be justified on the basis that academic scores can be reliably measured, have strong predictive value in relation to subsequent academic performance and are useful for selecting the most academically able candidates from large pools of applicants where cut-off scores are applied (Griffin, 2011; Reibnegger et al., 2010; Searle & McHarg, 2003). Exploration of the research on ‘cognitive’ predictors also suggests that they are broadly applied and are often used in combination with other predictors. For example, their application ranges from initial screening prior to lottery-based admissions under the system formerly employed in the Netherlands (Cohen-Schotanus et al., 2006; Hubbeling, 2017; Lucieer et al., 2016; Urlings-Strop et al., 2009, 2013) to combinations of aptitude measurements in the United Kingdom, the United
States of America, and Australia (Albanese et al., 2005; Callahan et al., 2010; Dennehy et al., 2013; Fernando et al., 2009; Wilkinson et al., 2011; Wright & Bradley, 2010).

Recently, de Visser et al. (2017) recommended curriculum sample selection by designing a selection procedure in which candidates are tested on tasks resembling those in early medical school, claiming that ‘applicants could be selected or rejected incorrectly, if selection is not based on specific performance representing the curriculum they apply for’ (p. 44). These authors went on to claim that ‘selection for medical school is not selection of the best doctors, but should be based on the applicant’s capability of being successful in medical school’ (p. 44). In making these claims, the authors contradicted discourses around selection outcomes for graduated doctors (Hautz et al., 2016; Medical Schools Council, 2014a; Paterson, 2012a).

Research efforts discussed so far have important capacity to inform how we select and educate doctors but are insufficient when applied alone. The main limitation of these research efforts has been their sole focus on academic ability, which is too narrow, considering the range of capabilities that medical practitioners require in order to practice effectively over a long career. Equally limiting is that this focus on academic capabilities is derived from what is valued by those who are already ‘privileged’ in the enterprise of medical education.

2.3.2 ‘Non-cognitive’ predictors

Bloom’s (1956) psychomotor domain involves the learning of skills. Originally it referred to physical skills such as catching a ball or repairing a wound but Rogers and colleagues have suggested that it can be usefully extended to include the learnable and practiceable skills involved in effective communication.
(Rogers et al., 2018). The affective domain in Bloom’s taxonomy (1956) concerns the acquisition of values and attitudes. In the case of the health professions, this means the values declared by the profession to which the applicant is seeking admission. Selection methods that fall into the affective and psychomotor domains have been widely researched, often referred to as ‘non-cognitive’ or ‘non-traditional’ and grounded in the social sciences (Powis, 2010; Prideaux et al., 2011; Rogers, 2010; Siu & Reiter, 2009; Sternberg, 2008).

Some research conducted in this field has attracted criticism that these characteristics are more difficult to measure than those related to academic performance and questions have been raised over the validity and reliability of many studies (McGaghie, 1990; Salvatori, 2001; Sedlacek & Prieto, 1990).

By far the most intensely researched ‘non-cognitive’ method is the pre-admission interview, which is designed to assess candidates’ verbal reasoning (though this, of course includes a considerable ‘cognitive’ component), language and interaction skills (Edwards et al., 1990; Elliott & Epstein, 2005; Fan et al., 2010; Gorman et al., 2008). Traditional, structured and semi-structured interviews have evolved into a variety of data collection methods that have been adopted from the field of psychology to complement academically-based admissions tests (Patrick et al., 2001; Stepp et al., 2005; Taylor, 1990).

Methodological problems continue to impede the successful implementation of the interview as a selection method (Broadley, 2010; Dore et al., 2006; Griffin & Wilson, 2010; Lumb et al., 2010). Some medical schools have abandoned interviews in favour of tools that are claimed to be less costly, can be more easily utilised and that have greater predictive validity (albeit for a narrow range of outcomes such as short-term academic performance) (Groves et al., 2007; The University of Queensland, 2009; Wilkinson et al., 2008).
McMaster University in Canada has led the field in replacing traditional interviews with the multiple mini-interview (MMI) model, designed to assess the (‘cognitive’ and ‘non-cognitive’) attributes of ethics, critical thinking, communication skills and knowledge of the health care system (Eva et al., 2004, 2009). This approach has been applied in admissions procedures globally and has been adapted to suit the individual needs of each medical school. For example, Griffith University in Queensland, Australia, where the present study was conducted, replaced its three-person semi-structured panel interviews with a Griffith University Multi Station Admissions Assessment (GUMSAA) in 2011 (Griffith University, 2011; Hughes, 2011; Hughes et al., 2012). A medical school in Israel claims to have strengthened the reliability of the MMI tool by applying its principles to their ‘MOR’ (Hebrew acronym for ‘selection for medicine’), described as a ‘simulation-based assessment centre for evaluating the personal and interpersonal qualities of medical school candidates’ (Ziv et al., 2008, p. 991).

MMI-based selection instruments continue to attract scholarly attention as they have been expanded to assess a broad range of ‘non-cognitive’ skills. For example, verbal and communication skills; effective teamwork skills; problem-solving ability; ethical responsibility; moral orientation; attitudinal disposition as well as psychomotor skill (Kumar et al., 2009; Oliver et al., 2014; Roberts et al., 2008; Zaidi et al., 2014).

Followers of the MMI method have also adapted its framework, which is similar to that of the objective structured clinical examination (OSCE), to video-based situational and or scenario-based assessment (Hughes, 2011; Kleshinski et al., 2008; Lemay et al., 2007; Lievens et al., 2005; Lievens & Coetsier, 2002; Lievens & Sackett, 2006; Siu & Reiter, 2009). Ongoing research demonstrates long term predictive validity, with claims that successful MMI results for
candidates at admission can predict their successful performance as junior doctors (Lambe & Bristow, 2011; Meredith et al., 1982; Reiter et al., 2007). A recent study also suggested that ‘carefully designed situational judgement tests (SJTs) may augment more costly MMIs’ (Husbands et al., 2015, p. 1).

Patterson et al. have promoted the use of Situational Judgement Tests (SJT) in terms of their acceptability, cost-effectiveness, reliability and predictive validity, above several of the other selection methods referred to in their comprehensive review of the medical selections literature (Patterson et al., 2016a). SJTs have been adopted by some Australian medical Schools in the form of on line ‘Computer-based Assessments for Sampling Personal Characteristics (CASPer)’ (Altus Assessments, 2016; Bradshaw, 2010; McMaster University, 2015). It is worth highlighting that there is evidence to suggest that SJTs remain at the developmental stage, with many basic issues awaiting resolution. One example of such evidence is the systematic review undertaken by Campion, Ployhart and MacKenzie (2014) that identified ongoing challenges for successfully implementing SJTs and called for further research to address cultural influences, increase applicant acceptability, manage potential factors around ‘faking’ and link criteria beyond job performance indicators (Campion et al., p. 299).

As mentioned earlier, in 2011 an MMI-based model replaced traditional interviewing as part of my local medical school's postgraduate admissions process (Griffith University, 2011; Hughes, 2011, 2013; Hughes et al., 2012; Lombard et al., 2013). Personal experience with both types of assessment proved useful yet inconclusive for me. Although my impression concurred with evidence suggesting that the MMI had advantages over traditional interviewing,
the evidence to support the range of capabilities required for medicine remained limited and confined to those valued by ‘privileged’ parties to the process.

In addition to the MMI and associated ‘non-cognitive’ approaches already discussed, there is some research evidence supporting the use of pre-admissions personality or psychometric testing (Doherty & Nugent, 2011; Griffin & Wilson, 2012; Knights, 2005; Powis, 2009; Tartas et al., 2011) Some psychometric tests have been adapted from those used in other occupations (such as paramedicine and pilot training) and most have evolved from the field of psychology and organisational psychology in particular (McCrae & Costa, 2003; Patterson et al., 2014; Poropat, 2005; Powis, 2009).

Some medical selection processes recognise the merits of using forms of psychometric testing (either singularly or in combination with other methods) to assess the suitability of candidates. For example, some schools have assessed for those attributes deemed to be desirable (such as extroversion, critical thinking and the capacity for self-directed study); or against those considered undesirable (such as introversion, compulsive behaviour and poor motivation) (Benbassat & Baumal, 2007).

Some work has focused on the relevance of the so-called ‘Big Five’ personality domains – ‘extroversion’, ‘agreeableness’, ‘conscientiousness’, ‘neuroticism’ and ‘openness’ for medical student selection (Ferguson et al., 2003; Lievens et al., 2009; Pytlík-Zillig et al., 2002). A review of research in this broad area was relevant for the present study only to the extent that parallels could be drawn between these domains and the capabilities identified for effective medical practice. For example, medical selections research has linked these five domains to other predictors such as the MMI (Griffin & Wilson, 2012); empathy
scoring (Magalhaes et al., 2012); undergraduate versus postgraduate entry (James et al., 2009) as well as self-report measures (Ferguson et al., 2003).

Tests have been developed to measure additional desirable characteristics, such as emotional intelligence (EI) (Austin et al., 2007; Brannick et al., 2009; Carr, 2009; Todres et al. 2010; Weng et al., 2008) and empathy (Chen et al., 2007; Hemmerdinger et al., 2007; Hojat, 2007), whilst others have explored the relationship between the MMI and EI (Yen et al., 2011).

Other selection tools are relevant to my study if they attempt to identify ‘good’ as well as ‘bad’ doctors, particularly those that demonstrate long-term, predictive validity. One such assessment, the Personal Qualities Assessment (PQA), was developed by Powis and his colleagues at the University of Newcastle in New South Wales, Australia (Powis, 2010; Powis et al., 2005). The PQA combines the assessment of cognitive reasoning skills with measures of desired personality traits and moral orientation, the latter having been introduced as the so-called, ‘MOJAC’ scale by scholars from the same institution at around the same time (Bore et al., 2005).

The Minnesota Multiphasic Personality Inventory (MMPI) and the California Psychological Inventory (CPI) are examples of psychometric tests identified in medical student selection research that not only assess undesirable personal characteristics but also have been claimed to predict poor performance and likely misconduct (Hodgson et al., 2007; Macintyre et al., 2002; Tutton, 1993; University of Minnesota, 1989).

Glick’s research added a simulation component to the MMI to assess the potential for medical error (Glick, 2000), whilst other authors proposed that self-report instruments should be used in combination with academic scores and
interviews (Dore et al., 2006). For example, Munro et al. (2005) designed a self-report questionnaire to measure empathic and narcissistic traits, referred to as the Narcissism-Aloofness-Confidence-Empathy (NACE) screening tool. The ‘Hogan Development Survey’, similarly, used self-report measures to identify interpersonal problems or dysfunctional tendencies that might not be detected in interviews alone (Hogan, 1998; Hogan & Holland, 2003).

Ongoing work to identify the most effective approaches in this area is vital because, as Powis (2015) put it:

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\text{The features common to both unsatisfactory doctors and unsatisfactory medical students appear to lie in the non-cognitive rather than the academic domain.}
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(p. 4)

In summary, although there is increased recognition for non-cognitively-based assessment in medical selections, many leading scholars continue to defend the use of cognitive-based testing on empirical grounds. Research attempts to link temperament to medical practice and malpractice hold value for this study when one considers that the range of personal capabilities identified to date has been informed largely by ‘privileged’ viewpoints.

2.3.3 ‘Mixed’ predictors

Selection methods that purport to assess a combination of candidates’ knowledge (cognitive) and attitude (affective) skills and that are often designed to educational and professional specifications, include the MCAT in the USA (Donnon et al., 2007; Matthew & Kroopnick, 2010; Violato & Donnon, 2005;
Zhao et al., 2010; the GAMSAT, discussed earlier (Australian Council for Educational Research et al., 2010; Coates, 2008; Elliott & Epstein, 2005; GAMSAT, 2010; Groves et al., 2007; Kleshinski, et al., 2009; Powis et al., 2004; Prideaux et al., 2000); the Health Professions Admissions Test – Ireland (HPAT-Ireland) (Kelly et al., 2013, Kelly, 2015; Australian Council for Educational Research, 2018); and the Undergraduate Medicine and Health Sciences Admission Test (UMAT) in Australia and New Zealand. The three papers that comprise the UMAT measure ‘Logical Reasoning and Problem Solving, Understanding People and Non-Verbal Reasoning’ (Griffin et al., 2013; Poole et al., 2012; Puddey et al., 2014; Wilkinson et al., 2011).

Additional potential predictors that are sometimes used in conjunction with all of the methods discussed thus far, include written or verbal references, letters of recommendation and testimonials (Kreiter & Axelson, 2013; Monroe et al., 2013; Siu & Reiter, 2009; van Mook et al., 2015); personal portfolios, statements or resumes (Benbassat & Baumal, 2007; Medical Schools Council, 2014a; Morrison, 2016; Oates & Goulston, 2012; Scammell et al., 2015; Sladek et al., 2016; Wright, 2015); as well as biographical and demographic (or contextual) data such as age, gender, ethnicity, family background, personal interests, schooling, social class and candidates’ work and life experiences (Koenig et al., 2013; Morrison, 2005; Nowacek & Sachs, 1990).

In summary, a broad and intensive body of research continues to plan, implement and evaluate medical student selection methods. Bloom’s (1956) taxonomy model was applied to explore selection methods across a range of ‘cognitive’, ‘non-cognitive’ and ‘mixed’ predictors. Although these attempts are
valuable for informing ‘for what’ to select, my research question attempted to
better inform medical student selection (and education) specifically from a
stakeholder perspective.

2.3.4 Medical student selection challenges

Significant challenges remain in the study of medical student selection. Discord
is evidenced by differences in research design, measures used, sample sizes,
time-frames and results. These ongoing concerns are noteworthy on five
accounts. Firstly, a relative pre-occupation with methods (or ‘how’ to select) at
the expense of ‘for what’ to select, with the latter often apparently ‘taken for
granted’ and drawn from an almost exclusively ‘privileged’ viewpoint may have
limited the scope of selection research.

Secondly, the duration of, and time variations in, medical programs make it
difficult to measure capabilities required for medical practice over time and at
key stages of a medical career. Robust, longitudinal studies focused on patient
encounters with doctors at various stages of their careers were found to be
lacking in the literature.

Thirdly, reliance on poorly validated selection tools may compromise outcomes
for medical schools, for applicants and particularly for patients. This is
particularly relevant amidst reports of increased enquiries into ‘medical
misadventure’ (Benbassat, 2014; Bismark et al., 2011a, 2011b; Dunbar et
al.,2011; Elkin et al., 2011; Houghton, 2013) and of burnout, distress and
suicide in medical students and doctors (Dean et al., 2016; Ludwig et al., 2015;
Pagnin et al., 2013; Sobowale et al., 2014; van Dijk et al., 2017).

Fourthly, complexities surrounding admission directly from school into
undergraduate medical programs versus admission into postgraduate programs
were relatively understated in the literature. For example, pathways into medicine via Bachelor of Medical Science degrees at Griffith and Sunshine Coast universities in Australia admit school leavers exclusively on academic achievement and provide direct entry to postgraduate medical studies without further selection, subject to satisfactory undergraduate academic performance (Griffith University, 2018; University of Sunshine Coast, 2018).

The two medical schools in Australia that do not conduct interviews prior to undergraduate direct entry place significant emphasis on the UMAT, which was designed to de-emphasise the impact of academic achievement. Most of the remaining medical schools spend significant time and resources on interviews and UMAT.

Finally, studies were divided over the range of capabilities thought to be required for different medical specialties. Whilst some studies specified capabilities for particular specialties, they assumed significance for my study when the prioritisation of particular capabilities might impact negatively on patients. Having critiqued these broader medical student selection challenges, I undertook further exploration of the literature to identify discourses around these specific concerns and attempts that had been made to address them.

It is well-recognised in the medical selections literature that ‘cognitive’ predictors such as academic scores are relatively easy to measure and raise fewer concerns about reliability (GAMSAT, 2010; Groves et al., 2007). These measures have been traditionally employed as the first step in most admission procedures and remain the preferred selection method globally (Salvatori, 2001; Searle & McHarg, 2003; Sternberg, 2008).
Whilst academically-driven admission tools hold predictive validity for academic performance early in medical school training, I concur with criticism that they are poor at predicting long-term performance (Griffin, 2011; Reibnegger et al., 2010). These ‘cognitive’ methods are also criticised by social scientists for ignoring personality predictors, a criticism that holds significance for this project by redefining scholarly interpretations of ‘good’ and ‘bad’ doctors (Mills et al., 2009; Pandey & Dixit, 2011; Peskun et al., 2007; Quinlivan et al., 2010; Wilkinson et al., 2008).

Most ‘non-cognitive’ selection methods, on the other hand, have been developed from qualitatively-based research studies that have attracted even greater criticism in the selection debate and are, at best, used currently to complement academic scores in the admissions assessments of most medical schools. An important consideration for my study, however, is that these qualitatively-based selection methods might better inform the range of capabilities required for effective, long-term medical practice (Lumsden et al., 2005; Munro et al., 2008; Powis, 2009, 2010; Prideaux et al., 2011).

Among the ‘non-cognitive’ methods, the traditional interview has lost popularity on empirical, financial and social accountability grounds (Brent et al., 2007; Broadley, 2010; Griffin & Wilson, 2010; The University of Queensland, 2009; Wilkinson et al., 2008). In spite of these limitations, the interview may still hold a place in admissions processes. It warrants consideration by being more inclusive of ‘less’ privileged stakeholders (for example, community representatives); and purportedly reliable if used in combination with other methods (Lumb et al., 2010; Powis, 2008; Talmor et al., 2017; Wilkinson et al., 2014).
Further concerns identified in the medical student selections literature have focused on organisational and administrative factors, such as ‘gate-keeping’ (Spooner & Spooner Jr, 1990) and legal challenges to admissions decisions (Demetriou, 1998; Mathers et al., 2008). These are associated with increasing pressure from larger and more fiercely competitive pools of applicants (Rogers et al., 2010; Thordarson et al., 2007).

There is further evidence of challenges related to the recruitment of candidates for remote area medical practice (Hudson et al., 2017; Peachey & McBain-Rigg, 2011; Puddey et al., 2015; Wilson et al., 2009; Wright & Woloschuk, 2008); the selection of international students (Australian Medical Association, 2011; Kelly et al., 2014; Mckimm & McLean, 2011; Schiller & Yang, 2010); intensifying debates over widening participation in and access to, medical education (Leduc et al., 2017; Medical Schools Council, 2014a; Patterson & Price, 2017; Powis et al., 2007; Reeve et al., 2016); as well as measures for increasing the diversity of applicants, which is linked to the social accountability of medical schools (Eckstrand et al., 2016; Ferguson et al., 2012; James et al., 2009; Medical Schools Council, 2014a; Preston et al., 2016; Prideaux et al., 2011).

The latter discourse that relates to social accountability is pertinent to my study as it emphasises the obligation placed on medical schools to select and graduate those candidates most able to demonstrate or develop the range of capabilities most suited for modern-day medical practice. Closely aligned with this challenge is the discourse around which of these capabilities are determined by inborn temperament and which are learnable (Hays et al., 2013; Kelm et al., 2014; Lim et al., 2016; Patterson et al., 2014; Wündrich et al., 2017). Interesting to note is research evidence for intervention programs to change certain personality traits, including emotional stability and extraversion.
(Roberts et al., 2017). Of particular interest is research by Krasner et al. (2009) that suggests the effectiveness of intervention programs such as mindfulness training to increase conscientiousness, agreeableness, empathy and emotional stability amongst medical students. Similar mindfulness-based programs have been incorporated into medical school curricula, for example, a communication skills model at an Australian medical school that links ‘mindfulness, affective reflection, impactful experience and a safe, supportive learning space’, which the authors refer to as ‘The MaRIS Model’ (Humphreys & Chan, 2017).

Equally pertinent to my study is research related to medical student attrition or drop-out rates (Arulampalam et al., 2007; Fortin et al., 2015; Maher et al., 2013; O’Neill et al., 2011); and more importantly, to the consequences of selection error, particularly for patients (McGurgan et al., 2010; Roach & Dorling, 2000; Patterson et al., 2014). The latter challenge has implications for medical schools, who may need to find better ways to exclude what some scholars have referred to as ‘the bad apples’ in medical education and subsequent practice (Jager, 2013; Kruys, 2015; Norman, 2015). As Norman (2015) puts it:

"Perhaps the most egregious is Dr. Harold Shipman, a British GP who is estimated to have killed 250 of his patients and was eventually convicted of 15 murders. The publicity surrounding his trial and conviction led to calls to reform the educational process ... In particular, we have seen increased focus on “non-cognitive” factors, particularly professionalism."

(p. 299)

In the light of the Shipman case where many patients regarded the practitioner positively prior to learning about the fatal outcomes, it might be argued that
patients have little ability to determine the quality of medical care when the doctor’s interpersonal skills are good. On the other side of the argument, the Bismark studies (2006, 2001a, 2011b, 2013, 2016) as well as enquiries into adverse patient events (Saunders, 2015; Green 2013; Newdick, 2013; Dunbar, 2011; Thomas, 2007) suggest that patients are often the means by which inappropriate practice comes to light. Patients have often been pivotal to informing changes to the care they receive from doctors.

Regardless of whether patients are able to judge all of the elements of effective medical care, their experiences with doctors remain an important adjunct to the views of other ‘privileged’ and ‘less privileged’ stakeholders for informing medical selection and education.

To sum up, the evidence to preference one method (or combination of methods) remains a complex and controversial challenge for medical selectors and educators. I endorse the added recognition that the excessive amounts of time and resources invested in admissions processes can no longer be justified. Powis (2015) referred to this impasse as ‘an unresolved challenge’, stating that:

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\text{The subsequent, frequently recurring, and continuing debate indicates that little progress has been made in establishing an optimal method for medical student selection.}
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(p. 1)

As alluded to earlier, these challenges are compounded by a climate of change and uncertainty, particularly in relation to cultural assumptions and population health needs. These trends have placed pressure on political leaders to reconsider how they plan health and workforce reforms, as well on medical
selectors and educators to graduate doctors who are adept at responding to such change (Pesce, 2010; Prideaux et al., 2011; Roberts & Prideaux, 2010; Trounson, 2011).

2.3.5 **Medical student selection solutions**

Recommendations for improving medical student selection have arisen in critiques of research methodologies and are evidenced in the guidelines, policies and standards implemented for individual institutions and for the medical profession generally. However, involving the voice of ‘less privileged’ stakeholders deserves increased emphasis, as it has largely been silent in the selection debate. By ‘less privileged’, I mean those marginalised in medical student selection and education decision-making by virtue of lower socio-political, financial and/or academic status or as end users of medical services. Scholars are, therefore, urged to be more inclusive of these marginalised groups and to be more critical of evidence that continues to ‘privilege’ the views of those given exclusive authority in medical student selection and education decision-making by virtue of their higher socio-political, financial and/or academic status.

Entry requirements for some medical schools have been driven by ‘privileged’ viewpoints in academia and the profession. For example, favouring admissions personnel in surveys to identify ‘core competencies’ for entry into medicine (Koenig et al., 2013); formulating admissions standards (Medical Schools Council, 2014b, 2017); and researching selection methods (Australian Council for Educational Research, 2014).

Attempts to better inform medical student selection have embraced a range of recommended strategies. These are related to implementing empirically-robust selection processes that address changing needs and capabilities of candidates and that honour communities’ expectations of ‘good’ doctors (Benbassat &
Baumal, 2007; Roberts et al., 2010). Equally relevant were calls for increased collaboration on local, national and international levels. For example, centralised admissions processes, mutual recognition between universities and a broader application and testing of selection methods (McManus & Powis, 2007; Powis, 2008, 2010). Conflicted and divided discourses in the medical student selection literature signalled the need to improve the application and consistency of research undertaken in this field. For example, Bore et al. (2009) advocated meta-analyses and larger-scale studies that test the reliability and validity of selection methods in combination – rather than as isolated variables – and that cover a broad range of settings.

Additional recommendations included increased accountability and transparency of selection procedures that could stand up to legal challenges. Examples cited included releasing selection results into the public domain (Prideaux et al., 2011); inviting senior medical students to participate as interviewers (Nicholson & Jaiyesimi, 2010) and identifying unsuitable candidates (Dwyer et al., 2011; Papadakis et al., 2004; Teherani et al., 2005). For Powis (2015), one solution was ‘a radical change in emphasis’ towards exclusion processes for unsuitable candidates’ (p. 1).

Medical selections research has gradually moved from recommending the use of one set of predictors over another, to combining ‘cognitive’, ‘non-cognitive’ and ‘mixed’ predictors. As early as 2003, the case for improved selections was summed up at an Association of American Medical Colleges meeting, where decision-makers were urged to focus on personal capabilities (Albanese et al., 2003). More recently, several authors have supported the use of multiple selection tools and flexible medical education models (Edwards et al., 2013; Katz & Vinker, 2014; Kecskes & Mitchell, 2017; Medical Schools Council,
2014a; Monroe et al., 2013; Morrison, 2016; Powis, 2015; Sladek et al., 2016). For Kecskes and Mitchell (2017) the solution lies in medical schools becoming ‘increasingly selective as to what is critical to being a safe, patient-centred doctor’ (p. 159).

Research efforts to improve medical student selection and education within changing health and working environments have prompted medical schools to examine their social justice policies, particularly in relation to including students from socially diverse, disadvantaged and rural backgrounds (Curtis et al., 2015; Hughes et al., 2011; Medical Schools Council, 2014a; Patterson et al., 2012; Reeve et al., 2016; Steven et al., 2016). Examples of recent efforts by scholars to address these issues and to invite increased collaboration included the launch of a Selecting for Excellence Executive Group (SEEG) in the United Kingdom in 2014 (Medical Schools Council, 2014a, 2017), as well as the launch of the first international Selection for the Health Professions Conference (SHPC) in Australia in 2015 (Monash University, 2016). Mahon et al. (2013) reviewed the historical context of medical admissions and asserted that ‘admission practices are undergoing fundamental changes in order to select physicians with both the academic and interpersonal and intrapersonal competencies necessary to operate in the health care system of the future’ (p. 1).

A systematic review by Patterson et al., (2016a) yielded useful strategies to address some key medical student selection challenges. The authors’ recommendations were highly relevant for my project as they positioned selection methods along a continuum that was inclusive of stakeholders and that focused on medicine as a career. Used with author permission, the proposed selections model is illustrated in Figure 1 below.
A recommendation by Wilkinson and Wilkinson (2016) to preference selection domains of attributes over selection tools holds equal promise for future medical student selection models. The authors drew on the gaps identified by Patterson et al. (2016a, 2016b) such as poor construct validity for selection predictors and proposed an ‘evidence-based blueprint for programmatic assessment in selection for an overall admissions scheme’ (p. 3).
Whilst the blueprint proposed by Wilkinson and Wilkinson (2016) included capabilities related to logical reasoning and problem solving; understanding people; communication skills and biomedical science, the authors acknowledged that they had paid less attention to capabilities relating to ‘professionalism, probity, empathy, teamwork etc.’ (p. 5). In spite of this limitation, the Wilkinson framework was useful for facilitating a comparison with my research findings in my discussion chapter (section 5.2.1).

After reviewing attempts to better inform medical student selection and conducting their own program of research in a medical school in Australia, Wilson and Griffin (2013) emphasised the complexities surrounding medical student selection. Wilson and Griffin’s (2013) recommendations encouraged further research to broaden understanding of such complexities to promote ‘fair but strict protocols for excluding students from the study of medicine’ (p. 116) and for emphasising the need for ‘closer alignment between the selection process and the curriculum so that students fit the expectations of the school more effectively’ (p. 115).

In summary, attempts to inform medical student selection have linked admissions tests to a range of capabilities required for effective medical practice. These admissions tests rely on evidence-based predictors (‘cognitive’, ‘non-cognitive’ and ‘mixed’), administered singly or in combination in a variety of ‘high-stakes’ contexts.

Although scholarly attempts to address key medical selection challenges have made progress, the process is far from complete and most efforts have favoured ‘privileged’ perspectives. This suggests the need for my study, which aims to inform medical student selection from a more inclusive stakeholder
perspective and to link the ‘capabilities’ required for effective medical practice to the ‘real-life’ doctor experiences of those stakeholders. My study, therefore, has the potential to contribute to future medical student selection research that ‘better serves all stakeholders’ as recommended by Kreiter and Axelson (2013, p. S55).

2.4 MEDICAL EDUCATION

Led by my evolving research question, I was interested to explore beyond the selection process, to better inform a selections-education continuum for medical students and graduates.

In contrast to the ambivalent discourses in the medical selections literature, there was general consensus in favour of ‘competency-based medical education’ (CBME) (Frank et al., 2010a; 2010b; Furstenberg et al., 2017). One heroic exception was raised by Whitehead and Kuper (2017) who criticised CBME for privileging interests and lacking an evidence base. The general consensus I identified was reflected in nationally and internationally-recognised outcome frameworks for medical education providers (Hautz et al., 2016). One such framework forms part of the Australian Medical Council’s (AMC) Standards for Assessment and Accreditation of Primary Medical Programs (2012).

Within the AMC framework (2012), medical education providers are required to demonstrate outcomes for entry-level medical practitioners in the domains of ‘science and scholarship’, ‘clinical practice’, ‘health and society’ and ‘professionalism and leadership’ (p. 7). Medical graduates are, therefore, required to demonstrate a range of capabilities across these domains. Within each, medical education providers are given the flexibility to tailor specific competencies to the needs of candidates, the university and the community.
The most widely accepted outcome framework for physician competency has been prescribed by CanMEDS (Frank et al., 2015; Royal College of Physicians and Surgeons in Canada, 2017). Recognised as a Canadian initiative to improve patient care by focusing on medical education and practice, the CanMEDS 2015 Framework is part of a larger Competency by Design initiative for physicians to demonstrate competencies at different stages of their careers (Frank et al., 2010a, p. 12). Several key competencies are identified for each of the CanMEDS domains of ‘communicator’, ‘collaborator’, ‘leader’, ‘health advocate’, ‘scholar’ and ‘professional’.

Among the most controversial issues in relation to CBME is the term used to describe the unit of outcome. A great deal has been written in the health professional and general education literature on this question in recent times (Frank et al., 2010a; 2010b; Fraser & Greenhalgh, 2001; Lurie, 2012; Miller, 1990; Van Der Vleuten & Schuwirth, 2005; Wilson et al., 2001); yet no clear consensus is evident, with authors referring to descriptors that encompass, amongst others, ‘learning outcomes’, ‘graduate attributes’ and ‘competencies’.

Such idiosyncrasies are reflected in contributions by Fraser and Greenhalg (2001), who have argued that ‘capability’ may be more appropriate to medical education as it includes ‘the ability to adapt to change, generate new knowledge, and continuously improve performance’ (p. 799). Similarly, Sandars and Hart (2015) have suggested that the idea ‘capability’ is less ‘reductionist’ (p. 516) and pays better attention to ‘topics with social relevance, such as professionalism, medical ethics and social justice’ (p. 516). As this debate is not central to my study, I have elected to exercise pragmatism and adopt ‘capability’ as a term that is intended to encompass all of the contender expressions, recognising, as Lurie (2012) has argued that reductionism can only take us so
far in the understanding of complex social competences and it is better to embrace complexity in relation to ‘patterns of human performance in the clinical setting’ (p. 56). For the purposes of my study, I have elected to refer to ‘capability’ as an overarching term to encompass descriptions of areas of ability that might variously be described as ‘learning outcomes’, ‘graduate attributes’, ‘competencies’ or a wider range of other descriptors.

Important to consider for my project were two recent studies by Furstenberg and colleagues (2017) that focused on physician and medical student perceptions of competencies identified for medical education programs. The first study by these authors demonstrated a consensus between physicians to prioritise ‘professional behaviour’, ‘communication’ and ‘patient management’ for new medical graduates (p. 3). The second study by Furstenberg and Harendza (2017) compared physician and medical student ratings of competencies for effective medical practice, based on the CanMEDS framework. Interesting to note was that medical students focused on ‘patient-centred’ competencies, particularly being a ‘good’ communicator; whilst physicians focused on ‘patient-management’ competencies, particularly junior doctor responsibilities (p. 4). Although the latter study involved medical students as stakeholders, most attempts to better inform medical education outcomes reflected a predominantly ‘privileged’ viewpoint.

Having identified key elements of CBME, several research reports discussed challenges relating to a ‘hidden curriculum’ that could negatively affect medical students and ultimately patients. Recognised as the informal influences of a medical school and workplace culture (Symonds & Talley, 2013), the ‘hidden curriculum’ was linked to claims of progressive declines in medical student empathy (Hojat et al., 2004, 2009; Pedersen, 2009; Neumann et al., 2011).
Although the Hojat-led studies focused on a single medical school, critical reviews by Pedersen (2009) and Neumann et al. (2011) also suggested empathy decline in students across several medical schools.

Claims of declines in medical student empathy have come under increasing scrutiny (Colliver, 2010; Kelm et al., 2014; Roff 2015; Jeffrey, 2016) with Costa et al. (2013) being amongst the strongest critics. The authors not only question the practical significance of this research but also claim that ‘findings from studies in empathy carried out in other countries are incoherent … [s]ome studies reported no variations … others found negative variations … while others reported increases throughout medical education … [f]inally, others found no difference in empathy as a function of educational level in medicine …’ (p. 510).

From these discourses around empathy in medicine, proposals found to be most relevant for my research topic include calls made by Jeffrey (2016), Colliver et al. (2013), Neumann et al. (2011) and Pedersen (2009) for more qualitative-based research that deepens our understanding and experience of empathy in medicine. Resonating particularly strongly with my research is the emphasis placed by Colliver at al. (2013) on ‘patients’ assessments of caregiver empathy in actual or simulated clinical encounters’ (p. 591) and the claim by Singh (2005) that ‘[u]ltimately, it is only the patient who can tell us whether trainees demonstrate empathy in a particular situation’ (p. 74). My study, therefore, contributes by exploring accounts of ‘actual’ clinical encounters from a diverse stakeholder perspective that includes patients.

These discourses around empathy in medicine are also valuable for informing medical selection and education decision-making about admitting candidates.
who have the capacity to become empathic practitioners (Kelm et al., 2014; Lim et al., 2016; Wündrich et al., 2017).

Apart from discourses around empathy, research attempts to address the potentially negative effects of ‘hidden curricula’ have focused on institutional, professional and personal strategies. Examples include keeping medical students emotionally engaged through immersion in interactive and interprofessional learning environments involving professional challenges (Rogers et al., 2017); mindfulness and resilience training (Dhingra et al., 2015; Dobkin & Laliberté, 2014; O’Callaghan, 2013); as well as strengthening professionalism through positive role-modelling (Doja et al., 2016; O’Callaghan, 2013; Passi & Johnson, 2016a, 2016b).

In summary, research attempts to better inform the outcomes of medical education were not as divided as those identified for improving medical student selection. Consensus was largely evident for competency-based medical education models that were flexible in their processes in order to accommodate diverse learning and clinical environments. The links established between CBME and discourses around ‘capability’ were valuable for highlighting my study’s focus on the range of capabilities required for long-term and effective medical practice.

Addressing medical education challenges such as ‘hidden curricula’ effects had implications for the review of admissions processes; particularly recognising those candidates with the capacity to learn desired capabilities for effective medical practice. Gaps identified in both the selections and medical education literature related to poor continuity between selection and education models and the exclusion of ‘less privileged’ stakeholders in determining outcomes. Guided
by my research question, I went on to explore the relevant stakeholder-based literature.

2.5 STAKEHOLDERS

Stakeholder definitions have been widely used in commercial, corporate and health care management sectors. Examples include the focus of stakeholder theories that inform business development models (Laplume et al., 2008; Mitchell et al., 1997; Phillips, 2011), as well as health care decision-making (Hoffman et al., 2010).

The traditionally narrow definition of stakeholders as the ‘end-users’ of products or services has broadened with the increasing complexity of corporate and health service delivery models. Within business research, reference to ‘executive’, ‘end-user’ and ‘expert’ stakeholders (Alexandrou, 2011) supports my choice of the word ‘stakeholder’ for the title of my project, which is an attempt to convey inclusion of a broad representation of those who have a stake in the delivery of effective medical care.

The observation that very few scholars in the medical selections and education field had adopted the use of the term ‘stakeholder’ provided further impetus for me to clarify my use of the term from the outset of my project. In my search of the literature, stakeholders were specifically mentioned by scholars who were attempting to better inform medical education with regards to educator role-modelling (Butani et al., 2013), cultural competency training (Kamaka, 2010) and social accountability (Preston et al., 2016). More recently, Kelly et al. (2018) published findings of a systematic review of stakeholder views of medical selection methods, which along with findings from Kelly’s mixed methods
doctoral study on medical student selection (2015), warranted further discussion below.

Taking these perspectives into account, I drew on the following two definitions to express what I meant by ‘stakeholder’ when reviewing the literature and discussing my findings:

*Any party – person, group, or community – with an interest in a particular effect or outcome.*

(Segen's Medical Dictionary, 2012)

*One who is involved in or affected by a course of action.*

(Merriam-Webster Dictionary, 2017)

Based on these definitions, I elected to define ‘stakeholders’ for the purposes of my project as ‘those involved in, or affected by, medical selection and education decision-making from a privileged or less privileged position’. By being ‘privileged’, I meant stakeholders who had traditionally been given exclusive authority in medical student selection and education decision-making by virtue of higher socio-political, financial or academic status; whilst ‘less privileged’ stakeholders were considered to be those excluded from this domain on the same grounds, with particular reference to patients (please refer to Appendix A). Important to clarify for my study was the distinction that I drew between my discussion of stakeholders in the existing literature and my study participants. However, the meanings I gave to ‘privileged’ and ‘less privileged’ were consistently applied throughout the project as they were key elements of the research question.
My exploration of the literature identified both diversity and disparity in the ways that stakeholders had informed medical student selection and education (Smith, 2008; Van Der Weyden, 2007). The studies I identified reflected a remarkable domination of the influence of ‘privileged’ over ‘less privileged’ stakeholders and also revealed debates on the choice of selection methods that were complex and controversial (Prideaux, 2009; Taylor, 2006; Tutton & Price, 2002).

Where ‘privileged’ stakeholders were taken to represent the collective interests of academic institutions and medical professionals, the outcomes of medical student selection had favoured these interests above those of patients and communities (Allen et al., 1997; Coulehan, 2005; Gillespie et al., 2004; Van Der Weyden, 2007). Stakeholder-based research that had contributed to informing medical student selection and education included multiple dimensions, the keys ones of which are discussed below.

2.5.1 Stakeholder perspectives of the ‘good’ doctor

The initial literature review focused on stakeholder perspectives of the ‘good’ doctor that might inform medical student selection and education. The limited number of studies identified provided the impetus for me to focus on this aspect for the initial part of my project.

At that stage, I found four studies that had focused on stakeholder opinion to better inform medical selection and education. The first was conducted by Linke, Chalmers and Ashton in Australia as far back as 1981. Their study surveyed the opinions of selected socioeconomic groups on admissions criteria for undergraduate entry to medicine and was limited to a small sample of what the study identified as upper socioeconomic groups or ‘privileged’ stakeholders. Recommendations provided in this study focused more on these stakeholders’
preferences to select a wider variety of applicants than specifically on their perspectives of the ‘good’ doctor or the experiences that had informed them (Linke et al., 1981).

A second study, conducted in South East Asia by Fones et al. (1998) sought the opinions of three stakeholder groups on the characteristics of a ‘good’ doctor. These data were qualitatively analysed and translated into a 25-item questionnaire, which was subsequently administered to a sample of doctors and patients to rate their importance. Although this study was similarly limited by a small sample, the findings were significant for informing medical student selection by identifying stakeholder consensus over ‘good’ doctor characteristics and specifically by emphasising humanistic traits alongside those of academic ability.

The authors of the second study noted further that, whilst doctors placed more emphasis on moral and ethical issues, patients were more concerned with ‘interpersonal and emotional domains’ (Fones et al., 1998, p. 572). These findings supported research that advocated for the inclusion of ‘non-cognitive’ predictors to better inform medical student selection (explored in the earlier section 2.3.2 of this chapter).

Lambe and Bristow’s Delphi study focused on ‘privileged’ stakeholders to identify ‘good’ doctor attributes (2010). They reported a consensus of opinion, not only within their study sample of medical experts, but also between their ratings of generic ‘good’ doctor attributes and those highlighted by the profession and described in the selections literature. These included doctors who were: ‘patient-centred; who had moral probity; who were effective communicators, team players and leaders; who were competent; who had
insight and a reflective manner; who were able to make decisions under pressure and use their own initiative; who had pro-social attitudes; who were curious and creative; who were ethical; who had resilience, compassion and motivation; and who were committed to lifelong learning and performance development’ (p. 349).

A fourth study by Çetin et al. (2011) similarly focused on stakeholder perspectives of the ‘good’ doctor. In this instance, the stakeholders were patients and doctors on a Turkish military base. The authors claimed that a paternalistic model of medical care had impacted negatively on patients’ perceptions of their doctors. The authors demonstrated how the context of the doctor-patient relationship influenced the opinions, expectations and experiences of both parties. Their findings are explored further in a later discussion on the ‘doctor-patient relationship’ in section 2.5.4 of this chapter.

Apart from patients and doctors, some scholars focused on medical student perspectives of the ‘good’ doctor. (Cuesta-Briand et al. 2014; Hurwitz et al., 2013; Maudsley et al., 2007). These less traditional and more inclusive research attempts were valuable for informing participant recruitment for my project. For example, Cuesta-Briand and colleagues (2014) used a qualitative approach to interview 49 medical students in 13 focus groups at a western Australian university over four years. For these participants, ‘being competent, a good communicator and a good teacher were the main characteristics of the ‘good’ doctor’ (pp. 6-8).

Equally valuable for my study was recent criticism of the poor recognition traditionally given to ‘less privileged’ stakeholders in medical student selection and education decision-making. For example, Walsh et al. (2016) interviewed
51 patients and concluded that they valued a range of ‘good’ personal qualities and communication skills in doctors. These were articulated as ‘being friendly and approachable, understanding, empathic and interested, kind and caring, honest and trustworthy, confident and reassuring, enthusiastic, respectful, humorous, conscientious and hard-working as well as being a good communicator by giving explanations in words that can be understood, giving time and being a good listener’ (p. 3).

These scholarly contributions were taken into account when planning further recruitment of stakeholders to my study. The gaps identified in the literature had provided the opportunity to better inform medical selection and education from a stakeholder perspective that was uniquely more inclusive, particularly of patients.

To sum up, attempts to inform medical selection and education from stakeholder perspectives of the ‘good’ doctor revealed studies that were limited in scope as well as in number. Of note was the predominance of quantitative research approaches (Çetin et al., 2011; Fones et al., 1998; Hurwitz et al., 2013; Lambe & Bristow, 2010; Linke et al., 1981) and of thematic-type analyses for most of the qualitative-based research (Cuesta-Briand et al., 2014; Maudsley et al., 2007; Walsh et al., 2016). The revelation that only two of the studies cited above focused on patients (Fones et al., 1998; Walsh et al., 2016) lent additional weight to my study.

2.5.2 Stakeholder views of selection methods

Although some of the research Kelly has conducted (2015) and led (2013, 2014a, 2014b) has involved quantitatively-based attempts to assess the effectiveness of selection tools (such as the HPAT-Ireland and MMI), her mixed
methods study for her doctoral research (2015) and her first-author publication this year (2018) are important for informing medical student selection from a stakeholder perspective. Particularly relevant for my research topic was Kelly’s qualitative approach to explore stakeholder acceptability of admissions in three medical schools in Ireland as part of her mixed methods study (2015).

These differences were useful for informing stakeholder-driven recommendations for improving the ways in which medical students are selected and educated. Kelly et al. (2018) recognised as much by stating that:

*It is critical to the operation of fair and defensible selection processes that we understand and appreciate the range and depth of views that they [stakeholders] hold … it highlights the need for better standards and more appropriate methodologies; for broadening the scope of the stakeholder groups included in future research.*

(p. 23)

2.5.3 **Stakeholders in health care**

The role of stakeholders in health care decision-making was widely recognised in the literature. However, in the context of medical selection and education decision-making, such recognition favoured discourses from ‘privileged’ viewpoints such as those related to medical workforce issues in health care delivery planning (Hudson et al., 2017; Kecskes & Mitchell, 2017; Murray & Wilson, 2017; Patterson et al., 2014; Tiffin, 2017).

Health-care decision-making that had been driven by patients as ‘less privileged’ stakeholders, was recognised more by other health care professions – nursing in particular – than by medicine (Gillespie et al., 2004; Hook, 2006; Huffman, 2005). However, research that focused on patients’ safety and their
health care rights was important to consider for my study (Fraenkel & McGraw, 2007; Luxford, 2011; The Australian Commission on Safety and Quality in Health Care, 2008a, 2008b, 2008c). For example, some authors noted an increased recognition of the importance of the patient safety and wellbeing by physicians; whilst arguing that ‘managing patient satisfaction can be deemed both a moral and professional responsibility for a physician and should be a core skill for medical students’ (Robichaud, East, Beard, & Morra, 2012, p. 256).

Compared with evidence for strengthening recognition and representation of stakeholders in global health care delivery debates (such as those led by the World Health Organisation), ‘less privileged’ groups of stakeholders have largely been excluded from the medical selection and education debate. Where stakeholders have participated in this debate, their inclusion has again been largely on the basis of exclusivity and ‘privilege’. For example, as leaders and groups invested with decision-making on academic, administrative, commercial and professional grounds rather than from patients and communities as the end-users of medical care and defined as being ‘less privileged’ for my study (Bore et al., 2009; Broadley, 2010; Chen, 2011; McManus & Powis, 2007; Medical Deans Australia and New Zealand, 2010; Powis, 2008; Van Der Weyden, 2008; World Federation for Medical Education, 2015).

Further evidence to support the poor recognition of patients in medical selection and education decision-making related to research that was more focused on performance outcomes for the student/graduate/doctor than on patient satisfaction (Bombeke et al., 2010; Brock, 2011; Gillespie et al., 2004; Luxford, 2011). These scholars supported others who were critical of a medical student selection process that had ‘privileged’ the interests of some stakeholders above
others (Aretz, 2011; Çetin et al., 2011; Fraenkel & McGraw, 2007; MacLeod, 2011; Maudsley et al., 2007; Young, 2010).

So far, exploration of the literature on stakeholders in health care revealed gaps similar to those identified for stakeholder perspectives of the ‘good’ doctor (discussed in the earlier section 2.5.1). Evident, again, was a greater focus on those invested with privileges to influence how future doctors are selected and trained than on the end-users of medical service provision. The aim of my research therefore, was to address this oversight and to drive further research that recognised patients in medical student selection and education decision-making.

2.5.4 The doctor-patient relationship

Pertinent to my study was research that explored the impact of the tension between the ‘art’ (humanism) and the ‘science’ (knowledge) of medicine on doctor-patient relationships. This tension was identified in discourses around the ‘good’ doctor from multiple stakeholder perspectives (Bandiera et al., 2015; Drane, 1988; Hurwitz et al., 2013; Lambe & Bristow, 2010; Price et al., 1971; Yurkiewic, 2012), including those of patients (Paterson, 2012b).

In the context of medical student selection and education, empathy was widely claimed to be at the centre of the doctor-patient relationship, with studies by Hojat and colleagues leading the field (Hojat et al., 2005a, 2005b, 2007, 2009, 2013, 2014, 2015; Hojat & Zuckerman, 2008; Hojat & LaNoue, 2014). Interesting to note was the wide recognition given to claims of progressive declines in medical students’ empathy. Although there was evidence in the literature to support these claims (Chen et al., 2007; Neumann et al., 2011;
Pedersen, 2009), more recent evidence has brought them into question (Bombeke et al., 2014; Colliver et al., 2010; Ferreira-Valente et al., 2017; Roff, 2015).

Discourses around medical student empathy have important implications for future medical education research and practice. From my earlier review of the relevant medical education literature (in section 2.4), a ‘hidden curriculum’ effect was thought to be associated with decreased empathy and consequent compromise of the doctor-patient relationship. However, these contributions lacked focus on the views and experiences of ‘less privileged’ stakeholders and of patients in particular – a criticism consistent with the ideas of Pederson (2009), who emphasised the need for qualitatively-based, stakeholder-driven research that could balance the ‘art’ with the ‘science’ of medicine.

An added dimension to scholarly focus on the doctor-patient relationship was that some scholars viewed empathy synonymously with altruism (Burks & Kobus, 2012; Jones, 2002) as well as with compassion (Cameron et al., 2013; Carmel & Glick, 1996; Green, 2013; Lown et al., 2011). Another scholar focused on discourses of caring and competence (including benevolence and humbleness), stating that ‘[d]iscourses of competence tend to be privileged while those discourses of caring are often marginalised’ (MacLeod, 2011, p. 375).

Lown et al. (2011) placed compassion between empathy and sympathy for their survey of 800 recently hospitalized patients and 510 physicians. Although their study demonstrated a shared emphasis on compassionate care for effective medical practice, it also demonstrated discrepancies between patients’ expectations and reality.

Closely aligned with discourses around empathy, altruism and caring, was research that had focused on the importance of emotional intelligence (EI) for
healthy doctor-patient relationships. Important for my study were contributions from ‘less privileged’ perspectives, evidenced by only two studies. The first identified EI as an important element of healthy doctor-patient relationships after surveying 994 outpatients and 39 doctors representing 11 specialties (Weng et al., 2008). On the basis of their findings, the authors attempted to better inform medical education models by recommending EI coaching for doctors.

The second study by Johnson (2015) cited the importance of EI for medical student wellbeing and healthy doctor-patient relationships. Her research attempted to better inform medical education models by promoting the acquisition of EI-related skills during medical training. Important to consider for my study was the inference made by the author and others (Carr, 2009; Cherry et al., 2014; Naeem et al., 2014; Stoller et al., 2013) that EI was a skill that could be learnt. Such inferences connect to a broader debate in the medical selection and education literature about the extent to which particular capabilities required for medicine should be assessed as part of admission procedures or can be strengthened at key stages during training. For example, EI has been included in resilience training (Dhingra et al., 2015; Stoller et al., 2013). There is also evidence to support the contention that empathy (Kelm et al., 2014; Lim et al., 2016; Wündrich et al., 2017), communication (Casey et al., 2014) and professionalism (Hays et al., 2013) can be strengthened during training. However, the question of ‘trainability’ of other capabilities remains largely unexplored in the stakeholder-based literature.

Aside from empathy and EI, communication was widely recognised as a key element of the doctor-patient relationship, not only in relation to medical education models (Abadel & Hattab, 2014; Best, 2011; Casey et al., 2014; Kelly
et al., 2013; Lim et al., 2012; Turner et al., 2016) but also to patient and doctor experiences. For example, according to Lown et al. (2011):

Patients and physicians alike agreed that health outcomes depend not only on the medical skills and knowledge of the physician, but also on his or her effective communication and emotional support.

(p. 1174)

Abadel and Hattab (2014) identified communication with patients as ‘the core clinical skill for the practice of medicine’ (p. 2). They referred to other studies that had highlighted the impact of poor communication on the doctor-patient relationship, citing that:

Research has shown that physicians who exhibit negative communication behaviours are more likely to have been sued in the past for malpractice than those with more positive doctor patient relationships.

(p. 2)

The work of the Picker Institute in Europe (2008) defined the public’s expectations of doctors by referring to ‘patient-centred professionalism’ and the ‘benefits to patients of a patient-centred approach’ (p. 6). A study by Maudsley et al. (2007) focused on medical students as stakeholders who had shared their perspectives and expectations of the ‘good’ doctor. These scholars proposed that further evidence was needed to ‘support ongoing commentary about
patients seeking qualities related to communication, caring, and competence in doctors’ (p. 476).

Stewart (2005) reflected on her experiences in general practice to emphasise healthy doctor-patient relationships by stating that:

*Doctor-patient relationships evolve over time and are built on regular consultations as well as other shared experiences, such as childbirth, hospitalisations or home visits. The goals of care at these encounters over time encompass the conventional goals of diagnosis and cure but also the broader goals of support and healing.*

(p. 793)

In summary, key capabilities identified from the stakeholder-based literature for healthy doctor-patient relationships were empathy (used synonymously with compassion, altruism and caring), EI and communication. Associated discourses focused on factors that could potentially compromise doctor-patient relationships such as ‘hidden’ medical school curricula. Whilst scholars generally agreed that medical students could acquire effective communication skills during training, evidence to demonstrate similar outcomes for empathy and EI was either inconclusive or lacking. Although some studies involved ‘less privileged’ stakeholders, a ‘privileged’ viewpoint dominated this part of the literature. Guided by my research question, I continued further exploration of the stakeholder-based literature.

2.5.5 **Patient-centredness**

This dimension was strongly linked to that of the doctor-patient relationship in stakeholder-based studies that could inform medical education and selection.
Referred to in some studies as patient-centred care (PCC), this dimension was also linked to discourses around the ‘hidden curriculum’ in medical education. For example Bombeke (2010) and Haidet (2010) promoted PCC from a stakeholder perspective that was student-centred and that supported medical educators and students to develop PCC in practice. Haidet (2010) contended that:

\[
\text{[P]atient-centredness is difficult to achieve in practice, because it challenges prevailing professional norms … it is difficult to see the points at which the patient’s perspective is at odds with our own, to respect such differences, and to give the patient’s perspective as much weight as our own while trying to reconcile differences between the two.} \]

(pp. 643-644)

An Australian-based study by McNair et al. (2016) applied a theoretical framework for patient-centredness from patient and doctor perspectives. Referring to a ‘therapeutic/power sharing alliance’ that focused on patients’ experience of their illness and doctors’ self-awareness, their study identified opportunities to develop and sustain PCC in medical curricula and concluded that ‘a new generation of doctors with a strong patient-centred focus is emerging’ (p. 1). These results were relevant because they were more inclusive of patients and acknowledged society’s investment in effective medical practice.

Stewart (2005) used her experience in the field of Family Medicine to identify interactive components of a patient-centred clinical method that would enable doctors to practice both the ‘science’ and the ‘art’ of medicine, within the context of the doctor-patient relationship. These components focused on paying
attention to the ‘patient’s unique experience of illness; practising holistically; sharing goals and clarifying roles [claimed by Stewart to be the most important in predicting positive patient outcomes]; teamwork; health prevention and promotion; equity; self-awareness [including being realistic]; compassion; empathy as well as trust and spirituality’ (pp. 795-797).

I drew parallels between Stewart’s patient-centred proposals (2005) and the work of other scholars. For example, for Little et al. (2001) a patient-centred approach included communication, partnership, and health promotion for vulnerable patients, whilst Robichaud et al. (2012) advocated patient engagement and empowerment as a critical component of patient-centred care. Coelho (2010) proposed a policy framework for ‘patient-centred comparative effectiveness research’ which was noteworthy for including multiple stakeholders, especially patients. Mainous et al. (2004) analysed data from 138 family physicians (GPs) and 4,454 patients, to explore their shared perceptions and to advocate for increased continuity of care for patients. Although the authors used a quantitative approach, their large-scale study was notable and made a valuable contribution to stakeholder-based discourses around patient-centredness.

In summary, the key elements identified from the literature for healthy doctor-patient relationships were consistent with those identified for ‘patient-centred’ medicine. These elements were also linked with research attempts to address barriers such as ‘hidden curriculum’ effects during training. Although many approaches remained student-centred, there was evidence of patient-centred initiatives from multiple stakeholder perspectives. Important to consider for my study, however, was the continued predominance of ‘privileged’ viewpoints and the relative paucity of research attempts to explore doctor-patient encounters in depth.
2.5.6 **Professionalism in medicine**

Having identified a range of desirable capabilities related to cultivating healthy doctor-patient relationships and patient-centredness from multiple stakeholder perspectives, my attention shifted to exploring discourses around professionalism in medicine that could better inform medical selection and education.

An Australian-based systematic review of ‘professionalism in medical education’ conducted by Birden et al. (2014) was useful for linking professionalism to the two previously identified dimensions – the doctor-patient relationship and patient-centredness – attaching significance to it as ‘the art that complements the science in an effective, well rounded physician’ (p. 1). Pertinent to my study was research that had placed patients at the centre of discourses around medical professionalism. For example, Barnhoorn and Youngson (2014) illustrated this point by defining professionalism as ‘placing the best interests of patients at the centre of everything you do’ (p. 1).

Apart from linking discourses around professionalism to attempts that had focused on patient-centredness and the doctor-patient relationship, there was evidence to link professionalism to discourses that had focused on ‘hidden curriculum’ effects. The latter element was identified as a potential challenge for medical education providers in section 2.4. Studies of interest were those that attempted to demonstrate the benefits of positive role-modelling for strengthening professionalism in trainee doctors from a medical student and junior doctor perspective (Al-Abdulrazzaq et al., 2014; Byszewski et al., 2012; Park et al., 2017; Salinas-Miranda et al., 2014). Of note was the shared proposal by these scholars for professionalism assessment to be initiated at selection and continued throughout medical training and practice.
Key priorities for professionalism were outlined and associated challenges for medical selectors and educators were explored by Alldridge et al. (2014) at a conference for health professional educators in Australia. The conference session focused on barriers to effective assessment for safe professional practice in trainee doctors and raised questions about which aspects of professional practice could be reliably assessed, including the appropriate times for each assessment. Participants endorsed the recommendation referred to earlier, which was for professionalism assessment to be initiated at selection and continued throughout medical training and practice.

Pertinent for my study was the subsequent implementation of a *Professional Behaviour for Medical Students Policy* in a local medical school (Griffith University School of Medicine, 2016). Although tailored to different learning and clinical environments, this policy aligned with the relevant legal and professional codes of conduct for trainee and qualified doctors. Such codes of conduct were embedded in regulations for medical students and doctors in Australia (Australian Health Practitioner Regulation Agency, 2015; Australian Medical Association, 2017; Australian Medical Council, 2009; Medical Board of Australia, 2014). Particularly relevant for my study, was the emphasis that these professional and regulatory bodies placed on ‘safe’ medical practice’ for all stages of a medical career.

Apart from some medical student involvement, discourses around medical professionalism had remained ‘privileged’. A recent study went some way towards addressing this limitation by involving a broader representation of stakeholders to explore medical professionalism within a local health care context in Kenya, Africa (Ojuka, Olenja, Mwango’mbe, Yang, & Macleod, 2016). The authors’ mixed methods approach combined interviews and surveys to
explore medical professionalism perspectives amongst clinicians, medical students and patients. The results were relevant to my study as they resonated with key elements previously identified for healthy doctor-patient relationships, for patient-centredness and for positive role-modelling. Interesting to note was that from the broad range of capabilities identified for professionalism, study participants prioritised respect, care for patients and communication as key elements, with the authors concluding that ‘the major pillars [of medical professionalism] are respectful service provided by skilful clinicians’ (p. 11). Although the study reaffirmed challenges previously outlined for medical education providers (such as technological advances, sociodemographic trends and the corporatisation of medical care), the emphasis placed on cultural competency for doctors was noteworthy.

Having explored how stakeholder-based discourses around professionalism could better inform medical selection and education, I went on to explore how lapses in doctors’ professional behaviours had impacted on stakeholders and on patients in particular. Two studies that involved medical students were identified. The first by Ginsburg et al. (2005) used a qualitative approach to explore 22 medical students’ experiences of professional lapses in their peers as well as in clinicians. The authors identified behaviours related to communicative violation, role resistance, objectification, accountability and harm and urged medical educators to ‘cultivate professionalism without entitlement’ (p. 39).

The second study by Robins et al. (2002) surveyed 120 medical students on their perceptions of professionalism, using the American Board of Internal Medicine’s taxonomy of ‘professional’ and ‘unprofessional’ behaviours as a frame of reference. The authors demonstrated that the desirable behaviours of
altruism, accountability, excellence, duty, honour and integrity and respect for others had created dilemmas for students in their learning and clinical environments. These had important implications for future medical education models, particularly in relation to tensions created by student-centred versus patient-centred models and to ‘hidden curricula’ effects of poor role-modelling referred to earlier in section 2.4. Of particular importance to my study was evidence of medical student reports of unprofessional behaviours amongst their peers and qualified doctors, such as ‘abuse of power, arrogance, greed, misrepresentation, impairment, lack of conscientiousness and conflicts of interest’ (pp. 526-530).

A landmark program of research by Bismark and colleagues highlighted the impact of poor professionalism on patients (Bismark et al., 2006, 2011a, 2011b, 2013; 2016; Taylor, 2006). The authors’ New Zealand-based study was useful for identifying doctors’ incompetence and poor communication from patient complaints (Bismark et al., 2006). This research was strengthened by evidence that linked large numbers of complaints with small groups of complaint-prone doctors (Bismark et al., 2011a). Interesting to note was the authors’ confirmed evidence of a link between specialty choice and patient satisfaction, which directed focus back to the doctor-patient relationship. The authors linked ‘the potential for power imbalances between doctor and patient’ with a ‘significant overrepresentation’ of complaints against surgeons and psychiatrists’ in their study (p. 26). It was pertinent, therefore, to bear this evidence in mind by including a diversity of patients and doctors in my study.

Although Bismark’s research identified ‘high risk’ doctors as being in the minority (with an estimated 3 per cent of Australia’s medical workforce accounting for 49 per cent of complaints), evidence that past complaints were
strongly predictive of future complaints lent strong support to the conclusions of the earlier landmark Papadakis studies in the USA (Papadakis et al., 2001, 2004, 2005). Papadakis’ work has been widely recognised for informing medical student selection and education by focusing on predictors for professional deficiencies and for identifying professionalism as a key competency for a career in medicine.

Publications that followed in the wake of Bismark and Papadakis’ research highlighted that in Australia in the past decade fewer than 500 doctors had managed to amass an incredible 4,726 patient complaints (Jager, 2013) and that these complaints were linked to unprofessional doctor behaviours such as over-confidence, arrogance and disregard for patient welfare (Buntine, 2011). Other scholars voiced similar concerns, for example, Vance et al. (2012) recommended that ‘medical schools should also be engaged in the task of promoting professionalism’ (p. 38). The accountability placed on medical schools to graduate professional doctors was evidenced by others in the literature. For example, according to Bonke (2006):

*Medical schools have a definite responsibility: graduating a student to be a qualified physician implies a reasonable guarantee that the person is fit to practise medicine on a professional basis.*

(p. 440)

More recent studies referred to professionalism in other contexts. For example, a qualitative study of doctor-patient encounters in Norway demonstrated the negative effect of doctors’ unprofessional behaviours on their patients’ wellbeing (Agledahl et al., 2011); whilst Barlow and colleagues (2015) identified breaches
in the 2010 *Australian Medical Association Guidelines for online professionalism for medical students and practitioners* and advocated for social media issues to be better addressed in medical curricula.

Unprofessional doctor behaviours from other stakeholder-based studies were identified to include those of [emphasis added] **incompetence** (Chiarella, 2012; Hall, 2015; Houghton, 2012a, 2012c, 2012d; McLean, 2006; Palacios-González & Lawrence, 2014); **arrogance** (Buntine, 2011; Hall, 2015; Katz & Vinker, 2014; Lombard et al., 2012; Mendelsohn, 1991; Robins et al., 2002); **disrespect** (Arora et al., 2010; Ebrahimi et al., 2012; Roberts et al., 2014; Scott et al., 2015; Simpson, 2012); **poor communication** (Arora et al., 2010; Hays & Worthington, 2012; Jager, 2013; Johnson, 2015; Powis, 2015; Zaidi et al., 2014); **a disregard for safety** (Houghton, 2012a, 2012b; Mushtaqq & Ratneswaran, 2015); **narcissism with impaired judgement** (DeGrazia, 2014; Hall, 2015; Munro et al., 2005; Powis, 2015; van Mook et al., 2015) as well as **criminality** (Brockbank et al., 2011; Helbig, 2012; Houghton, 2012a, 2012d, 2013; McLean, 2006; Oberhardt, 2010; Paterson, 2012a; Powis, 2015; Stone, 2014).

Studies by (Ginsburg et al., 2005; Kaldjian et al., 2012; Roberts et al., 2002, 2014) referred specifically to rudeness and disrespect for others, various violations of appropriate communication rules and breaches of trust with patients; whilst Roberts et al. (2014) linked stakeholder perceptions of unprofessional doctors with the specialties of surgery and obstetrics/gynaecology, stating that:

*Patient care-related behaviours tended to be some form of benign neglect or lack of compassion, either for the patient or the family of the patient … Violence/mistreatment ran*
the gamut, from throwing things, hitting and pushing and threatening, to being cold and uncaring to patients.

(p. 4)

An important consideration for my study was that earlier evidence of a link between patient complaints and the specialities of surgery and psychiatry (Bismark et al., 2011a) was partly borne out by this more recent research by Roberts et al. (2014). Recommendations from studies on professionalism were significant for informing medical student selection and education. They ranged from a general consensus to apply legal, ethical and professional codes of conduct to specific guidelines for the initial and subsequent assessment of trainee doctors.

In summary, a range of capabilities for effective professional medical practice was described in the literature. Discourses around professionalism were affiliated with key elements identified in the existing literature for healthy doctor-patient relationships and patient-centredness, which were discussed in earlier sections of this chapter (2.5.4 and 2.5.5). Equally relevant for my study was identifying research that demonstrated the impacts of poor professional practice, particularly on patients. Although there was evidence of increased stakeholder participation in this field of research, the predominance of ‘privileged’ viewpoints still prevailed. Equally pertinent was that even where studies had demonstrated multiple stakeholder involvement, they had often failed to explore doctor-patient encounters in any depth. I therefore, narrowed further exploration of the stakeholder-based literature accordingly.
2.5.7 Stakeholder experiences of doctors

There has been little published research on this topic, with a preference for quantitative above qualitative approaches, such as empirically-based measures of empathy for medical students and doctors that attempted to inform medical student selection and education (Pedersen, 2009). This lent significance to my project, particularly in relation to its phenomenological and interpretive focus. Equally lacking was stakeholder-based research that attempted to give a voice to vulnerable groups of stakeholders (particularly patients) in the medical selections and education debate.

A study by Poncelet et al. (2013) explored patients’ experiences of continuity of care with medical students and proposed that this was not only valued by patients, but that in the context of the doctor-patient relationship (referred to earlier in section 2.5.4), these relationships were perceived to be mutually beneficial. Moreau and colleagues (2016) bestowed a stakeholder role upon parents in paediatric settings by relying on their assessment of ‘soft’ (or humanistic) skills in medical residents, which the authors claimed were ‘fundamental to the practice of medicine and inclusive of communication, collaboration, leadership, advocacy, scholarship and professionalism’ (pp. 1123-1124).

Safran et al. (2006) promoted the use of patient-based surveys as unique ‘windows into patient experiences’ (p. 13). The authors focused on patient-centred care and shared accountability as benchmarks for quality assurance in health care, asserting that:

[T]he survey addressed two broad dimensions of patients’ experiences: quality of physician-patient interactions (communication quality, interpersonal treatment, whole-
person orientation, health promotion, patient trust, relationship duration) and organizational features of care (organizational access, visit-based continuity, integration of care, clinical team, and office staff).

(p. 14)

In the light of earlier critiques, although this study claimed to focus on patient experiences, it lacked detail about the complexity of patients’ experiences with doctors. However, it contributed to research on safety and quality in health care, the doctor-patient relationship, patient-centredness and medical professionalism (discussed earlier in sections 2.5.4, 2.5.5 and 2.5.6).

In her paper titled Reflections on the doctor-patient relationship: from evidence and experience, Stewart (2005) reflected on many years of general practice to highlight the mutually beneficial value of the doctor-patient relationship and to advocate for patients, stating that:

The GP actively seeks to enter the patient’s world to understand his or her unique experience of illness: the patient’s feelings about being ill, their ideas about their illness, how the illness is impacting on their function and what they expect from the doctor. Each person’s illness experience is unique.

(p. 794)

The author corroborated other research that had emphasised the importance of the patient’s perspective, including demonstrating strong preferences by patients for patient-centred care (Little et al., 2001; Mainous et al., 2004; Weston et al., 1989).
Along with patient advocacy, Stewart’s paper lent strong support to earlier references that were made in section 2.5.4 to addressing the ‘art’ versus the ‘science’ of medicine to better inform medical selection and education, stating thus:

One needs to strive constantly to obtain a balance between science and caring … the greatest challenge facing contemporary medicine is for it to retain … or regain its humanity, its caritas – without losing its essential foundation in science … Just as the doctor does not abdicate his or her expert role when attending to the patient’s voice, the teacher of medical students and trainees does not have to abdicate the role as teacher to listen more to the student’s voice, enter more the student’s world.

(Stewart, 2005, p. 799)

Stewart’s advocacy for student-centred medical education models was supported by others. For example, a mixed methods study by Butani et al. (2013) focused on medical resident and student perceptions of the ‘good’ educator (distinguished from the ‘good’ doctor). I drew parallels between these research findings and those related to role-modelling in my earlier review of the most relevant medical education literature in section 2.4. Useful for my study were findings by Butani et al. (2013) that trainee and qualified doctor participants had positively evaluated role-models who displayed professional skills (such as accountability, respect and humanism); who fostered a safe learning environment, an empowering teaching style and technique (by showing enthusiasm, providing clear expectations, directly observing students, demonstrating problem solving and engaging in feedback); and who
demonstrated effective leadership skills (through teamwork and balancing supervision with autonomy).

A study by Rentmeester, Brack and Kavan (2007) complemented this focus on positive role-modelling by exploring medical student attitudes about and experiences with, callousness. Although limited by a strictly quantitative approach, this research was significant for informing medical education by revealing how the effects of ‘hidden curricula’ (citing poor role-modelling as an example) could impact negatively on students and place patients at risk of callous medical practice. More recent research that focused on medical students as stakeholders to inform medical education included studies by Al-Abdulrazzaq et al. (2014) and Byszewski (2012) that likewise, exposed the effects of ‘hidden curricula’ and demonstrated that medical students had identified role-modelling as a key element of their learning.

Parallels could also be drawn between this and other stakeholder-based research that focused on preferences to combine the science with the art of medicine, to acknowledge the influences of hidden curricula and to research the interplay of these factors to better inform medical selection and education. However, although these authors had gone some way towards being inclusive of ‘less privileged’ stakeholders, their predominantly student-centred approaches took priority over patients. More pertinent to my study was a single, published account by a medical student that captured the importance of a patient-focused approach:

“My iconic, high pressure, state-of-the-art mentors, thriving on challenging cases and for whom every minute is valuable had failed, over many weeks, to notice a person behind the condition. The most valuable lesson I learned
at the best private hospital in town is what it is like to be a patient.

(Reeve-Johnson, 2013, p. 228)

The paucity of research in this area reaffirmed the need to address gaps in the literature and to guide the process for balancing my recruitment of ‘privileged’ stakeholders with those considered to be less so, particularly patients. An interesting dichotomy that emerged and that needed clarification at this point was distinguishing research that had focused on the ‘experience of illness’ from my focus on the ‘doctor experience’ phenomenon. Where several studies explored the ‘experience of illness’ with patients (Baron, 1985; Little et al., 2001; Mainous et al., 2004; Stewart, 2005; Weston et al., 1989) as well with doctors (McKevitt & Morgan, 1997), very few had focused on doctors’ experiences with other doctors. This paucity of focus facilitated my recruitment of doctor participants to explore the ‘doctor experience’ phenomenon in novel ways and from their unique perspectives.

An early paper by Baron (1985) attempted to inform medical education by proposing a phenomenologically informed view of medicine to explore the experience of illness rather than the illness itself. He claimed that ‘humanities can teach us about the experience of illness that our traditional paradigm does not’ (p. 609). The author emphasised the need to explore the relationship between an abstract world of science and a concrete world of human experience. His advocacy for placing patients and their experiences at the centre of phenomenological enquiry was highly pertinent to my study,
particularly for his focus on patients as marginalised stakeholders in medical selection and education decision-making.

Little seems to have changed since McKeivitt and Morgan (1997) claimed to have encountered ‘few studies of the experiences of doctors who become ill and use medical services’ (p. 645), making the inclusion of doctors valuable and timely for my study. These authors explored their topic, titled *Anomalous patients: the experiences of doctors with an illness*, more in the context of the doctor-patient relationship (discussed in section 2.5.4 of this chapter), than in relation to the experiences of doctors that could better inform medical selection and education. However, their work was useful for exploring doctors’ conflicting identities as well as for challenging attempts to link poor medical treatment of doctors (when they assumed the roles of patients) to complexities around role performance.

McKeivitt and Morgan’s (1997) findings were valuable for claiming that:

\[
\text{[T]he doctors’ experiences gave them an insight into the productive nature of their power. The desire to have someone else to take control was a desire for a qualified and competent person to show concern and provide reassurance, as well as take responsibility for the task of restoring order.}
\]

(p. 664)

Only one other doctor-centred, qualitative study could be found that was more recent (Nimmon & Stenfors-Hayes, 2016); being similar to McKeivitt and
Morgan’s (1997) focus on power-sharing and in the context of the doctor-patient relationship (discussed in section 2.5.4). The Nimmon and Senfors-Hayes study (2016) was useful for informing medical education models by addressing what the authors referred to as asymmetry in the doctor-patient relationship. They urged physicians to ‘learn to enact ethical patient-centred therapeutic communication through reflective, effective, and professional use of power in clinical encounters’ (p. 8).

Where there was a paucity of patients’ experiences with doctors in the medical selection and education literature, I identified a few informative examples in popular literature. These were briefly explored as non-fictional accounts of positively and negatively evaluated doctor experiences.

The first example was written by an Australian doctor who, with her doctor-husband, became world-renowned for alleviating the suffering of women affected by childbirth-related injuries in Africa (Hamlin, 2001). Pertinent to my study were the powerful messages conveyed that related to patient-centred care and to healthy doctor-patient relationships in diverse and difficult health care environments. The book also imparted inspirational messages for patient advocacy (particularly for vulnerable and disadvantaged patients) as well as for positive role-modelling in health care teams. The author’s positively evaluated experience of such advocacy was captured in this extract:

*When the patients were ready to go home he [her doctor-husband] would gather them together in their new dresses and talk to them … usually the nurses would gather round for this talk and when it was over they would take part in the traditional dance of joy with the patients … he never treated them [his patients] as just another case, but took time with them … it was touching to see how often this*
humble ceremony caused a smile, and eyes to sparkle, as hope was born again in the patient’s heart. Just to be loved and cared for means so much to these women who have suffered rejection and isolation.

(Hamlin, 2001, pp. 366–367)

Contrasting with these positively-evaluated experiences from multiple stakeholder perspectives, were problematic experiences presented in three popular literature sources. The first two of these focused on what was colloquially termed The Blunderberg Disaster where patients (and staff) alleged that they had suffered at the hands of ‘rogue surgeon’ Jayant Patel (Dunbar et al., 2011; Thomas, 2007). I drew parallels between this enquiry and a recent discourse on the failings within the National Health Service in Britain (Green, 2013; Saunders, 2015; Wang, 2015). These were important to consider for my study, as they described patients’ negative accounts of malpractice, which were linked to failures in health administration policies. Equally important to consider, were the links between such phenomena and disrupted doctor-patient relationships. Whilst some authors related this to an evolving distrust in a relationship that had become too contractual (Wang, 2015), others related it to declines in empathy as part of poor role-modelling for health professionals (Butani et al., 2013; George & Green, 2017; Roberts et al., 2014). Others still, questioned whether virtue (often interpreted as compassion, empathy, genuine concern and caring) could be taught (Saunders, 2015). Furthermore, investigations into Jayant Patel’s medical career (Dunbar et al., 2011) were supported by research findings in the academic literature that linked
unprofessional behaviour during medical school to later medical malpractice (Gill et al., 2014; Papadakis et al., 2004, 2005).

The books written by Dunbar (2011) and Thomas (2007) that focused on events surrounding enquiries into Bundaberg Hospital in Queensland, Australia, narrated the intensely negative doctor experiences of many stakeholders. Although the most serious of these were relayed by patients themselves or the families of patients who had died as a result of alleged medical malpractice, there were other stakeholders (‘privileged’ and ‘less privileged’) whose accounts were noteworthy. These accounts involved those whose personal and professional welfare had been compromised by advocating for their patients and peers, by raising their concerns in a hostile clinical environment and by assisting legal and disciplinary proceedings.
These compromises were summed up in the words of Thomas (2007):

Nobody had assessed Patel’s surgical technique. If it was anything like his personality – hot and cold, ranging from brash, domineering and rough to charming and obsequious – the staff and patients were in for a wild ride.

(p. 45)

Thomas’ book contains several other descriptions of Patel’s personality by diverse stakeholders who had ‘expressed alarm at the lethal repercussions of his work’ and who had referred to him as ‘Australia’s Dr Death’; ‘a psychopathic narcissist’; ‘ambitious’; ‘full of swagger and confidence’; ‘powerful’; ‘untouchable’; ‘invincible’; ‘cavalier’; ‘intimidating’; ‘flirtatious’; ‘bullying’; ‘obnoxious’; ‘bombastic’; ‘callous’; ‘paranoid’; ‘a lethal menace’; ‘dishonest’, ‘dangerous and incompetent’; ‘doing more harm than good’; ‘lacking integrity’; ‘displaying bravado’; ‘delusional about his own abilities’; ‘arrogant bordering on megalomania’; ‘indignant in the face of criticism’; ‘a clinical fraud’; ‘having a self-confidence that was almost pathological’; ‘having a colossal ego and self-belief that refused to entertain the idea that he might be found out’; ‘a trademark cocksure manner and a rhinoceros-thick hide’; ‘someone who shamelessly complimented himself, thrived on conflict’ and who regarded himself as a stellar surgeon who had been grievously wronged’. Amidst claims of privileged stakeholder support for Patel’s two-year ‘reign of terror’, the book documented how the efforts of patient advocates resulted in legal proceedings that culminated in Patel being banned from medical practice in Australia in 2015.

Significant for informing medical selection and education at this point were risks for a ‘Blunderberg Disaster’ repetition if the warnings from these accounts went
unheeded, particularly calls for medical selection processes to be improved to screen out candidates who could potentially become rogue doctors (Buntine, 2011).

Apart from the two stakeholder-based literary contributions that had focused on the negatively evaluated doctor experiences of multiple stakeholders, the third focused on a family who lost their son, brother and partner to HIV/AIDS in 1991 (Courtenay, 1993). Although this popular author was renowned for his works of fiction, authentic and powerful true-life doctor-patient encounters were shared in this book. Although some doctor experiences were positively evaluated, the negatively evaluated experiences were most impactful. Important to consider for my study was the author’s perception of consultants and specialists that resonated with discourses around poor role-modelling and links between temperament and specialty choice in the existing academic literature. For example, in one encounter, the author referred to doctors as ‘the high priests of the social temple … surrounded by the pliant, schoolboy obedience of the interns. They [the senior doctors] responded by being bad tempered, intimidating, ill-mannered and pompous’ (p. 15). In another encounter, the author’s narration focused on a specialist who was ‘constantly accompanied by a dozen fawning, white-jacketed interns at whom he would bark instructions or point out faults … he would ridicule the student in front of his peers … [his] grunt [of approval] was considered the ultimate sign for them to go forth and practise medicine with divine confidence’ (pp. 33-44).

The author expressed feelings of anger, frustration and helplessness over behaviours displayed towards him by doctors when his son’s condition deteriorated. Describing such behaviours as ‘arrogant, careless, callous, unthinking, incompetent, ignorant, patronising, socially inept, superior, second
to God and a vainglorious aristocrat’, he explained his decision to avoid ‘making a scene’ with a specialist by going ‘to shake his hand … but both hands were now clasped behind his [the specialist’s] back … so intimidated was I … that I seemed not to be able to help myself’ (p. 41).

Of further importance for my study was the author’s advocacy for patients whom he believed were marginalised in medical decision-making. Furthermore, his focus on poor doctor-patient relationships resonated with similar concerns raised in the literature, such as his perceptions of doctors who communicated ineffectively or inappropriately, or who objectified patients, even to the point of witnessing his son being treated as a medical curiosity. These negative perceptions were illustrated in the author’s closing remarks that:

*He [the doctor] was so removed from what was happening to the three young people in the room, on an emotional level, that he might as well have been addressing a class of first-year medical students.*

(p. 629)

The third popular literature source to focus on stakeholders’ negatively evaluated doctor experiences that resonated with the academic literature was also non-fictional: *The spirit catches you and you fall down* (Fadiman, 1997). Highly relevant for my study was the author’s focus on ‘less privileged’ stakeholder encounters with medicine, particularly those of vulnerable refugee families. Equally relevant was the way in which the experiences of this particular family resonated with discourses in the academic literature around patient-centredness, doctor-patient relationships and professionalism (discussed earlier in sections 2.5.4, 2.5.5 and 2.5.6). This book was, therefore, valuable to better
informing medical selection and education from a ‘less privileged’ viewpoint.
The author focused on the experiences of a young child (diagnosed with epilepsy) and her family, documenting how doctors’ misunderstanding of their belief system irreparably compromised this family. The author emphasised how cultural competency, as part of a healthy doctor-patient relationship, could have prevented the tragic loss of this child. In her words:

*The most important lesson is the necessity of seeing a case from the patient's point of view. Even if the doctor's knowledge exceeds the patient's by an incalculably huge factor, that knowledge will do little good if the patient does not trust the doctor or if the doctor does not understand the patient. The best remedy for both those problems is for the doctor to look at things from the patient's perspective (which may be culturally influenced).*

(p. 303)

2.6 LITERATURE REVIEW SUMMARY

In summing up this chapter, I undertook a review of the medical student selection and education literature to guide my initial research question and methodology. The first part of the review focused on scholarly attempts to inform medical selection and education. Discourses around medical student selection related to various selection methods, associated challenges and possible solutions for improvement. Although there was evidence to support admissions processes to select candidates on the basis of ‘cognitive’ (academic), ‘non-cognitive’ (psychometric) or a combination of both predictors, the evidence was conflicting and inconclusive. Discourses around medical education models were less contentious and focused on graduating ‘competent’
doctors. There was evidence to support attempts to address medical education challenges such as negative effects of ‘hidden curricula’ in medical schools and clinical placement settings. From my exploration of these attempts to better inform medical selection and education, I identified a critical gap, which related to ‘what’ range of capabilities we should be selecting and educating for to facilitate long-term, effective medical practice in contemporary society.

Having identified that a broader focus on ‘what’ to select and educate for in a ‘good’ doctor was required, I explored research that had attempted to inform medical selection and education from a stakeholder-based perspective. These attempts included discourses around the ‘good doctor’, stakeholder involvement in health care delivery, doctor-patient relationships, patient-centredness and medical professionalism. Similar to the gaps identified in discourses around selecting and educating future doctors, insufficiencies were also identified in this part of the literature. Firstly, research attempts had focused more on expressed stakeholder perceptions than on deeper explorations of their experiences with doctors. Secondly, although ‘less privileged’ stakeholders were represented, a ‘privileged’ viewpoint was prioritised. These gaps prompted me to refine my research question and to recruit stakeholders from ‘less privileged’ positions, particularly patients, for my study.

In the next chapter, I will outline the development of my research approach based on the findings of the literature review.
CHAPTER 3 RESEARCH DESIGN

3.1 BACKGROUND

This chapter will discuss the development and then execution of my research design. It will consider the general choice of methodology, the conduct and findings of the pilot study, as well as the impact of the pilot study on the main research project. Finally, it will describe the processes of the main study including how the resultant data were analysed. Chapter 4 will then present the findings of that analysis.

The exploration of the existing literature presented in the previous chapter was useful for aligning my choice of research design with my research question. Keeping the literature in the foreground of my project was equally useful for determining how best to contribute to the body of medical selection and education research from a unique perspective. The most suitable design for my project would therefore need to provide a framework for exploring in-depth doctor-patient encounters with a diversity of stakeholders.

My choice for a suitable research design took into account a number of factors. Firstly, the literature contained a large volume of research attempts to better inform medical selection and education over a protracted period of time. Secondly, the many and divided discourses in the literature reflected a medical selection and education debate that was both complex and controversial. This was partly due to inconsistencies in the use of methodologies and disputes over the plausibility of results. Thirdly, contributions to this body of research extended well beyond the field of medicine. For example, evidence to support psychometric testing for medical selection was linked to personality trait theory.
It was evident that quantitative and qualitative approaches had been employed either singly or in combination to inform discourses around medical selection and education. Although a few studies had included stakeholders, their privileged viewpoint and choice of methodology limited their ability to explore doctor-patient encounters. A judicious choice of research approach and methodology was required to address these gaps and to align with my research question. I determined that the empirical underpinnings of quantitative research were not suited to my research question, because use of predetermined questions and items assume that the nature of stakeholders’ experiences match those questions and items, which would preclude exploration of unexpected or poorly-explored aspects of experiences with doctors. Instead, more exploratory, qualitative research would most closely align with my research question.

Qualitative approaches include ethnography, defined as ‘the intensive study of community, organisational or corporate structures’ (Boyle, 2013, p. 4); narrative research (using words to tell rich and powerful stories of individual experiences); grounded theory (development of a theory that is grounded in the data); case-study (in-depth focus on a case or small number of cases); action research (undertaken to facilitate social change) and phenomenology (focuses on ‘lived experience’ to understand the ‘essence’ of a phenomenon) (Cleland, 2017; Creswell, 2013; Ng, Lingard, & Kennedy, 2013).

Having determined that a qualitative approach was required, I needed an approach that would enable me to work at what Reeves and colleagues have called a ‘micro’ level within the grand theoretical domains of social constructivism and interactionism (Reeves et al., 2008; Creswell, 2013). Phenomenology appeared to best accomplish this and Smith’s IPA method (2004) appeared particularly suitable for exploring ‘lived’ experiences with
doctors in order to answer the research question. IPA was, therefore, chosen as the most suitable paradigm above some other qualitative research approaches. For example, whilst narrative research is similarly rooted in the social sciences and humanities, it focuses on narrative stories to capture participants’ life experiences, whereas IPA offers a deeper exploration of how participants attempt to make sense of, and derive meaning from, their experiences with doctors.

Phenomenology therefore, offered the most suitable paradigm for exploring how stakeholder experiences with doctors could better inform medical selection and education, while allowing me to explore what stakeholders could tell us about doctor capabilities, based wholly on their experiences. This connection between stakeholder experience and the range of capabilities required for medical practice had the potential to address the gaps identified in the literature, emphasising for what we should be selecting and educating for from a uniquely inclusive perspective. For these reasons, a phenomenological paradigm was most closely aligned with my research question.

3.2 METHODOLOGY

Phenomenology originated from the work of Edmund Husserl, a 20th century philosopher who challenged traditional positivist approaches to develop a strong following in the human and social sciences where ‘qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them’ (Cohen & Crabtree, 2011, p. 1). From these origins, phenomenology as a research methodology gained popularity in the fields of education, health and psychology. For example, as an educator, Max van Manen (2001) focused on the ‘lived experience of everyday situations and relations’ (p. 10); whilst Jonathan Smith
introduced interpretive phenomenological analysis (IPA) to explore patients’ experiences of illness (Smith, 2004, 2011; Smith et al., 2009; Smith & Osborn, 2008).

An important methodological consideration for my study was van Manen (2001) and Smith’s (2015) shared focus on hermeneutic phenomenology. Hermeneutics originated in the interpretation of ancient biblical texts and subsequently aligned with the writings of philosophers such as Schleiermacher, Heidegger and Gadamer and social scientists such as Mead, Dewy and Weber (Smith et al., 2009; Van Manen, 2001). Although Heidegger deviated from Husserl’s writings, his hermeneutic circle (inferring a process of reciprocal analyst-participant meaning-making and interpretation) was useful for informing my analytical method. Hermeneutics would facilitate deep engagement with my study participants to explore meanings and interpretations around their doctor experiences. Equally important was Smith’s (2009) proposal to apply a double hermeneutic where ‘the participant’s meaning-making is first-order, while the researcher’s sense-making is second-order’ (p. 36).

I drew parallels between phenomenology and discourses in my earlier review of the relevant existing literature. For example, research that emphasised patient-centred medical practice and IPA-based research focused on patients’ experience of illness (Biggerstaff & Thompson, 2008; Smith, 2004; 2011); on improving health care delivery for patients (Harris, 2015) and on ‘the relationship between the abstract world of the sciences and the concrete world of human experience’ (Baron, 1985, p. 609). My research was similarly intended to give stakeholders an opportunity to be heard, which resonated with phenomenological research that demonstrated a commitment to ‘give voice to
the concerns of participants’ (Larkin et al., 2006, p. 102) or to ‘truly listen to the voices of the vulnerable’ (Van Manen, 2001, p. xii).

The characteristics of a phenomenological approach, tabulated by Creswell (2013) were useful for informing my research method by identifying the unit of analysis as ‘several individuals who have shared the experience’ (p. 104) (recruited purposively); collecting data from interviews (as a primary source) as well as from sources from the literature, diary, memos and field notes (as secondary sources); organising raw data (using computer assisted data analysis software); analysing data (descriptively, interpretively and comparatively); presenting outcomes in a reflectively written report that included anonymised, verbatim extracts (rich, raw data) in the text. Creswell (2013) distinguished between phenomenology and other qualitative approaches (referred to earlier in section 3.1) regarding the ‘extensive steps required for data analysis in phenomenological research’ (p. 79). Key dimensions of these steps are outlined below from (a) to (e). Pertinent for my study were descriptive and interpretive dimensions ascribed by phenomenologists for these stages, particularly within an IPA framework.

Within a proposed IPA framework I identified the following key elements for my project:

(a) Using an inductive approach (bottom up versus top down) by engaging in a flexible data-collection process that would allow me to probe interesting data as they emerged from participant experiences with doctors. According to Smith:

\[\text{IPA researchers employ techniques which are flexible enough to allow unanticipated topics or themes to emerge}\]
during analysis. The data collection techniques need to be flexible enough to allow this to happen.

(Smith, 2004, p. 43).

(b) Purposively recruiting participants who had an interest in the topic and who were open to a deep exploration of their experiences with doctors (Creswell, 2013).

(c) Managing the complexity of experiential data through rigorous and systematic analysis. A double hermeneutic approach would strengthen rigour, focus and coherence of the project (Reid et al., 2005; Smith, 2004).

(d) Balancing the idiographic (distinct and detailed) nature of each participant’s data with experiences that were shared between participants (Smith, 2004).

(e) Increasing rigour and credibility by being transparent and plausible (Reid et al., 2005).

One of the most important IPA elements guiding this project was that to which Larkin et al. (2013) referred as ‘the interpretation of first person accounts, which is committed to situating personal meaning in context’ (p. 117). It should, therefore, be borne in mind that participant experiences with doctors informed medical education and selection from a strongly contextualised paradigm of personal, social and professional relationships, in which I (as the researcher) played a central role. I, therefore, had to balance the practice of reflexivity with that of bracketing to keep the project transparent, robust and credible by, for example, acknowledging the influence of my personal values, beliefs and experiences on this research role and positioning myself, as far as possible, as
a detached observer (Elliott et al., 1999; Flood, 2010; Hopkins et al., 2016; Kafle, 2011; Larkin, 2013; Tavakol & Sandars, 2014b).

Hopkins et al. (2016) recently summed up these key elements by stating that:

*In phenomenology, the researcher is the primary instrument for gathering data and interpreting data ... Phenomenological researchers must address their ‘pre-understandings’ by balancing bracketing and reflexivity.*

(pp. 21-22)

Hopkins et al. (2016) proposed a framework for negotiating positionality in phenomenological research that highlighted important methodological considerations for my study. Reaffirming the emphasis placed by Smith (2009) and van Manen (2001) on skilful writing, Hopkins et al. (2016) positioned writing at the centre of their framework, intersected by key elements along three trajectories. I obtained permission from the authors to replicate their proposed phenomenological research model in *Figure 2* below. Referred to as ‘The 3+1 phenomenology framework’ the ‘+ 1’ component symbolises writing, which they prioritised by positioning this activity at the centre of the research process.

At the end of each of three intersecting lines, the authors identified continua between general (essence) and particular (idiographic); between reduction (bracket and ignore) and reflexivity (acknowledge and use) and between description and interpretation. The Hopkins et al. (2016) framework offered a structure for the positioning of phenomenological research that was more flexible than earlier approaches whilst acknowledging the importance and varied dimensions of writing.
I recognised the importance of writing for a number of methodological reasons. To produce ‘oriented, strong, rich, deep texts, which invite dialogue with those who interact with them’ (Van Manen, 2001, p. 21). Van Manen (2001) argued that ‘language is a central concern to phenomenological research because responsive-reflective writing is the very activity of doing phenomenology’ (p. 132). Similarly, Smith (2009) asserted that ‘IPA narrative represents a dialogue between participant and researcher that is reflected in the interweaving of analytic commentary and raw extracts’ (p. 110). These writing guidelines informed all stages of my method as well as the discussion of my findings.
The quality of my writing would, therefore, need to meet qualitative research standards (O'Brien et al., 2014; Tong et al., 2007).

To this end, I utilised the dimensions of the phenomenological framework proposed by Hopkins et al. (2016) to better understand IPA as it could be utilised in my research. Firstly, in order to capture the ‘essence’ of the doctor-experience phenomenon, I positioned my analytical method between idiographic (distinct and detailed) data of individual participants and the general data of shared participant experiences. My data analysis was strengthened by moving fluidly between the individual ‘parts’ and the ‘whole’ in a hermeneutic circle. Secondly, my analytical position moved from initial description of participant experiences with doctors, to deeper interpretation of those experiences. Applying a double hermeneutic enabled me to understand the meaning of these experiences. Thirdly, as mentioned earlier, I was required to pay equal attention to the bracketing and reflexive dimensions of my research role. On the one hand, I needed to acknowledge that my experience as a health professional and medical educator could potentially bias my interpretations and influence participant responses. On the other, I needed to suspend (or bracket) any subjective biases that could potentially compromise the credibility of my results.

A further methodological consideration for my project was to manage the tension between the small sample sizes recommended for IPA studies and my participant recruitment strategy. In order to address my research question and the gaps identified in the medical selection and education literature, my purposive sampling method deviated from recommended ‘small and homogenous sample sizes’ (Smith et al., 2009, p. 49). I needed to involve stakeholders previously marginalised in medical selection and education
decision-making and as end-users of medical care. Exploring the doctor experience phenomenon from multiple perspectives addressed this need and served to triangulate the data. According to Reid et al. (2005):

*The explanation of one phenomenon from multiple perspectives can help the IPA analyst to develop a more detailed and multifaceted account of that phenomenon. This is one kind of ‘triangulation’.*

(p. 22)

A further justification for my larger-than-usually-recommended sample size for an IPA study was that my research contributed to the body of IPA research, by demonstrating the feasibility of group interviewing for IPA studies that had traditionally focused on individual interviews or case studies (Larkin, 2013; Smith, 2004).

In summary, a qualitative research approach was needed to address the complexities inherent in my research question of how stakeholder experiences with doctors could inform the capabilities we need for selecting and educating future doctors. From the six qualitative research approaches identified (ethnography, narrative research, grounded theory, case-study and action research), phenomenology was most closely aligned with my project’s attempt to capture the ‘essence’ of the doctor experience phenomenon. Within a phenomenology framework, I identified IPA and hermeneutics as key elements to explore the doctor experience phenomenon deeply and meaningfully. I also identified key methodological considerations for my research role that included my stance or positioning within a proposed phenomenological paradigm. Although my sample size was unconventionally large, my study contributed to
IPA research by exploring the doctor experience phenomenon from multiple perspectives. I tested this methodology in a pilot study, which facilitated refinement of my research question and improvement of my data collection and analysis methods.

3.3 METHOD

3.3.1 Pilot Study

Background and formulation of initial research question

An opportunity arose to undertake a pilot study in June 2011 when I was invited to lead a 45-minute ‘personally-arranged learning session’ (PeArLS) at the annual Australian and New Zealand Association for Health Professional Educators (ANZAHPE) conference in central Australia (Lombard et al., 2011).

The theme of the conference in which the pilot was undertaken was ‘ethics and education’ and my abstract was titled ‘What makes a good doctor? How would patients like us to select medical students?’ I had consulted the existing literature to formulate this title as my initial research question.

Ethics approval was granted by Griffith University’s Human Research Ethics Committee on 16th June 2011 (Reference number MED/21/11/HREC). Please refer to Appendix E. Approval was sought and obtained from the conference organisers to conduct the session in this way, as well as to have it audio-recorded.

The aim of my pilot study was to practice data collection and analysis methods that aligned most closely with my proposed phenomenological hermeneutic framework. A planned conference session determined my specific objective, which was to explore the perceptions and experiences of a group of health
professional and medical educators who had an interest and/or expertise in, medical student selection. The following prompt questions were prepared for discussion and provided the framework for the semi-structured group interview schedule:

What does the ‘good’ doctor mean to you?

How would patients like us to select medical students?

What are the issues surrounding medical student selection?

How might we address these issues? For example, is the community getting a good return on future doctor investment?

**Pilot Study Participant Description**

An information sheet was distributed to conference delegates at the start of the session, to gain their cooperation and consent. Of the 27 who selected to attend this session from other concurrent sessions, 14 consented to be audio-recorded during the session and 13 to disclosing some personal information. The participant group was receptive to the semi-structured interview format that was prepared for the session, and shared commonalities as health professional educators who were willing to participate in the PeArLS. This shared interest was useful for my purposive sampling method (Larkin, 2013; Reid et al., 2005; Tavakol & Sandars, 2014a).

The participants represented medical and health professional educators from local, national and international universities. No age ranges were recorded for these participants, who were predominantly female. Nine participants identified as medical educators; two as health professional educators; one as a medical student and one as a medical selections officer. One participant did not disclose
her role. Four of the nine medical educator participants were practising medicine in Australia or abroad. Two of the remaining five medical educator participants were also practising nursing (one in Australia and one abroad).

**Pilot Study Data Collection**

The prompt questions that were prepared for the semi-structured group interview facilitated active engagement by all 14 participants. I encouraged them to explore the topic in depth, aiming to capture as much data as the allocated 45 minutes allowed. A colleague assisted for the duration of the session by recording notes of the interview, as well of subsequent participant feedback and enquiry. These data were added to the verbatim transcriptions for each participant and my colleague and I met post-interview to check the accuracy of the data collected.

Data from the interview notes and audio-recording were de-identified to preserve anonymity. The interview was given a number (1) and the participants were allocated numbers 1.1 to 1.14. The audio-recording was transcribed verbatim soon after the session. Feedback and discussion were sought from the colleague who assisted me and the transcript was discussed with my supervisors. Having collected the data, my first step was to use computer-assisted qualitative analysis software (QSR International Pty Ltd, 2007) to organise the data. After importing the de-identified transcripts into NVivo®, I read and re-read these to identify initial patterns in the data-set whilst referring to the literature and my (then) research question: ‘*What makes a good doctor? How would patients like us to select medical students?*’
Pilot study analysis

Having identified patterns in the data-set, I immersed myself more deeply in the data to explore participants’ meaning-making and experiences that were related firstly, to ‘the good doctor’ and secondly, to ‘how would patients like us to select medical students?’

Data analysis for the first part of the pilot study yielded two high level ‘units of meaning’ from participant experiences of ‘good’ doctors, which were:

(a) Effective interpersonal skills

One of my participants described this experience saying:

> Basically communication ... I want to be listened to ... I want to be taken seriously ... we want them to look at that person as a human being with a mind, body, spirit and soul.

[Participant 1.11 – medical educator]

For this participant, being a ‘good communicator’ not only meant ‘being listened to’ and being ‘taken seriously’ but also to being communicated with on an intellectual, physical, spiritual and psychological level. Another stated:

> I think the biggest one is interpersonal skills, so basically communication that is easy, comfortable, they’re a person. Obviously I want them to be professional but I don’t want to have an alienating experience where they’re, you know, the professional up on high, they know everything. I certainly want to be listened to as a patient, it’s my body ...

[Participant 1.3 – medical educator]
The second participant reinforced the first’s focus on ‘communication’ and ‘being listened to’ but shifted her focus to how poor communication, particularly that which rendered her powerless, would be an alienating, negative experience for her.

(b) Empathy

This meaning unit was typified by this observation:

*My most memorable experience as a patient was … I had clinical depression and I went to a GP that was recommended by a friend of mine ‘cos she was really good. I told her about what was happening with my life … she was really empathic, saying things like ‘Ah your life really sucks, it must be really hard; I don’t know how you do that’.*

[Participant 1.7 – medical educator]

Being treated empathetically by a doctor whom she saw for the first time, who did not judge her and who recognised how vulnerable she was feeling, created a positive experience and lasting impression for this participant. Another said:

*We want empathetic people but we don’t want the ones who are really, really empathetic and burn out within a year.*

[Participant 1.12 – medical educator]

Whilst recognising empathy as an important element of doctor-patient relationships, this participant’s experience as a medical educator emphasised
the need for empathy to be practiced in a way that also protected the emotional wellbeing of doctors.

To summarise, the first part of the pilot study focused on what being a ‘good doctor’ meant for participants. Data analysis revealed capabilities that included effective interpersonal skills (including communication and holistic, patient-centred care) and the importance of empathy for healthy doctor-patient relationships. Empathy needed to be practiced effectively to care for patients but also to protect the emotional wellbeing of doctors. This part of the pilot study was useful for informing the main study by demonstrating that face-to-face, individual interviews with an increased diversity of participants (particularly patients) would be necessary to facilitate a deeper exploration of this ‘good doctor’ phenomenon.

Data analysis for the second part of the pilot study yielded a further three ‘units of meaning’ from participant perceptions and experiences of medical student selection. These focused on medical student selection methods, challenges and solutions.

(a) Medical student selection methods

An Australian medical student participant listed:

A [traditional] interview, good GPA [Grade Point Average] and **GAMSAT** [Graduate Australian Medical Schools Admission Test] scores were the ones they used to select me. They worked well.

[Participant 1.1 – medical student]
This participant was positively disposed towards the combination of three selection methods for her postgraduate entry into medicine. In my earlier literature review I referred to these as ‘non-cognitive’ (her ‘traditional’ interview), ‘cognitive’ (her GPA score) and ‘mixed’ (her GAMSAT score) predictors. An educator participant noted that:

*Selection at [names a university in the Pacific Islands] is based on marks that are obtained by the students … there is no formal interview as [names participant 1.1] pointed out and we don’t have any problems.*

[Participant 1.2 – medical educator]

This second participant was, similarly satisfied with using a single ‘cognitive’ predictor for undergraduate entry to medicine in the Pacific Island region. Likewise, he expressed satisfaction with this method. Although reliance purely on academic performance has some support in the literature, I agreed with scholars who had questioned the heavy reliance upon this. It was interesting to note that these two disparate yet ‘satisfactory’ medical student selection experiences mirrored scholarly debate over undergraduate versus postgraduate entry into medicine. Of particular interest was evidence that had challenged the widely-held assumption that ‘successful students’ made ‘good doctors’. Another participant observed that:

*[Names an Australian University] does have a [traditional] interview process. It’s a panel interview and there are three members on the panel and one of those is a community member … That interview is equally weighted with student [academic] scores and they have a written entry essay where they have to demonstrate key skills like*
resilience and independence and consideration for others
... it's not so much academic qualities that we're looking for as personality traits.

[Participant 1.3 – medical educator]

This participant’s experience as a medical educator reflected satisfaction with a combination of selection methods similar to that shared by the first participant but at a different Australian university. Although support for using academic scores in combination with ‘pre-selection’ and traditional interview methods was variable in the existing literature, this participant’s focus on selection for ‘non-academic’ capabilities was encouraging. Another participant offered:

I would say to date the [traditional] interviews and the essays and the various ‘SATS’ [metric tests such as the UMAT and GAMSAT] of various sorts have not been successful.

[Participant 1.4 – health professional educator]

This participant’s criticism concurred with critiques in the literature that questioned the validity and reliability of traditional interviews (included in a review of ‘non-cognitive’ predictors in section 2.3.2) and of the long-term predictive validity of metric testing (included in a review of ‘mixed’ predictors in section 2.3.3).
Scepticism over the reliability of the traditional interview method was similarly expressed by other participants:

*I have noticed that medical students are still varied in personality and [there are] many high functioning ‘Asperger’s’ who get in, even with [traditional] interviews.*

[Participant 1.9 – medical educator]

This participant’s awareness of the diversity of temperaments required for equally varied careers in medicine was noteworthy, as was her recognition of the limitations evidenced for ‘traditional’ selection interviews. The apparent denigration of ‘Asperger’s’ candidates here gives rise to concern about the potential for discrimination on the basis of disability. On the other hand, it may be that the ability to connect effectively with patients on a human level is, in fact, an ‘inherent requirement’ of medical practice, making its absence a legitimate selection criterion.

Another participant offered:

*I would say every cohort, regardless of the [traditional] interview, we get between four and six students who are ‘criminal’, ‘unethical’, ‘amoral’ ... who really just should not be there ... and once they are there we have a major problem ... I don’t think the [traditional] interview has helped us very much in weeding out that sort of person or weeding out the ones who don’t really want to be there…*

[Participant 1.6 – medical educator]
This participant dismissed the ‘traditional’ interview method in much stronger terms but was unable to suggest a solution to identifying unsuitable candidates. The gravity of the undesirable capabilities that she identified (‘criminal’, ‘unethical’, and ‘amoral’) was concerning. Equally noteworthy was her experience of being unable to identify other potentially unsuitable candidates, such as those who were reluctant to apply. Further exploration of the possible reasons for this would have been useful.

Two participants positively evaluated the revision of admissions procedures for their respective (Australian) medical schools. Of particular interest was the substitution of ‘traditional’ interviews with multiple mini interviews (MMIs):

_We’ve just changed our admission procedure … We used to do a [traditional] interview process, the problem being everyone knew what our interview questions were! We’re going to do multiple mini interviews that will involve the community as well as doctors … it’s kinda the best that you can do._

[Participant 1.12 – medical educator]

_What we’re going to be doing is making it more like a selections-type OSCE [Objective Structured Clinical Examination]: Instead of the MMI where there’s the sitting and the talking to an interviewer, there’s going to be a couple of similar stations, but there will also be ‘doing’ stations. For example, after reading a scenario, they have to bring a rowdy meeting – played by actors – under control. It’s very exciting and we’re looking forward to doing it, so hopefully it will help us in our selections process._

[Participant 1.14 – medical selections officer]
The latter participant’s description of a modified MMI method was more detailed than her colleague’s. Although the latter participant’s interpretation of the MMI may not have been entirely in accord with the usual methodology, what was noteworthy was that both participants supported phasing out ‘traditional’ interviewing for a more reliable MMI method supported by evidence in the medical selections literature. Of particular interest was the distinction drawn by one of these participants between ‘selection’ (for successful training outcomes) and ‘education’ for effective, long-term medical practice:

We have tried to focus our MMI on people who will be ‘good’ medical students rather than doctors ‘cos we realise it’s our job to turn them into ‘good’ doctors.

[Participant 1.14 – medical selections officer]

The discourse concerning perceived benefits of revising selection methods became more engaging when a participant gave a first-person account of a novel approach to ‘exclusion’ or ‘weeding out’ unsuitable candidates, raised earlier in this group interview:

So what we’re doing is a PQA [personal qualities assessment] which is a personality questionnaire and excludes on the extremes of personality over five criteria so that we don’t get the few people with ‘personality disorders’ that take up 90 per cent of our time.

[Participant 1.12 – medical educator]
This participant’s endorsement of a novel ‘non-cognitive predictor’ for medical student selection (discussed in section 2.3.2) had some support in the literature, particularly when combined with the MMI.

Having explored participants’ perceptions and experiences of medical student selection methods, a second ‘unit of meaning’ emerged from their perceptions and experiences of medical student selection challenges.

(b) Medical student selection challenges:

Two participants raised concerns over the maturity of candidates to manage the early part of their careers:

_We’re talking about age … what gets me very excited is that we have five first-year medical students that are 16 this year … we’re putting these 16, 17, 18 year-olds out into community placements, rural placements and expecting them to behave as mature adults. They simply can’t do it because they’re not mature people and don’t have the necessary life experience._

[Participant 1.10 – medical educator]

For this participant, the young age of candidates posed challenges, not only for candidates themselves, but for those responsible for educating them – a concern raised by other medical educator participants:

_We still have an undergraduate program … How can we be assessing those kinds of characteristics that are going to determine a ‘good’ doctor in young people with no life experience whose brain isn't even matured? I think … trying to select who’s going to be a ‘good’ doctor is a bit of a ‘furphy’ [untruth]! How can you determine the resilience_
of 18 and 19-year-olds who have very little life experience?

[Participant 1.9 – medical educator]

This participant similarly perceived that young age and limited life experience disadvantaged candidates. She shared the scepticism expressed by other participants over the predictive validity and long-term reliability of some selection methods, given the lengthy and arduous nature of a medical career. Her concerns resonated with the literature, particularly in relation to discourses surrounding undergraduate versus postgraduate entry, and the extent to which capabilities (such as resilience) were related to temperament or could be learned. For example, for one participant (based on her experience), selection methods had been ineffective for undergraduate as well as post-graduate entry:

*I’ve been through training traditional [undergraduate] students, graduate-entry students, students of all ages and from all sorts of backgrounds and from my experience selection has made no difference …*

[Participant 1.7 – medical educator]

Similar disillusionment with selection methods in general was expressed by others. For example:

*And [names an Australian University] across the board has decided academic results … full stop that’s it. And the cut off is until the course is full. And it hasn’t made a blind bit of difference … but you just may as well take anyone and see what happens really! [laughter from the group].*

[Participant 1.5 – health professional educator]
The doctors of today are actually no better than the doctors of my day, and so all the screening that we do is at HUGE expense! We do all this and at the end of the day are we actually getting what we think we’re getting with all this ‘stuff’?

[Participant 1.4 – health professional educator]

One participant dismissed academic scores and performance as reliable predictors for selecting and educating ‘good doctors’ by stating that:

We have very ‘bad’ students with very high grades and we’ve got ‘fabulous’ students with low grades. At our [Australian-based] medical school the assumption that students with good grades make ‘good doctors’ has not been the case.

[Participant 1.5 – health professional educator]

Whilst two participants shared earlier concerns over unsuitable candidates gaining entry into medicine, they did not share the confidence that some had on their ability to exclude such candidates.

We’ll never be able to weed out the personality disorders because they’re so smart, most of them and the narcissistic ones especially have no insight …

[Participant 1.13 – medical educator]

We do [traditional] interviews, which are INCREDIBLY labour-intensive and expensive! There’s a high likelihood
that we’re getting rote answers even ‘though we write new vignettes every two to three years. We have to acknowledge that [traditional] interviews are a flawed process as we still get a handful of what you could call ‘sociopaths’.

[Participant 1.3 – medical educator]

These participants’ concerns were mirrored in ongoing research attempts to find ‘non-cognitive’ predictors to legitimise the exclusion of candidates who could potentially harm patients. As another participant observed:

*I don’t think the [traditional] interview really helps to weed out the really, REALLY ‘bad’ ones who lie, steal, cheat and do really terrible things! We then have a lot of trouble getting anybody, including the medical board [regulatory authority at the time] or the university to take matters seriously. There are also inconsistencies like they [medical students] need police checks to get into clinical placements, yet a police check is not a pre-entry requirement at our [Australian] medical school.*

[Participant 1.6 – medical educator]

This participant’s experience was valuable for affirming earlier criticisms of ‘traditional’ interviews and for focusing on potential conflicts of interest between stakeholders within medical schools, universities and the profession.

Participants’ shared concerns over medical selection issues were eloquently reflected in the words of one participant thus:
I think the selection process is inherently flawed … totally!
What we have to remember is we’re selecting medical students … not practitioners … I think the harsh reality is that the selections process is to weed down from your 1500 applicants to your 150 places … we talk all the niceties around it but I think that’s the harsh reality.

[Participant 1.14 – medical selections officer]

Data analysis of participants’ perceptions and experiences of medical student selection progressed from the first and second ‘units of meaning’ (selection methods and selection challenges) to a third ‘unit of meaning’. This unit emerged from their individual and shared attempts (as health professional and medical educators) to address medical student selection challenges.

(c) Medical student selection solutions:

Data analysis for this ‘unit of meaning’ revealed participant perceptions and experiences that extended beyond medical selection to medical education, given that medical education complemented a clinician role for many of them.

One participant mirrored scholarly attempts to better inform medical selection and education by suggesting that we increase the diversity of the medical student population to reflect that of the general population. For example:

I think getting any kind of standardisation across the board will be very difficult because we need to select [medical] students for the places that we’re servicing. Having said that, we also have a responsibility to produce graduates who are equipped to practice in a variety of places. We don’t want to pigeon-hole them, so I think that is also another challenge.
Important to consider for my study was another participant’s acknowledgment of challenges related to preparing doctors for a range of capabilities that they would require at different stages of their medical careers.

*You’ve got to train people for the real world … it depends on the context. So if you’re training a doctor for the hospital environment with support, with graduated responsibility … that’s different to a community experience.*

[Participant 1.7 – medical educator]

Another participant identified professionalism issues for medical education providers, concurring with scholarly contributions discussed in section 2.5.6 of the literature review.

*I really think we have a strong responsibility to pick up those professional issues through the course and weed them out before they’re interns. We’re trying to make professional behaviour assessable and what is assessed for is a hurdle. I think it’s scary and we’re all frightened of pulling people up but we’ve all seen it in the system … it’s got to be something the university will accept for rules of exclusion. That’s why we’ve made it into assessment because beforehand we couldn’t get rid of them and they did take up 90 per cent of our time and then they’re interns and then God knows what happens to them …*

[Participant 1.13 – medical educator]
This participant’s experience resonated with concerns that a fellow participant had expressed over potential conflicts of interest between stakeholders within medical schools, universities and the profession. Her expressions of fear, helplessness and frustration from trying to address ‘unprofessional’ medical student behaviour in a corporately-driven tertiary environment, were concerning. Whilst recognising the need for medical schools to be socially accountable, her experience reified research evidence of the consequences of medical selection failure, not only for graduates but, potentially (and more seriously), for patients:

We’ve struggled with all these things … we feel that there’s always going be some people that slip through the selection process no matter what you do … we have tried to focus our multiple mini interviews on people who will be good medical students rather than doctors because we realise it’s our job to turn them into doctors.

[Participant 1.13 – medical educator]

Whilst acknowledging the limitations and failures of medical selections processes, the accountability that this participant placed on medical education providers to graduate ‘good doctors’ was supported by others:

It’s our responsibility to make the best doctors we can with what we’ve got. We could be doing more to teach these young impressionable brains the skills they need to become ‘good doctors’.

[Participant 1.9 – medical educator]

As you [referring to participant 1.9] say, there’s a whole process in place here, but if they [medical students] are placed in the presence of the right nurturers and we
[medical education providers] can deliver … we have to deliver to this young generation what they need to become ‘good doctors’.

[Participant 1.11 – medical educator]

It’s our job to turn these medical students into potential ‘good doctors’ … so ranking on personality and admitting on that is probably not a great idea.

[Participant 1.12 – medical educator]

There’s actually a different hidden question underneath the question of what makes a ‘good’ doctor. And that is who’s going to be a ‘good’ student who is going to get through so we don’t have to deal with attrition rates; and who is going to be a ‘good’ student and not give us hassles?

[Participant 1.6 – medical educator]

These participants’ attempts to address medical selection challenges in this way were valuable on two levels. Firstly, they suggested that, at least to some extent, capabilities for a career in medicine could be acquired after selection. Secondly, they acknowledged that different sets of capabilities would be required for different stages of a long and varied medical career. It is important to remember, however, was that their viewpoint was from privileged position.

Participant perceptions and experiences informed medical education decision-making by focusing on the negative effects of ‘hidden curricula’. As evidenced in the literature (in section 2.4) such effects impacted negatively on student wellbeing and on future doctor-patient relationships.
The first years express some very idealistic notions … I see it in years three and four that they do start to get ‘squashed' by what we call the ‘hidden curriculum’ … so perhaps we need to select people that are socially robust and resilient that they can withstand the ‘hidden curriculum effect’ …

[Participant 1.8 – anonymous]

For this participant, the answer lay in selecting candidates who were sufficiently resilient to manage the demands of a career in medicine.

The second participant’s experience focused on medical student empathy, which resonated with research that had linked empathy decline with ‘hidden curricula’ effects:

It doesn’t matter what you do to get them in, once they’re in, they’re then immersed in this culture and environment, well actually SUBMERSED! They keep trying to get their head up and they keep getting pushed back under. So by the time they get out the other end … it doesn’t matter how ideologically sound they were when they began, by the time they’ve finished they’re not that anymore … we beat that out of them … a number of them also found a disconnect between what they’d been taught and what they had to deal with.

[Participant 1.7 – medical educator]

Further parallels were drawn between this participant’s concerns and those identified in the literature. For example, a ‘disconnect’ between students’ academic and clinical learning environments and incongruence between medical school and workplace cultures.
In summary, a third ‘unit of meaning’ in the pilot study emerged from analysing participants’ attempts to address medical student selection and education challenges that were meaningful to them. These attempts focused on selection approaches aimed at more closely matching medical student capabilities with population health needs; on addressing poor professionalism in students; on the social accountability of medical schools; on establishing which capabilities were assessable on entry and which could be learned; and on addressing ‘hidden curricula’ effects.

To sum up, I achieved the aim of my pilot study, which was to trial data collection and analysis methods that aligned most closely with my proposed phenomenological hermeneutic framework. I took the opportunity to explore my initial research question with a group of stakeholders who had an interest and expertise in the topic.

In response to the first part of the pilot study research question, capabilities identified for a ‘good’ doctor included effective interpersonal skills and empathy in healthy doctor-patient relationships. These were mirrored in the literature that I had explored earlier in sections 2.5.1 and 2.5.4. In response to the second part of the pilot study research question, of ‘how would patients like us to select medical students?’ challenges outlined (in section 2.3.4) and solutions proffered (in section 2.3.5) were mirrored by some of my pilot study participants, particularly those experienced in medical student selection and education.

Conclusions from research undertaken by Kelly et al. (2108) enabled useful comparisons between preferences expressed by some of my pilot study participants and those identified for stakeholders in the 71 studies reviewed by Kelly et al. (2018). The authors cited support for interviews, particularly MMIs
(p. 18) and mixed responses to aptitude tests (p. 19), which concurred with my pilot study analysis.

However, there are two important distinctions between the Kelly-led attempts to better inform medical student selection (2013, 2014a, 2014b, 2015, 2018) and my pilot study. Firstly, where these authors linked stakeholder views to medical selection tools, my phenomenological method focused on experiences rather than opinions in ways not previously evidenced in the literature. Secondly, where my pilot study informed a sampling technique more inclusive of ‘less privileged’ stakeholders for my main study, Kelly et al. (2018) acknowledged this as an important limitation in their systematic review of stakeholder-based attempts to better inform medical student selection. For my study ‘less privileged’ stakeholders means those marginalised in medical student selection and education decision-making by virtue of their lower socio-political, financial and/or academic status or as end users of medical services.

Other parallels I drew between my pilot study findings and the literature related to unresolved decisions over selection predictors and medical education dilemmas. These parallels were not surprising, given that the pilot study participants were a ‘privileged’ group of stakeholders.

It was important to recognise the limitations of the pilot study. These were related to my sampling and recruitment methods (self-recruitment of ‘privileged’ stakeholders) and to my interview method (a single semi-structured group interview). Also important to note was that the pilot study findings focused more on medical selection methods, challenges and solutions than on participants’ ‘good’ doctor experiences. This could be explained by the pilot study setting (a health professional educators conference); the study sample (a homogenous
group of educators) and participants’ expectations (to share their experiences more as professionals than as patients), a reminder that recruitment settings and methods can powerfully influence findings.

A useful framework for assessing the quality of my pilot study was that proposed by (Guba & Lincoln, 1989) as follows:

**Credibility:** Establishing ‘a match between the constructed realities of respondents (or stakeholders) and those realities as represented by the evaluator and attributed to various stakeholders’ (Guba & Lincoln, 1989, p. 237). I therefore, addressed issues around subjectivity to give credibility to my pilot study. Strategies included debriefing with peers and supervisors; ‘bracketing’ or putting aside my personal views and experiences; and being ‘reflexive’ by acknowledging and examining the potential influence of my role on participants’ responses.

Of interest was capturing the understanding of one of the participants’ experience of the MMI as a selection method in a way that was not supported in the literature. This was evident in her comparison between ‘traditional interviews’ and a modified version of the MMI that had recently been introduced to her Australian-based medical school. However, given that the role of the researcher in an IPA study is to explore a phenomenon from the participant’s perspective and to use verbatim extracts to capture this; and given that the aim of my piloting process was to test my IPA method, altering the verbatim extract in question would not have been appropriate. It was, therefore, important to note this variation whilst remaining true to my IPA method and maintaining the trustworthiness of my pilot study results.
Shortfalls in relation to this criterion informed strategies for the main study such as ‘prolonged engagement’ with participants and ‘triangulation’ (of data, of investigators and of methods) (Frambach, van der Vleuten, & Durning, 2013; Guba & Lincoln, 1989; Korstjens & Moser, 2017).

**Transferability:** ‘The major technique for establishing the degree of transferability is thick description’ (Guba & Lincoln, 1989, p. 241). Although the single group interview chosen for the pilot study limited the yield of sufficiently thick and rich data, there were repeated examples of issues being raised that were subsequently discussed in depth and extended in coverage, encouraging the further use of this method. Further, the findings can readily be applied to different settings with other ‘respondents’ (Frambach et al., 2013; Korstjens & Moser, 2017). The pilot study was therefore useful for informing the main study by demonstrating the need to explore the ‘good doctor’ phenomenon in greater depth with an increased diversity of participants, while attending to effective and broad recruitment and encouraging discussion and development of ideas.

**Dependability:** ‘The technique for documenting the logic of process and method decisions is the dependability audit’ (Guba & Lincoln, 1989, p. 242). The pilot study met this requirement by outlining research steps to address the research question, by referring to the literature and by remaining close to the data. The limited time meant data saturation was not achieved after the single group interview and participants did not evaluate the findings. Nonetheless, it was possible to verify that the data matched the apparent ‘saturation’ of the existing literature (Frambach et al., 2013; Korstjens & Moser, 2017), with a similar range of topics raised. For the main study, it was important to ensure participants had sufficient time for data to reach saturation and for participants to evaluate the findings.
**Confirmability:** ‘The usual technique for confirming the data and interpretation of a given study is the confirmability audit’ (Guba & Lincoln, 1989, p. 243). I attempted to achieve confirmability for the pilot study by keeping a diary, by compiling field notes, by referring to the literature, by peer debriefing and by data checking with supervisors. I tried to eliminate bias by being transparent, by ‘bracketing’ data during analysis and through critical self-reflection (Frambach et al., 2013; Korstjens & Moser, 2017). Similar methods were later applied in the main study.

Overall, the pilot study was useful for informing the main study. It confirmed gaps identified earlier in the medical selection and education literature and facilitated improved sampling, data collection and data analysis techniques. I remained cognisant of the literature to redefine the initial research question in a way that would make a unique connection between stakeholder experiences and doctor capabilities.

### 3.3.2 Main study

**Background and formulation of the final research question**

I progressed the necessary steps for my project thus far by reviewing the existing literature; by choosing a qualitative phenomenological research approach and by undertaking a pilot study to trial the feasibility of this approach. Guided by the literature, I developed the initial research question for the pilot study to explore the ‘good doctor’ phenomenon to better inform medical selection and education. That question was ‘What makes a good doctor? How would patients like us to select medical students?’

I drew two major parallels between the pilot study results and the prior existing literature. The first was that attempts to better inform medical selection and
education had largely been based on the determinations of ‘privileged’ parties. Secondly, that relatively little attention had been paid to the range of capabilities required for long-term, effective medical practice.

Progression to the main study therefore required a refinement of the research question to address these gaps. Within a flexible research design and guided by the literature, I engaged stakeholders to explore this ‘good doctor’ phenomenon more deeply in ways that had not previously informed medical selection and education decision-making. Hence a redefined research question of: ‘How can the experiences of stakeholders with doctors inform medical selection and education’ was best suited to making this unique connection between stakeholder experiences and doctor capabilities.

Within a phenomenological paradigm, the key elements of my research question crystallised to ‘How can the experiences of stakeholders with doctors inform medical selection and education’ after conducting a pilot study. As part of the methodology for the main study, consulting the literature was critical to guiding my field note coding, an extract of which is referred to in Appendix D.

Although terms relating to the use of the words ‘stakeholders’, ‘doctors’, ‘medical selection’ and ‘medical education’ were previously discussed and contextualised, these terms were now more precisely defined in the manner presented in the following sections.

3.3.2.1 ‘Stakeholders’

For the literature review, I referred to ‘stakeholders’ as ‘those involved in and/or affected by, medical selection and education decision-making from a ‘privileged’ or ‘less privileged’ position. By being ‘privileged’ I meant stakeholders who had been given exclusive authority in medical student selection and education
decision-making by virtue of higher socio-political, financial and/or academic status whilst ‘less privileged’ stakeholders were considered to be those excluded from this domain on those grounds, with particular reference to patients.

As the research question evolved, ‘stakeholders’ were identified according to my chosen a phenomenological framework (Smith, 2015) for their interest or expertise in my research topic and, more significantly, for their willingness to share their experiences with doctors in ways that could better inform medical student selection and education. Succinctly put, the term ‘stakeholders’ referred to ‘those involved in and/or affected by, medical selection and education decision-making from a privileged or less privileged position’.

3.3.2.2 ‘Doctors’

In the Australian context, ‘doctors’ includes medical school graduates who practised either as ‘Junior Medical Officers’ (doctors still undertaking pre-registration training, including interns, house medical officers, resident medical officers or registrars); or as ‘Senior Medical Officers’, ‘Specialists’ or ‘Consultants’, who have completed further training and are registered for independent practice (Australian Medical Association, 2016). For the purposes of my project, the term ‘doctors’ applied to any of these roles, regardless of the practice settings. To put it succinctly, ‘doctors’ were defined as ‘medical school graduates who gained license to practise at junior, senior or advanced levels in a variety of practice settings’.

3.3.2.3 ‘Medical selection’

As outlined in the literature review, candidates gain entry into medicine via a number of pathways, which typically were designed to graduate ‘good’ doctors.
Decision-making over the range of capabilities required to be a ‘good’ doctor proved to be complex and controversial and there was often conflict between outcomes desired for graduates and the needs of patients. Nonetheless, the process of becoming a doctor consistently begins with entry to university medical training.

Consequently, in the context of my research question, ‘medical selection’ was defined as ‘an application process for undergraduate or postgraduate entry into an accredited medical program’. During this process applicants are assessed and ranked according to specific requirements that usually include academic scores and/or aptitude tests. For some medical schools, such assessments are administered in combination with supplementary information, an interview-based method and/or psychometric testing.

3.3.2.4 ‘Medical education’

Although my review of the relevant medical education literature evidenced variations for individual medical school curricula, there was considerable agreement over ‘competency-based medical education’ (CBME) models. There was also shared recognition of medical education accreditation standards such as those proposed by the World Federation for Medical Education (2015). For my project, ‘medical education’ was defined as ‘an accredited program that facilitates the acquisition of knowledge, skills and attitudes for safe and competent practice for the duration of a licenced medical career’. My definition is consistent with the Australian Medical Council (2012) goal for medical education providers, which is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.
3.3.2.5 Main study setting

The setting for my project was the Gold Coast, which is located in the south-east corner of Queensland, Australia, just south of Queensland’s capital city of Brisbane. The sixth largest city in Australia in terms of population, the Gold Coast is situated on the land of the Yugambeh/Kombumerri people whose descendants are among the city’s estimated 600,000 culturally and linguistically diverse population (Gold Coast City Council, 2017).

Every year local, national and international applicants compete for entry to one of the Gold Coast’s two medical schools at Griffith and Bond universities. These two universities then compete for medical student clinical placements at local, regional and rural public and private health care facilities.

The Gold Coast was the intended location for the individual and group interviews planned for my project. The settings for each of these interviews are described as part of my study’s sampling and recruitment strategy below.

3.3.3 Main study sampling and recruitment

Within my chosen phenomenological hermeneutic framework, participants were purposively sampled for the main study. This strategy aligned van Manen’s (2001) hermeneutic interviewing of participants who have ‘more than a passing interest’ in the research project and who have willingly involved themselves in it’ (p. 98). My participant recruitment method also aligned with purposive homogenous sampling advocated by Smith et al. (2009) for participants with a shared interest in the topic and for whom the research question held meaning.

I recruited participants whom I could personally interview either one-on-one or as part of a group. I sought to include a broad a range of stakeholders to allow exploration of my research topic in the required breadth and depth, as well as to
address gaps identified in the medical selection and education literature (discussed in chapter 2). Included in this recruitment process were stakeholders referred to previously as being ‘privileged’ or ‘less privileged’ in medical student selection and education decision-making (Section 3.3.2.1).

Advantages of undertaking individual as well as group interviews were that individual interviews facilitated in-depth exploration of the topic in the privacy of one-on-one settings, whilst group interviews offered opportunities for participants to share their doctor experiences. I purposively recruited participants for individual as well as for group interviews during 2012 and 2013.

3.3.3.1 Purposive sampling for group interviews

Smith et al. (2009) support the use of group interviews to allow multiple voices to be heard at one sitting, to draw a larger sample into a smaller number of data collection events, to allow the researcher to hear the concerns of a larger number of participants and to include a range of stakeholders. Table 1 below outlines how the 68 participants were purposively sampled during 2012 and 2013 for group interviews. The 14 pilot study participants had been self-recruited as ‘Group 1’ (and allocated numbers 1.1 to 1.14) whilst the main study participants were grouped as follows (words bolded for emphasis):

A total of 28 ‘medical educators’ were recruited for one of three group interviews (2, 3 and 7). Group 2 participants were allocated numbers 2.1 to 2.11, Group 3 numbers 3.1 to 3.12 and Group 7 numbers 7.1 to 7.5.

A total of 15 ‘patients’ were recruited for one of two group interviews (4 and 5). Group 4 participants were allocated numbers 4.1 to 4.7 and Group 5 numbers 5.1 to 5.8.
A total of 19 ‘medical students’ were recruited for one of two group interviews (6 and 9). Group 6 participants were allocated numbers 6.1 to 6.7 and Group 9 numbers 9.1 to 9.12.

Six ‘community organisation and health consumer representatives’ were recruited for group interview 8 and allocated numbers 8.1 to 8.6.

**Table 1 Participants recruited for semi-structured group interviews for the period 2012 to 2013**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Participant description</th>
<th>Number of participants recruited</th>
<th>Participant number allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Medical Educators</td>
<td>11</td>
<td>Group 2 * (2.1 – 2.11)</td>
</tr>
<tr>
<td>2012</td>
<td>Medical Educators</td>
<td>12</td>
<td>Group 3 (3.1 – 3.12)</td>
</tr>
<tr>
<td>2013</td>
<td>Patients</td>
<td>7</td>
<td>Group 4 (4.1 – 4.7)</td>
</tr>
<tr>
<td>2013</td>
<td>Patients</td>
<td>8</td>
<td>Group 5 (5.1 – 5.8)</td>
</tr>
<tr>
<td>2013</td>
<td>Medical Students</td>
<td>7</td>
<td>Group 6 (6.1 – 6.7)</td>
</tr>
<tr>
<td>2013</td>
<td>Medical Educators</td>
<td>5</td>
<td>Group 7 (7.1 – 7.5)</td>
</tr>
<tr>
<td>2013</td>
<td>Community organisation and health consumer representatives</td>
<td>6</td>
<td>Group 8 (8.1 – 8.6)</td>
</tr>
<tr>
<td>2013</td>
<td>Medical Students</td>
<td>12</td>
<td>Group 9 (9.1 – 9.12)</td>
</tr>
</tbody>
</table>

* Note that ‘Group 1’ was the participant group for the pilot study*

**3.3.3.2 Group interview participant profiles**

Groups 2, 3 and 7 comprised a total of 28 ‘medical educator’ participants. Although these participants were from diverse professional backgrounds, such as nursing, emergency medicine, law, allied health, pharmacy, general practice, psychology, social work and academia, they shared an interest in, and willingness to participate in, the project. Across the three groups, there were more females (19 versus 9 males) and ages were evenly distributed between
30 and 50 years of age (with one participant in the 20-30, one in the 60-70 and one in the 70-80 age-bracket). Of the 28 ‘medical educator’ participants, nine were practising doctors; nine were nurses; three were pharmacists; two were physiotherapists; one was a social worker; one a medico-legal academic; one a psychologist; one a respiratory scientist; and one a physiologist. The majority of these participants gave Australia as their country of origin. Countries of origin for the remaining participants included the United Kingdom (three), Italy (one), Russia (one), Iran (one), India (two), Croatia (one) and Malaysia (one).

Groups 4 and 5 comprised a total of 15 ‘patients’ who were part of a ‘Volunteer Instructional Patient’ (VIP) bank at one of the local medical schools. These VIPs agreed to be interviewed on days when they were on site for medical student education activities. They were purposively sampled as patients who were intimately engaged with medical students on a regular basis and whose chronic medical conditions necessitated regular visits to generalist as well as specialist doctors. Across the two groups, females were by far in the majority (twelve, as opposed to only three males). Patients’ ages were evenly spread between 60 and 80 years of age (with two participants in the 40-50 and one in the 50-60 age-brackets). Their medical conditions were generally described as being chronic: Group 4 included patients diagnosed with neuromuscular conditions such as multiple sclerosis, whilst Group 5 patients had been diagnosed with chronic rheumatological conditions such as arthritis. The majority of these patients gave Australia as their country of origin, with the exception of The Netherlands (one) and United Kingdom (two).

Groups 6 and 9 comprised a total of 19 medical students who consented to be interviewed after permission had been granted by their medical schools. I managed the medical student participant invitations through student
representatives, some of whom were known to me. I needed to reassure these participants of no conflicts of interest between my roles as their interviewer and as a potential educator/assessor for some of them. I indicated that, as medical students, they were considered an important part of the project and could offer their unique perspective on the topic. The seven medical student participants from Group 6 were purposively sampled from a group of approximately 50 medical students who were undertaking a campus-based learning activity in their final postgraduate year of study at one of the local medical schools. They responded to verbal and written invitations issued to the larger group at the start of this week-long process. This group’s unanimous preference not to disclose their personal information at the time of the interview was respected and their information was de-identified in the same way as other participants during the transcription process.

The twelve medical students from Group 9 represented all year levels from both of the two local medical schools. These students voiced no preferences about how the interview was to be conducted, and shared transport to attend the interview on one of the local campuses after hours. Across the two medical student groups, there were twelve males and seven females; and ages were evenly distributed between 20 and 30 years (with the exception of one participant in the 30-40 age-bracket). The majority of students were in their final year of study (fourth year of a Bachelor of Medicine, Bachelor of Surgery degree) at one of the two local medical schools. The remaining students were distributed over the lower year levels and equally represented the two local medical schools. Highest prior qualifications for all participants varied considerably, including: Year 12 of secondary school (one participant), a Bachelor of Medical Science (three participants), a Bachelor of Biomedical
Science (five participants – two with honours), Bachelor of Science (five participants – two with honours), Bachelor of Pharmacy (one participant), Master of Public Health and Tropical Medicine (one participant) and Bachelor of Education (two participants). Two participants had each obtained a Bachelor degree in Science as well as in Education. The majority of the students identified Australia as their country of origin. Countries of origin for the remaining participants included The Philippines (one), South Africa (one) and New Zealand (one).

Group 8 participants were recruited as local community organisation and health consumer representatives. Although in excess of 30 people initially expressed their interest in the research topic, many cited logistical reasons for not being able to participate (notably the shortage of people to manage service-provision in their absences). Of the ten who initially responded positively to my invitation, six participated in the interview. The participants represented local community organisations that included cancer support, transition from hospital to home care, disability support, men’s wellbeing, community child health services and youth support. The age range of these participants varied widely as follows: From 20-30 years (two), 30-40 years (one), 40-50 years (one), 50-60 years (one) and 60-70 years (one). As with all other group participants, the majority of this group identified Australia as their country of origin (with the exception of New Zealand for one participant).

3.3.3.3 Purposive sampling for individual interviews

Within a phenomenological hermeneutic framework, face-to-face interviewing was the method of choice for yielding the rich, deep data required for IPA. The purposive sampling method for the main study facilitated recruitment of those participants who could shed a meaningful perspective on the ‘phenomenon of
interest' (Larkin, 2013, slide 14). Whilst patients and doctors had been purposively sampled for some of the group interviews, I focused more specifically on practising doctors and patients for the individual interviews. Although a few of these patients were involved with the VIP program of one of the local medical schools, the majority were recruited via a snowballing technique. According to (Byrne, 2001) ‘a snowballing sampling technique is used to recruit additional participants from those already selected to participate in the study’ (p. 497).

In addition to patients and doctors, I purposively recruited ‘key stakeholder’ participants for individual interviews, based on their years of experience and expertise in my research topic. Apart from doctors and patients, these participants were ‘key’ to representing health care leadership; medical academia (including ethics); health professional practice (including nursing, midwifery, alternative health, allied and Indigenous health) and rural health (including leadership and education). They were identified as leaders in their fields of expertise, so I anticipated that their doctor descriptions and experiences would add depth to the data as well as further contextualising them.

Table 2 below outlines how 39 participants were purposively sampled during 2012 and 2013 for individual interviews as follows (words bolded for emphasis):

Thirteen (13) ‘practising doctors’ were recruited for one-on-one interviews and were allocated numbers 1 to 13.

Eleven (11) ‘patients’ were recruited for one-on-one interviews and were allocated numbers 14 to 24.
Fifteen (15) ‘key stakeholders’ were recruited for one-on-one interviews and were allocated numbers 25 to 39.

Table 2 Participants recruited for semi-structured individual interviews for the period 2012 to 2013

<table>
<thead>
<tr>
<th>Time period</th>
<th>Participant description</th>
<th>Number of participants recruited</th>
<th>Participant number allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Practising doctors</td>
<td>13</td>
<td>1 – 13</td>
</tr>
<tr>
<td>2013</td>
<td>Patients</td>
<td>11</td>
<td>14 – 24</td>
</tr>
<tr>
<td>2013</td>
<td>Key stakeholders</td>
<td>15</td>
<td>25 – 39</td>
</tr>
</tbody>
</table>

3.3.3.4 Individual interview participant profiles

Demographically, gender was evenly distributed for the 13 ‘practising doctor’ participants and their ages ranged between 20 and 60 years. They represented a balance of years of experience (the years in which they graduated from medical school ranged between 1979 and 2011). They were practising across a broad range of specialities and in a diversity of settings, including Emergency Medicine, Cardiology, Psychiatry, General Practice, Intensive Care, Rural Medicine, Maternal and Child Health, Health Informatics, Medical Research and Neurosurgery. Nine out of the 13 participants were also actively involved in medical education. Just over half of all 13 participants cited their country of origin as Australia, whilst others cited Switzerland, New Zealand, South Africa, The Netherlands, United States of America and Sri Lanka (one each) as a country of origin.

Purposive sampling for the 11 ‘patients’ was similar to that used for the ‘Group 4’ and ‘Group 5’ patient interviews (via the ‘VIP’ bank of one of the local medical schools), whilst a snowball sampling technique was added for inclusivity. These
patients’ ages and genders were fairly evenly distributed (with the youngest being in her twenties and the oldest in his seventies). Their diagnostic profiles covered a range of acute and chronic conditions, as well as inherited disabilities and post-trauma pain. The majority of these patients cited Australia as their country of origin (exceptions being New Zealand and South Africa).

The 15 ‘key stakeholders’ represented leadership in government and corporate health consultancy; health executive management (public as well as private); senior medical academia; medical ethics; health professional practice (including nursing, midwifery, allied health; indigenous health and alternative health) and rural health (including leadership and education). Females outnumbered males in a ratio of 10:5. The ages of these participants ranged between 40 and 50; and between 50 and 60 years, with one person being between 70 and 80 years of age. Senior academics were evenly spread across the two local medical schools. Ten out of the 15 participants cited Australia as their country of origin, whilst others cited the United Kingdom, South Africa and Kenya as a country of origin.

To summarise, a total of 107 participants were purposively sampled for the project. Of these, 39 were recruited as doctors, patients and ‘key stakeholders’ for face-to-face interviews, whilst the remaining 68 participants were recruited for one of eight group interviews. Participants were recruited through networking, personal communication as part of a snowball sampling technique. Initial face-to-face communication was followed up via emails and telephone calls once participants had consented to be involved in the study.

The interviews were arranged at participants’ convenience. For example, for the individual interviews, patients generally preferred the privacy of their homes;
corporate managers and health executives preferred their workplaces or telephone interviews, whilst doctors were interviewed when and where it was possible for them. Participants attending group interviews preferred locations at their places of study, of work or when volunteering as patients for one of the local medical schools. Being willing participants and having already consented to being in a ‘VIP program’ overcame barriers that I may have encountered to recruit patients in other ways (for example, patient confidentiality requirements for general practices). A community-based venue was hired for the group interview with community organisation and health consumer representatives.

My collegial relationship with some of the study participants supported my purposive sampling method, as did snowball sampling when study participant recommendations facilitated recruitment of participants with a shared interest in the research topic (Byrne, 2001; Tong et al., 2007). My purposive sampling method was guided by the research question, in consultation with the literature and within a phenomenological hermeneutic framework. This framework placed my research role at the centre of the subsequent data collection and analysis phases. It enabled me to cultivate relationships with the participants, engaging them to ‘share and to make sense’ of their doctor experiences (Larkin, 2013). I could therefore, ‘work with respondents in flexible collaboration to identify and interpret the relevant meanings that were used to make sense of the topic’ (Reid et al., 2005, p. 22).

3.3.4 Main Study Data Collection

In line with many IPA studies, semi-structured interviewing was my primary data collection method (Boyle, 2013; Creswell, 2013; Reid et al., 2005; Smith, 2004; Smith et al., 2009). Secondary data collection methods were employed to add rigour to my project. Data collected from each semi-structured interview
(individual and group) were supplemented with data extracted from notes and observations during the interview to capture as much of the conversational interview as possible, such as non-verbal expressions and observed behaviours (de Vries-Erich, Dornan, Boerboom, Jaarsma, & Helmich, 2016; Van Manen, 2001).

Additional supplementary data were extracted from a research diary, field notes and memos. Data checking was undertaken with participants post-interview when possible. Data were also checked post-interview with my PhD supervisors. A PhD supervisor was present in one of each of two group interviews, which facilitated data checking as well as debriefing and feedback on my interview technique.

3.3.4.1 Ethics Approval

I sought ethics approval from the Griffith University Human Research Ethics Committee (GUHREC). Approval was granted on 8th May 2012 (GU Ref No: MED/04/10/HREC). Please refer to Appendix F.

3.3.4.2 Semi-Structured Interviews

Informed by the pilot study and guided by the literature, an interview schedule for the main study evolved, an example of which and is detailed in Appendix C. An information sheet (see Appendix G) was designed to accompany the interview schedule and was given to each participant ahead of each interview. Providing participants with an information sheet complied with the ethical requirements for the study, such as ensuring voluntary participation and anonymity (including being able to withdraw from the study at any time); with policies for the safe and confidential storage of data; as well as with strategies to ensure the safety and wellbeing of interviewees. For example, it was
important that participants knew they would have access to necessary support and referral if the interview prompted distress in the process of relaying a particular doctor experience. Fortunately, this did not occur during any of the interviews.

Within a phenomenological hermeneutic framework, the prompt questions for the semi-structured interviews were designed to yield rich, deep data for IPA. As advocated by Smith (2004):

> The advantage of semi-structured interviewing for IPA is that the researcher is, in real-time, in a position to follow up interesting and important issues that come up during the interview … it capitalizes upon IPA’s ability to explore unanticipated and unexpected findings.

(p. 50)

Van Manen (2001) also proposed that one should optimise the gathering of lived experience material. He referred to the technique of hermeneutic interviewing, which gave participants roles as collaborators in the research project.

Audio-recording commenced once the interview process had been explained, participant consent confirmed, and anonymity preferences established (such as the use of a pseudonym). Group interview introductions included negotiating guidelines for shared and respectful communication. Participants responded enthusiastically to the initial prompt questions of ‘What does the ‘good’ doctor mean to you?; ‘Could you tell me more about this?; ‘Without naming people or places, are you able to give some examples?’
Subsequent prompt questions that had been prepared for the semi-structured interview schedule were dominated by the initial prompt questions as I engaged in a hermeneutic circle of reciprocal meaning-making and interpretation of participants’ doctor experiences. Note-taking accompanied each audio-recording and each interview was concluded with my summarising participant responses and inviting final comments. These data contributed to those captured in the verbatim transcription for each semi-structured interview.

Semi-structured interviews were conducted with a total of 107 participants over an eight-month period as follows (please refer to Tables 1 and 2 in section 3.3.3.2 for the participant recruitment summaries): During May and June in 2012 with 13 practising doctors (one-on-one); during November in 2012 with two medical educator groups; during April and May in 2013 with 11 patients (one-on-one), two patient groups and one medical student group; during July and August 2013 with one group of medical educators and one-on-one with the 15 ‘key stakeholders’; during September 2013 with one group of community organisation and health consumer representatives and one group of medical students.

3.3.4.3 Duration of semi-structured interviews

Interviews lasted between 40 and 90 minutes. On reflection, the groups with higher numbers of participants were found to be the most challenging to interview, confirming Creswell’s (2013) point that ‘… in phenomenological interviews, asking appropriate questions and relying on participants to discuss the meaning of their experiences requires patience and skill on the part of the researcher’ (p. 173). I sought assistance to address some of these challenges by inviting two of my three doctoral supervisors to co-facilitate each of two of the larger group interviews that were conducted with medical educators in
November 2012 (identified as ‘Group 2’ and ‘Group 3’ in Table 1, section 3.3.3.2).

3.3.4.4 Participant consent and de-identification of semi-structured interview data

As alluded to earlier, at each interview, verbal consent was obtained from each participant after providing him/her with the ethics committee-approved information sheet. Please refer to Appendix G. Participants were given the option of using a pseudonym during the interview and of opting out at any stage of the interview or project. After each interview, the audio-recording was transcribed verbatim with each transcript and was further anonymised by removing any identifying data (such as names of people and places) as well as by allocating each participant a number (please refer to Tables 1 and 2 in section 3.3.3.2 for participant number allocations). Although assistance was sought to transcribe a few of audio-recorded interviews, I worked closely with a transcriber to ensure the accuracy of the interview data. I used a reputable transcription service whose advanced technology mitigated some of the time demands of sole-researcher transcription.

3.3.4.5 Data collection within an IPA paradigm

My data collection method was guided by IPA principles that facilitated the concurrent collection, analysis and interpretation of the semi-structured interview data. I used an inductive approach, engaging in a flexible data-collection process to probe interesting data as they emerged from participant experiences with doctors. My data collection technique was sufficiently flexible to allow unanticipated topics to emerge, particularly when the ‘good’ doctor phenomenon was modified by participants who focused on ‘bad’ doctor experiences. This dynamic and flexible approach was endorsed within my
phenomenological framework, supporting me to modify the semi-structured schedule as the interviews progressed. According to Dicicco-Bloom and Crabtree (2006):

_The interviewer should be prepared to depart from the planned itinerary during the interview because digressions can be very productive as they follow the interviewee’s interest and knowledge._

(p. 316)

After each interview, I conducted an iterative or layer-by-layer process of transcription and initial analysis before proceeding to the next interview. In addition to identifying inductive and iterative IPA principles for my research role, the phenomenological framework proposed in Figure 2, section 3.2 by Hopkins et al. (2016) facilitated concomitant collection and analysis of the data. The semi-structured interview schedule, therefore, evolved to enable me to engage with participants to yield rich, deep data. In a hermeneutic cycle, I moved between idiographic data collected from each individual participant’s experience (or ‘part’ of the phenomenon) and the broader data-set of shared doctor experiences (or the ‘whole’ phenomenon).

I applied the principles of bracketing and reflexivity to keep my data collection techniques rigorous. By bracketing, I put aside any preconceptions that could influence the quality of data collected. By being reflexive, I remained aware of how my role as a medical educator could influence participant responses, particularly those who were medical educators or medical students at the medical school I was working at. These principles of bracketing and reflexivity have been described as ‘the tension between striving for reductive focus and reflective self-awareness’ (Pringle et al., 2011, p. 11).
I continued recruitment in each of the stakeholder categories until I had assembled a rich data-set of experience and saw evidence of saturation, meaning that truly novel stakeholder experiences were no longer emerging from the interviews (Mason, 2010; Reid et al., 2005; Ringsted et al., 2011; Tavakol & Sandars, 2014b; Tong et al., 2007).

Reaching saturation after 39 individual and eight group interviews yielded a larger data set than was most IPA studies (Reid et al., 2005; Smith & Osborn, 2008). Whilst recognising the value of larger studies, some IPA scholars raised potential problems for applying experiential analysis to complex social activities (Reid et al., 2005). Bearing this in mind, I conducted semi-structured interviews to the point of saturation, to inform medical student selection and education from multiple perspectives and to achieve what Creswell (2013) referred to as ‘an exhaustive description of the phenomenon’ (Creswell, 2013, p. 106). Claims by Morse (1995) that saturation would occur more slowly with snowballing (referred to earlier as part of my sampling method) and that saturated data are rich, full and complete, resonated with my project. According to Dicicco-Bloom and Crabtree (2006):

*This iterative process of data collection and analysis eventually leads to a point in the data collection where no new categories or themes emerge. This is referred to as saturation, signalling that data collection is complete.*

(pp. 317-318)

The data collected during the group interviews with 28 medical educators yielded descriptions of experiences with doctors from participants who shared many years of clinical and medical education experience. Group interviews ‘2’
and ‘3’ were co-facilitated by two of my three PhD supervisors, which strengthened my data collection and checking processes and provided valuable guidance for managing the remaining group interviews. At this stage of the data collection process, the semi-structured interview schedule allowed the research question to be explored in sufficient depth with these stakeholders.

The data collected during the interviews with the 22 practising doctors yielded equally-rich descriptions from participants defined as ‘privileged’ for this project; meaning that they (alongside the 28 ‘medical educator’ and 15 ‘key stakeholder’ participants) held more powerful positions than those ‘less privileged’ participants (the 19 medical students and particularly the 26 patients). The semi-structured interview schedule was sufficiently flexible to allow rich data to emerge, including doctors’ individual selection experiences as well as their personal experiences with current medical selection processes.

The data collected during interviews with a total of 26 patient participants included deep descriptions and experiences of doctors, mainly in the context of their interactions with doctors as patients themselves or on behalf of their family members. Similarities as well as differences were observed in the data that emerged from these patient interviews, when compared with data from interviews with the other participants, thus strengthening the use of an IPA paradigm (referred to earlier in this section) for later comparative analysis.

The semi-structured interview schedule was sufficiently flexible to accommodate new data as they emerged from these patient interviews whilst maintaining focus on the research question. Even at this early stage, these data signalled unique opportunities for addressing the research question from the perspective of patients as ‘less privileged’ stakeholders who had been
marginalised in or absent from, prior debates on this topic. This accords with Brock’s (2011) proposal for medical educators to ‘put patient contact at its heart and to inspire future doctors to serve patients better in every way’ (p. 576).

The data collected during interviews that were undertaken with a total of 19 medical students emerged in the contexts of their experiences with doctors as well as their recent experiences of selection processes, of current medical education models and of peer interaction at different stages of their curricula. These data facilitated subsequent comparative data analysis with findings from the literature, which will be discussed in the following chapter.

Data collected during interviews with the six community service and health consumer representatives emerged in the context of the diversity of their service provision roles. The data demonstrated how much patients relied on these stakeholders for support to navigate their way around complex health care delivery systems where they faced numerous encounters with different doctors across diverse settings. These stakeholders not only offered rich contextual data from their community service provision perspective, but also gave an important additional voice to patient stakeholders in the context of the research topic.

The final data collection phase focused on one-to-one interviews with 15 ‘key stakeholders’, who were defined as ‘those study participants recruited for individual interviews who identified as ‘key’ representatives of health care leadership, medical academia (including ethics); health professional practice (including nursing, midwifery, alternative health, allied and indigenous health) and rural health (including leadership and education)’. These participants were purposively sampled on the basis of their investment in my research topic, as
leaders in their fields of expertise and with many combined years of experience with doctors. Although these interviews proved to be the most labour-intensive part of the data-collection process, they provided a broader perspective and ‘rounding out’ of the data collected earlier.

An important element of my data collection technique was staying close to the data by reading and re-reading the transcripts, in preparation for deeper analysis and interpretation. I initiated a code book and upskilled in the use of computer assisted qualitative data analysis software (CAQDAS) for storing and organising the large volume of interview data. Please refer to Appendix D for an extract from the coding book field notes.

In summary, data were collected primarily from semi-structured in-depth interviews with 107 participants, either individually or as part of a group, over a nine-month period in 2012 and 2013. The semi-structured interviews facilitated the exploration of doctor experiences with a diversity of stakeholders, particularly those underrepresented previously in studies of this kind. Data collection techniques yielded rich, deep data for analysis and interpretation in the context of the narrative and meaning that each participant brought to the project to inform the selection and education of future doctors.

3.3.5 Main Study analytical sequence

The concept of data saturation was applied within my phenomenological framework to signal that sufficient data had been collected for me to be able to identify concepts and themes from the patterns that were emerging in the data (de Vries-Erich et al., 2016). Underlying this qualitative research principle of saturation was the expectation for data collection and analysis to be simultaneous.
As Dicicco-Bloom and Crabtree (2006) put it:

_Qualitative data analysis ideally occurs concurrently with data collection, so that investigators can generate an emerging understanding about research questions, which in turn informs both the sampling and the questions being asked._

(p. 317)

This approach facilitated the fluidity and flexibility needed to explore my topic in sufficient breadth and depth. Smith et al. (2009) claimed this ‘dynamism’ to be at ‘the heart of good qualitative analysis’ and described analysis as:

_A[n iterative process of fluid description and engagement with the transcript … the analytic process is multi-directional; there is a constant shift between different analytic processes._

(p. 81)

Equally relevant to my project were the data analysis strategies proposed by Smith et al. (2009), which included organising and describing the data (‘descriptive analysis’); analysing single transcripts (‘to identify the claims, concerns and understandings of each participant – idiographic analysis’); analysing combined transcripts to identify patterns/themes across the data (‘emphasising convergence and divergence, commonality and nuance-comparative analysis’) initially from individual perspectives and then from multiple perspectives; developing a data analysis structure (‘to illustrate relationships between themes’) to guide detailed commentary and interpretation
of data extracts (‘different levels of interpretive analysis’) (pp. 79-80). I was able to employ these data analysis strategies for my project, which although outlined distinctly in the sections below, formed part of a dynamic and flexible data analysis process.

3.3.5.1 Descriptive analysis

I approached the large volume of data that I had gathered by actively engaging with it, organising it and preparing it for further analysis and interpretation. For example, I developed a code book (DeCuir-Gunby, Marshall, & McCulloch, 2011; Saldaña, 2009) in conjunction with CAQDAS (Bazeley, 2007; Beekhuyzen, Nielsen, & Von Hellens, 2010; QSR International Pty Ltd, 2007).

The extract from the coding book field notes in Appendix D demonstrates how data were initially coded, in line with my research question and the literature. For example, a code for ‘empathy’ emerged from verbatim participant descriptions of the ‘good’ doctor such as:

*I think empathy is the key to being able to relate to people and to understand people, particularly for a doctor.*

[Participant 18 – patient]

*I think sometimes it’s okay to shed a tear with your patients, so in terms of having empathy ... trying to put yourself in their shoes and really trying to relate to your patients.*

[Participant 12 – doctor]

*Being empathic, so they can actually look at someone and think ‘I can almost imagine myself sitting in that chair*
where they [the patients] are and reacting to what it is that the patient is feeling.

[Participant 8.4 – community representative]

The prior existing literature supported similar participant descriptions of medical empathy. For example, a recent study where medical student participants had emphasized that ‘a doctor should try to understand and put himself or herself in the patient’s shoes’ (Park et al., 2017, p. 2).

As part of my methodology (discussed in section 3.2 of this chapter) I attempted to apply the principles of reflexivity and bracketing by keeping an analytical diary (for transparency); by remaining in contact with as many participants as possible (for credibility) and by regularly consulting with PhD supervisors and other experienced researchers (for plausibility). At this stage of my data analysis I had produced ‘a comprehensive and detailed set of notes and comments of the data’ (Smith et al., 2009, p. 83).

True to phenomenological practices, my data analysis had started while new data were still being collected in an ‘iterative, constant comparative process’ (de Vries-Erich et al., 2016, p. 820). This process lent sufficient ‘breadth’ to the data-set, allowing me to explore new avenues of enquiry and to refine the focus of my research question. I had, therefore, employed data collection and analysis techniques that were flexible enough to allow unanticipated topics or themes to emerge during analysis (Smith, 2004). I acknowledged the view by Pope et al. (2000) that ‘high quality analysis of qualitative data depends on the skill, vision, and integrity of the researcher’ (p. 114); and that the use of software packages (such as NVivo®, the program I employed) could assist initially, but could not be used to short-cut rigorous and systematic analysis.
At this stage of my data analysis it was pertinent to clarify my preference for referring to ‘units of meaning’ rather than to the ‘categories’ or ‘themes’ described in many qualitative studies. The mixed connotations of these terms, particularly for ‘thematic analyses’ to which many studies are limited, confirmed my preference to identify ‘phenomenological themes’, ‘units’ and ‘sub-units of meaning’ for my data analysis structure. According to van Manen (2001):

*Phenomenological themes may be understood as the structures of experience … it is helpful to think of the phenomenon described in the text as approachable in terms of meaning units, structures of meaning or themes. Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of that experience.*

(p. 78)

My choice of methodology for the main project was therefore, to repeat the first step in the data analysis process (referred to as ‘phenomenological/insider analysis’) that was effective for the pilot study (Reid et al., 2005); by capturing participants' stories and prioritising their exploration of the research question into ‘units of meaning’. These broad ‘units of meaning’ were contextualised by the research question, and focused on what these participants’ experiences could tell us about the qualities of ‘good’ and ‘bad’ doctors to inform medical student selection and education, as the first descriptive phenomenological step of data analysis. As with the pilot study, I used the NVivo® software program to organise the data into these ‘units of meaning’.

Smith et al. (2009) referred to IPA as an ‘iterative inductive cycle’, which needs to be flexible, particularly when working with larger samples:
It involves flexible thinking, processes of reduction, expansion, revision, creativity and innovation … one important element of this involves moving between the part and the whole of the hermeneutic circle …

(p. 81)

Given the size and complexity of my study data, my analysis thus far had demonstrated fluidity in moving from broad descriptions of commonalities to initiating small comparisons within the data set. Within this phenomenological framework, I developed a data analysis structure to facilitate movement between the ‘whole’ (descriptive analysis of shared participant experiences) and ‘the parts’ (deeper analysis and interpretation of rich, individualised participant experiences). Smith et al. (2009) contend that:

IPA with larger numbers of participants constantly involves negotiating a relationship between convergence and divergence, commonality and individuality.

(p. 107)

3.3.5.2 Data analysis structure – schematic representation of the data

Variations in the data set were mirrored in the structure of the interviews (outlined in Appendix C) with initial participant responses yielding predictive and descriptive data that often changed to being more deeply experiential and unanticipated as the interview proceeded interviews progressed. This phenomenologically-driven iterative and inductive cycle enabled me to identify key phenomenological themes for my project. I was guided by the literature to progress to this next stage of my data analysis by developing a data analysis
structure as a ‘graphic representation of the structure of the emergent themes’ (Smith et al., 2009, p. 99).

Descriptive data yielded from my field coding informed the data analysis structure. For example, the extract presented in Appendix D demonstrated how participant descriptions of ‘good’ doctors were initially coded into ‘sub-units’ of meaning from verbatim extracts as follows (words bolded for emphasis):

> From my viewpoint the paramount importance is being safe. If you can be a safe doctor then you’ll have done what you need to do for your patient (emphasis added).

**[Participant 1 – practising doctor]**

This extract was coded for the ‘sub-unit’ that focused on ‘safety’.

> My expectations of my doctor are simple things like just being friendly, warm and kind (emphasis added).

**[Participant 30 – clinical ethicist]**

This extract was coded for the ‘sub-unit’ that focused on ‘showing genuine concern’.

> To be a good doctor you not only have to be good at what you do, but you have to be a good ‘people person’ and a caring person (emphasis added).

**[Participant 19 – patient]**

This extract was coded for the ‘sub-unit’ that focused on ‘combining competence with caring’.

Where I had supported my field note coding with such verbatim participant responses, CAQDAS supported this strategy for me to remain close to the data. For example, I imported the anonymised transcripts into the software, reading
and re-reading them and highlighting raw extracts for my analytical commentary. Guided by my field coding and the research question, I employed the NVivo® ‘nodes’ feature to develop my analytical structure, linking ‘sub-units’ and ‘units of meaning’ to broader phenomenological themes.

My research question provided further guidance for the data analysis structure, which is outlined in Table 3 below. This outline captured the data in two ‘phenomenological themes’, four ‘units of meaning’ and 11 ‘sub-units of meaning’. According to Smith et al. (2009):

*The analyst develops a charting or mapping of how they think the themes fit together, based on the research question … IPA is usually supported by some form of visual guide (map, diagram or table).*

(pp. 79, 96)

Within this phenomenological framework, this analytical mapping of ‘themes’, ‘units’ and ‘sub-units’ of ‘meaning’ served to capture the ‘essence’ of the ‘phenomenon’ of participants’ experiences with doctors that could better inform medical selection and education. This aligned with Van Manen’s (2001) reference to ‘phenomenological themes’; as well as the Hopkins et al. (2016) reference to the ‘general dimension’ of phenomenological research, discussed and replicated with permission of the authors in Figure 2 (section 3.2). The data-analysis structure was therefore, the culmination of initial descriptive analysis, subsequent idiographic analysis (of single transcripts of what Smith has called ‘signature’ stakeholders or participants – see section 3.3.5.3.1 below); as well as the analysis of combined transcripts to identify patterns as well as convergence or divergence of these data (Smith et al., 2009).
The structure is presented in Table 3 in order to demonstrate the analytical method employed. Its contents will be described more fully in the next chapter, which presents the finding of the main study.

**Table 3 Data Analysis Structure of stakeholders’ positively and negatively evaluated doctor experiences**

<table>
<thead>
<tr>
<th>Phenomenological theme</th>
<th>Unit of meaning</th>
<th>Sub-unit of meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Positively Evaluated Doctor Experiences</td>
<td>3.1.1</td>
<td>(a) Ensuring ‘patient safety’</td>
</tr>
<tr>
<td></td>
<td>Being ‘patient-centred’</td>
<td>(b) Showing ‘genuine concern’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(c) Combining the ‘art’ with the ‘science’ of medicine (competence with caring)</td>
</tr>
<tr>
<td></td>
<td>3.1.2</td>
<td>(d) Being ‘a good listener’</td>
</tr>
<tr>
<td></td>
<td>Being a ‘good communicator’</td>
<td>(e) Allowing ‘sufficient time’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(f) Being ‘respectful’</td>
</tr>
<tr>
<td>3.2 Negatively Evaluated Doctor Experiences</td>
<td>3.2.1</td>
<td>(g) Being ‘disrespectful’</td>
</tr>
<tr>
<td></td>
<td>Being ‘unprofessional’</td>
<td>(h) Being ‘arrogant’</td>
</tr>
<tr>
<td></td>
<td>3.2.2</td>
<td>(i) Having ‘impaired judgement’</td>
</tr>
<tr>
<td></td>
<td>Compromising the ‘safety of self and others’</td>
<td>(j) Being ‘a poor communicator’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(k) Being ‘incompetent’</td>
</tr>
</tbody>
</table>

The top half of data analysis structure in Table 3 above, links the first three ‘sub-units’ of meaning (a), (b) and (c) to the first ‘unit of meaning’ (3.1.1). A further three ‘sub-units’ of meaning (d), (e) and (f) are linked to the second ‘unit of meaning’ (3.1.2). All upper ‘sub-units’ and ‘units’ of meaning are linked to one broad phenomenological theme (3.1).
The lower half of data analysis structure in Table 3 above, links a further three ‘sub-units’ of meaning (g), and (h) to a third ‘unit of meaning’ (3.2.1). The last three ‘sub-units’ of meaning (i), (j) and (k) are linked to the fourth ‘unit of meaning’ (3.2.2). All lower ‘sub-units’ and ‘units’ of meaning are linked to the second broad phenomenological theme (3.2).

CADAS provided the necessary technological support for my schematic representation of the data in Table 3. Within a phenomenological framework, Smith’s (2009) reference to an iterative, inductive cycle facilitated progression from ‘this iterative process of fluid description … to a synergistic process of description and interpretation’ (pp. 80, 92) or what Lindseth and Norberg (2004) referred to as ‘phenomenological hermeneutics’ (p. 147).

My analytical method had thus far addressed the research question in the required ‘breadth’ by focusing on the broader phenomenon of participants’ experiences of doctors that could better inform how we select and train them. A shift in focus was now required to address my research question in the required ‘depth’ to complete what Smith et al. (2009) referred to as the ‘part-whole relationship of the hermeneutic circle’ (p. 115). The rich and deep data that my study had generated enabled me to capture the ‘essence’ of the phenomenon by engaging with participants for mutual understanding and deeper interpretation of their experiences.

I had progressed to the data analysis stage of what Larkin (2013) referred to as an ‘organised, detailed, plausible and transparent account of the meaning of the data’ (2013, slide 14). The key elements of IPA (outlined for my methodology in section 3.2) informed the next stage of analysis. These included a hermeneutic circle of reciprocal analyst-participant meaning-making and interpretation and
applying a double hermeneutic where I made sense of participants making sense of their doctor experiences. My IPA narrative needed to reflect an interpretive dialogue with participants, weaving verbatim expressions into my analytical commentary.

Also in preparation for the next stage of analysis, I aligned with the Hopkins et al. (2016) emphasis on the ‘writing’ dimension of phenomenological research, discussed and replicated with permission of the authors in Figure 2 (section 3.2). This emphasis was supported by Lindseth and Norberg’s (2004) claim that:

> [For] research purposes lived experience has to be fixed in texts, which then always need interpretation ... we search for possible meanings in a continuous process ...

(p. 147)

### 3.3.5.3 Interpretive analysis

The data analysis structure outlined in Table 3 facilitated progression to this stage of analysis – referred to earlier as completing the part-whole relationship of the hermeneutic circle. According to Smith et al. (2009).

> Writing up for larger numbers of participants or for group-level analysis will demand summarising, condensing and illustrating what you consider the main themes to be … you will also need to identify key ways that you as the analyst think about the participants’ experiences, addressing the core of what participants were thinking and experiencing.

(p. 115)

Although emphasised in this part of the analysis, this creative writing process was fundamental to all stages of my project, illustrated in Figure 2, section 3.2
as the ‘overall and indispensable dimension of phenomenology’ (Hopkins et al., 2016, p. 23); as a way to create depth by constructing multiple layers of meaning in the data as well as by ‘exploring the phenomenon in all its experiential ramifications’ (Smith et al., 2009, p. 152). This practice of writing was, therefore, fundamental to demonstrating my meaningful engagement with participants for deeper understanding and interpretation of their experiences with doctors.

The flexibility and fluidity of this approach is reflected in my IPA write-up in the following two chapters. Given the Smith et al. (2009) assertion that ‘there is no clear-cut distinction between analysis and writing up and that each theme needs an interpretive component’ (p. 110), my analytical commentary could move sequentially from broad description and schematic representation to IPA of the more deeply experiential data.

Based on the recommendations by Smith et al. (2009) to be selective in the choice of extracts, and particularly in view of the large number of participants in my project, I selected those whose doctor experiences most strongly represented the ‘phenomenological themes’, ‘units of meaning’ and ‘sub-units of meaning’ of my data analysis structure (outlined in Table 3, section 3.3.5.2). How I referred to them in my IPA narrative is explained below.

3.3.5.3.1 ‘Signature’ and ‘supporting’ stakeholders

During the analysis, it became clear that some stakeholders had particularly clearly represented specific issues. These ‘signature’ stakeholders were those participants whose doctor experiences were found to most strongly demonstrate the ‘phenomenological themes’, ‘units’ and/or ‘sub-units’ of meaning in the analytical structure outlined in Table 3 (section 3.3.5.2) and
supported by verbatim quotes in the text. For example, participant 37 was identified as a ‘signature’ stakeholder as idiographic analysis of that single transcript yielded particularly rich, deep data. Descriptive data in that transcript were initially coded to ‘sub-unit’ (b) – ‘showing genuine concern’. Raw extracts of these data were captured for this participant in the field coding notes in Appendix D as follows:

A respectful collaborative partnership [between the woman and her doctor] is really important …

I would look for someone … who really wanted to look at their patient as an individual …

A doctor who make[s] women feel that they [are] involved in their care is important …

Converging and supporting data from other participant experiences were then incorporated into my analytical commentary and linked to similar experiences of what I have called ‘supporting’ stakeholders. This process followed the advice by Smith et al. (2009) that analysis:

[S]hould start with the interview that is found to be most detailed, complex and engaging. For example, choose experiential material from a signature stakeholder that can be supported by other stakeholder experiences.

(p. 82)

In summary, guided by the literature and my research question, my data collection and analysis methods had facilitated exploration of a ‘doctor experience’ phenomenon from a unique participant perspective. A larger-than-
conventional sample of participants had been recruited and interviewed to a point of saturation, when their responses about their experiences ceased to generate new data. My data analysis structure was informed by an inductive process of initial descriptive analysis, with subsequent idiographic analysis of single transcripts and combined transcript analysis. I applied the principles of hermeneutics to move fluidly between the ‘parts’ and the ‘whole’ of the hermeneutic circle, engaging deeply with the data to capture the ‘essence’ of the ‘doctor experience’ phenomenon. I engaged with participants in a double hermeneutic in a reciprocal activity that would deepen understanding and interpretation of each experience. A further and significant justification for applying this analytical approach to the project was that it supported a unique effort to listen to the voices of all stakeholders who could inform medical student selection and education and not just to those who had traditionally been ‘privileged’ in the context of previous studies.

Within this framework, IPA was initially conducted on the transcripts of selected participants (referred to as ‘signature’ stakeholders and defined in section 3.3.5.3.1). I went on to identify similarities in the data between these participant transcripts and those of others (referred to as ‘supporting’ stakeholders and defined in section 3.3.5.3.1).

The IPA process used within this project was intended to demonstrate how these double hermeneutics (me making sense of selected stakeholders making sense of their experiences) could inform medical student selection and education through a variety of contexts. From these analyses, commonalities as well as differences within the data-set could be explored (Reid et al., 2005), culminating in comparing data from this project with those in the literature (for
example, comparing data relating to stakeholders’ experiences of doctors’ empathy). This methodology was ideally suited to managing a large and complex data-set as I could build analytical outcomes layer-by-layer that could give a voice to stakeholders on a research topic that had not previously been explored in this way. This methodology also allowed me to build credibility and transferability (Guba & Lincoln, 1989) of the findings by firstly, demonstrating a thick and rich analysis (Boyle, 2013; Edvardsson, 2015) of stakeholder experiences to inform medical student selection and education; and secondly, by raising the analysis to a level that facilitated comparisons within the broader literature.

I continued to follow the IPA guidelines of Smith et al. (2009) for the next two chapters. Firstly, to address the first part of my research question with an IPA commentary, detailing not only the experiences of selected participants (or ‘signature’ stakeholders) with doctors but how other participants (or ‘supporting’ stakeholders) with similar experiences could deepen understanding of the phenomenon. The aim for this stage of my IPA write-up would, therefore, be to identify convergent patterns in the data by exploring these shared experiences or commonalities. According to Smith et al. (2009):

*This part of the interpretive account is a close reading of what your participants have said without reference to the existing literature.*

(p. 112)

This focus will be adopted in chapter 4, while in chapter 5 I will incorporate comparison with the existing literature to explore how my participants’ stakeholder experiences with doctors can better inform how we select and train
them. The unexpected themes that emerged, particularly in relation to negatively evaluated doctor experiences, went on to inform the topic from a compelling and unique perspective. At that stage I could also my place my work in a broader context by making comparisons with the literature.
CHAPTER 4 DATA ANALYSIS – FINDINGS

Analysis of participant responses to the initial interview question of ‘what does the ‘good’ doctor mean to you?’ yielded descriptive data that were captured in a coding book and referred to in Appendix D. In a hermeneutic circle, I engaged with participants to gain a deeper understanding and exploration of this ‘good’ doctor phenomenon. This exploration yielded rich, deep data that were inductively analysed and tabulated as follows:

Analysis of three ‘sub-units’ of meaning (‘ensuring patient safety’; ‘showing genuine concern’ and ‘combining competence with caring’) yielded a ‘unit of meaning’ that focused on doctors ‘being patient-centred’ (please refer to ‘unit of meaning’ 3.1.1 with ‘sub-units’ a, b and c in Table 3, section 3.3.5.2). Analysis of a further three ‘sub-units’ of meaning (‘being a good listener’; ‘allowing sufficient time’ and ‘being respectful’) yielded a ‘unit of meaning’ that focused on doctors ‘being good communicators’ (please refer to ‘unit of meaning’ 3.1.2 with ‘sub-units’ d, e and f in Table 3, section 3.3.5.2). Further analysis of these ‘sub-units’ and ‘units’ of meaning yielded a phenomenological theme that expectedly focused on participants’ ‘positively evaluated doctor experiences’.

Unanticipated and impactful for my study was when the analysis of a further two ‘sub-units’ of meaning (‘being disrespectful’ and ‘being arrogant’) yielded a ‘unit of meaning’ that focused on doctors ‘being unprofessional’ (please refer to ‘unit of meaning’ 3.2.1 with ‘sub-units’ g and h in Table 3, section 3.3.5.2). Analysis of a further three ‘sub-units’ of meaning (‘having impaired judgement’; ‘being a poor communicator’ and ‘being incompetent’) yielded a ‘unit of meaning’ that focused on doctors ‘compromising the safety of self and others’ (please refer to ‘unit of meaning’ 3.2.2 with ‘sub-units’ i, j and k in Table 3, section 3.3.5.2). Further analysis of these ‘sub-units’ and ‘units’ of meaning yielded a
phenomenological theme that unexpectedly focused on participants’ ‘negatively evaluated doctor experiences’.

Starting with the first phenomenological theme of ‘positively evaluated doctor experiences’ my data analysis structure went on to inform my study findings as follows:

4.1 POSITIVELY EVALUATED DOCTOR EXPERIENCES

I applied an ideographic approach to single out ‘signature’ stakeholders from the participant pool for IPA on data that were found to be the most deeply experiential. To establish credibility and transferability of the findings, I selected ‘supporting’ stakeholders who had made sense of their experiences in the similar ways, thus building the analytical outcomes layer by layer.

4.1.1 Interpretive analysis of what ‘being patient-centred’ meant for selected participants (identified in the data-analysis structure, Table 3, section 3.3.5.2)

The first ‘unit of meaning’ that was identified from the data on participants’ positive doctor experiences was that of doctors being ‘patient-centred’. This phenomenon was eloquently expressed by one of the ‘signature’ stakeholders (a health care professional) as follows:

I then accompanied her [a pregnant client] to see a doctor at [names a local hospital] who was extremely supportive of the woman’s wishes, who really took note of her birth-plan and what she wanted, who really respected the fact that she needed to make an informed decision for what she wanted … and she [the doctor] facilitated all that happened and that woman had a beautiful [vaginal breech] birth with that doctor present as well.

[Participant 37 – midwife]
This participant found meaning in what she saw as the doctor’s ‘woman-centred’ approach, expressing how important the doctor’s supportive and respectful approach appeared to be in facilitating a positive birth experience, which impacted not only on the woman but on the broader community as well:

_That woman’s good doctor experience had a big ripple effect within the community. And to me, that was an amazing experience with that doctor because she was really supportive and really woman-centred. She really respected what that woman wanted. And because of that, we got a good result rather than a woman who, if she hadn’t have been supported at that point, was prepared to ‘free birth’ at home in an unsafe environment._

[Participant 37 – midwife]

The midwife (as a ‘signature’ stakeholder in this case) made sense of her experience by expressing her surprise at finding a doctor who upheld a commitment to keep a potentially high-risk patient and her baby safe.

_She [the client] needed reassurance from the doctors that they had tried everything first, that they had put her at the centre of their care plan and had considered her needs first … everybody’s risk level is different and I think we need to take that into account when we provide care for women._

[Participant 37 – midwife]

The midwife went on to express how her world view had changed as a result of this experience with resultant changes to her own practice as well. This ‘unit of
meaning’ therefore reflects the positive effects of a health professional’s doctor experience that was witnessed to be not only woman-centred but which carried benefits for other women as obstetric clients in the future.

At a second hermeneutic level in this analysis, we can see that the midwife’s sense-making included an emotional progression from surprise to appreciation that this doctor was willing to accommodate the woman’s needs. Her choice of the words ‘extremely supportive’, ‘amazing’, ‘beautiful’ and ‘really respected’ convey the emotional destination that she reached and confirm that this experience impacted significantly on her world view of doctors through her sense-making of a woman’s needs around birth.

This ‘unit of meaning’ (‘positively evaluated doctor experiences in relation to ‘patient-centredness’) was further analysed into the following three ‘sub-units’ of meaning: ensuring patient safety, showing genuine concern and combining the ‘art’ with the ‘science’ of medicine (competence with caring).

(a) **Ensuring patient safety** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

Further interpretation of the midwife participant’s positive doctor experience revealed meaning-making in the context of the patient’s safety:

*That doctor was good because she worked with the woman to choose to birth safely in a controlled environment [a hospital-based birthing unit] rather than take the risk of birthing unassisted in the uncontrolled environment of her home.*

[Participant 37 – midwife]
Her element of surprise was combined with admiring and praising the doctor for being able to offer her client a safe birthing option in challenging circumstances (respecting her birth choices whilst acknowledging her level of obstetric risk).

This ‘sub-unit’ of meaning was congruent with the positive doctor experiences of other ‘supporting’ stakeholders. For example, for one patient participant the importance of being made to feel safe was expressed in terms of seeking reassurance from her doctor to allay her fears of the unknown:

*He [her oncologist] reassured me I was in good hands. I felt safe instead of being left to float around, wondering what was going to happen. [So, you’re saying you value somebody who makes you feel safe as a patient?] Yes, absolutely! It’s a pretty basic request, isn’t it?*

[Participant 16 – patient]

This participant’s experience evoked powerful meaning related to her not only feeling held and protected by her doctor (in the true sense of ‘patient-centredness’), but also of her finding reassurance in his strength and protectiveness.

Other participants or ‘supporting’ stakeholders similarly made sense of what ‘being safe’ meant for them:

*He [her GP] was so nice! He talked to me; he made me feel so normal. He was interested and he was so good at what he did – very professional. I felt completely safe in his hands …*

[Participant 18 – patient]
So, I guess from my viewpoint, the paramount importance is being safe: If you can be a safe doctor, then you'll have done what you need to do for your patient.

[Participant 1 – practising doctor]

In the context of ‘patient-centredness’, interpretation of these two ‘supporting’ stakeholder experiences yielded significantly diverse meaning-making. For the patient (participant 18), the analogy that was applied in the interpretation of the previous patient’s experience – that of being made to ‘feel safe in his hands’ (participant 16) could again be applied here. At the second hermeneutic level her language revealed the sense she made of her experience. Her use of the words ‘nice’, ‘interested’, ‘good at what he did’ and ‘professional’, conveys a sense of her confidence in her doctor’s ability to care for her.

On first impression, the doctor’s emphasis (participant 1) on patient safety appears to have been expressed more as a viewpoint or discourse than experientially. However, her use of the term ‘paramount importance’ appears to demonstrate an emotional investment in being able to keep her patients safe when analysed at the second hermeneutic level.

Another ‘supporting’ stakeholder shared a doctor experience that linked her understanding of ‘patient safety’ to that of ‘competency’ for ‘good’ medical practice:

I remember a doctor for helping his patients to feel safe, not only physically but emotionally. Competence is so crucial because kindness is not enough to keep patients safe [strong affirmation from the participant group].

[Participant 7.2 – medical educator]
As with the doctor’s (participant 1) experience, this participant positively evaluated a doctor experience that developed into a discourse when shared during her group interview.

IPA yielded an interesting apparent contradiction in this case. Although participant 7.2 remembered her doctor for his kindness in keeping his patients physically and emotionally safe (utilising what might be referred to as ‘soft’ skills in the context of practising the ‘art’ of medicine), she countered that a requirement for competency superseded ‘kindness’ when patient safety was at stake (referred to as ‘hard’ skills in the context of practising the ‘science’ of medicine). This appears to demonstrate an unresolved ambivalence in the sense-making process when examined at the second hermeneutic level.

(b) **Showing genuine concern** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

A different kind of ‘patient-centredness’ emerged from the doctor experiences of other stakeholders, which was interpreted to focus more on the personal welfare of patients than on their individual wishes or perceived needs:

*She [the GP] absolutely focuses on you and she has eye contact and she challenges you. She’ll challenge anything I say … not in a horrible way, but just to make me think about what I’ve actually said. If I’ve gone about a cough or whatever, she’ll say: ‘Now let’s have a look: Have you had your Pap[anico] smear and your mammogram and all of this? Are you up to date with all these things? Are you doing that?’ So, it’s her holistic approach, which is good; you feel like she’s genuinely concerned about you.*

[Participant 18 – patient]
This participant found the meaning of her experience with this doctor as a sense that the doctor was genuinely concerned for her welfare. Her reference to specific episodes of care (when she had a cough or may have needed cervical and breast screening) conveys an impression at the second hermeneutic level that she felt cared about. Her experience reveals a doctor whose care was both individualistically and holistically focused.

The doctor experience of another stakeholder revealed a different facet of this ‘caring’ phenomenon:

*When I see my doctor he doesn’t just focus on my medication but says: ‘How are you going? How’s your family doing? I haven’t seen your little brother in a coupla years, which is good that he cares for me as a person and not just another medical problem … he actually just seems to genuinely care and to work out what is going on.*

[Participant 9.1 – medical student]

Although ‘caring’ was again interpreted as being individualistically focused for this participant (expressed in her words ‘that he cares for me as a person and not just a medical problem’); her doctor’s concern was further explored in a social context (that of her family) as well as in the context of medically-driven goals (expressed in her words ‘not just a medical problem’ … ‘and to work out what is going on’). This participant found meaning in this experience that related not only to her individual needs, but to her welfare in the context of a wider social and aetiological milieu as well.
Data that emerged from another stakeholder’s experience added further to this ‘sub-unit’ of meaning for ‘showing genuine concern’:

*It was important for the doctor to share his experiences with me: Where you’ve had a family member … or a doctor shares that they have had a family member who has had a similar experience, so they understand what it might be like for you [as the patient]. I think that can be very powerful and a positive experience because if you feel that you’re not alone and you’re supported … that the doctor ‘gets it’. So, someone who is patient and understanding and can put themselves in their patients’ shoes.*

[Participant 2.6 – medical educator]

This participant described a particular phenomenon in which doctors disclose experiences from their personal lives to patients. Although this is a practice that some may see as transgressing professional boundaries, this medical educator’s use of phrases such as ‘understand what it might be like for you’ and ‘very powerful’ convey a sense at the second hermeneutic level that ‘positive’ demonstrations of a doctor’s support had a significant emotional benefit that made him feel less ‘alone’.

(c) **Combining the ‘art’ with the ‘science’ of medicine (competence with caring)** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

The ‘unit of meaning’ (positive doctor experiences in relation to patient-centredness) continued to be further analysed from data that emerged from stakeholder experiences in the context of this phenomenon.
One participant related an experience that he interpreted to mean that his doctor was able to embrace an equal partnership with him:

She [his GP] treats patients as equals, not as if they are beneath her. She relates to them on their level and explains everything and I think that patients really appreciate that they are being treated like human beings as opposed to just numbers or diseases or symptoms. You can see by the looks on her patients’ faces that they appreciate her being patient-centred, that it’s about the patient rather than the doctor …

[Participant 9.7 – medical student]

Interpretive parallels were drawn between this participant’s experience of a doctor and earlier meanings that related to medically driven goals versus a broader social and aetiological milieu. These meanings were illustrated by this participant’s choice of the words ‘they are being treated like human beings as opposed to just numbers or diseases or symptoms’. The observation that this stakeholder was a medical student added further significance to this ‘unit of meaning’ for ‘combining competence with caring’: His experience of ‘seeing the looks on the patients’ faces’ points to a meaning related to patient-centredness. At a deeper level this experience suggests the medical student’s longing and resolve to be similarly admired by his own patients in the future.

Another stakeholder focused on an experience that underlined for him the value of doctors who were able to combine the ‘art’ with the ‘science’ of medicine (referred to earlier as ‘soft’ and ‘hard’ skills by participant 7.2):

When I was doing my major, we had a professor of physiology who was a doctor. We were a weird bunch and
some of us wanted to do medicine. He advised us that if we were only interested in the science of medicine, then we should study science, as medicine is an art as well as a science.

[Participant 6 – practising doctor]

This participant’s account captured the youthful, formative essence of his experience (‘we were a weird bunch’), which changed his understanding of what being a doctor meant. As he made meaning from his experience he described how much patients could benefit therapeutically from such human interactions:

His [the professor’s] belief was that doctors who only focus on the ‘science’ of medicine risk becoming ‘glorified technicians’ and that doctors can fake being ‘good’ by acting ‘nice’. I am still interested in the ‘why’ and ‘how’ of making people feel better. Patients often express feeling better for just having interacted with their doctor, when in fact he has done very little.

[Participant 6 – practising doctor]

This participant’s experience captured the complexity of this ‘art’ versus ‘science’ of medicine phenomenon. What was revealed as significant was not only that this doctor’s formative experience with his professor had set a pattern for his world view of medicine but that it had prompted him to question ‘why’ and ‘how’ just ‘being’ with a patient-centred doctor could make people feel better. What was more profound was his recognition that doctors faking ‘good’ by acting ‘nice’ was not what medicine was all about.
Another participant’s experience focused more on a doctor’s competence than his ‘bedside manner’:

> The second experience was very different … with a musculoskeletal specialist that I saw this time as a patient, who absolutely lacked in the bedside manner component of his practice but made up for it entirely in his competence: So, a short history, a short physical exam[ination], knew exactly what needed to be done and managed to diagnose the condition on that very quickly, very confidently and almost arrogantly! [Participant’s laughter prompts laughter from the participant group]. It was actually really impressive, as a result of which I was surprised, given his [poor] bedside manner. So, as a patient I didn’t really mind about the doctor’s poor bedside manner because he ‘fixed’ me … he was good at it and confident with it too and made me feel safe as a result.

[Participant 9.3 – medical student]

Parallels are evident between the positive doctor experience of this medical student and the emphasis that other participants placed on being made to feel ‘safe’. The significance of this participant’s experience was interpreted at the second hermeneutic level in the sense that he was not only impressed by his doctor’s high level of competence (given his doctor’s poor ‘bedside manner’), but that his experience had surprised him and unsettled prior beliefs.

This juxta positioning of ‘hard’ versus ‘soft’ skills in medicine was revealed in another participant’s positive doctor experience:

> In hindsight, I think: wow! That surgeon! Even ‘though he was abrupt, I still have contact with him because he saved my life! It was his knowledge … he knew that I had to get
there [to another hospital] in a certain time frame and even ‘though I would’ve liked him to be ‘nice’ [smiles], I can kinda see where the views of competence versus compassion are coming from as well. So, there’s the professional perspective [of doctors needing to be competent] and the patient perspective [of doctors needing to be compassionate] as well [affirmation remarks from group participants].

[Participant 7.4 – social worker]

As in the case of the meanings that participant 9.3 made of his experience, this health professional shared an experience that was deeply meaningful for her, acknowledging not only the juxta positioning of ‘hard’ versus ‘soft’ skills in medicine but revealing the essence of the doctor-patient relationship (expressed in her words ‘the professional perspective and the patient perspective’). Interestingly, her apparent choice (at the second hermeneutic level) to accommodate her doctor’s lack of compassion, which extended even to the point of rudeness, since he was perceived as having ‘sav[ed] her life’, was supported by other health professionals in that group interview.

Another participant added to this ‘sub-unit’ of meaning of ‘combining competence with caring’ by expressing his confidence in a doctor whom he experienced to be technically competent for a procedure that was crucial for his survival:

I knew he [the cardiologist] was going to put the catheters in here and poke them up there [gestures towards his neck] and do all this stuff, but once he told me he thought it was in his competence to fix it, I was happy to just leave it there and to get on with it, which is exactly what we did.

[Participant 32 – senior academic]
‘Patient-centredness’ for this participant meant a doctor who had secured sufficient trust in his competence for the patient to be able to relinquish control, when needed.

Adding to these shared participant experiences of doctors ‘being patient-centred’, the experience of one ‘key stakeholder’ revealed her feelings of gratitude for and personal commitment to, being a ‘patient-centred’ doctor herself:

*I’m really grateful that I got to do medicine because I love it and I love people and I love taking care of patients and I take my Hippocratic Oath very seriously. I’m not in it for the money or the status or for whatever else motivates the wrong people to choose medicine!*

[Participant 39 – health executive]

This participant engaged in distilling her experience on a macro, life-long scale. The sense of privilege and gratitude for the hand she had been dealt emerged in a way that was striking for a senior practitioner who brought a youthful focus to her experience.

This ‘sub-unit’ of meaning of ‘combining competence with caring’ could be summed up in the words of one patient participant:

*I would go back to my GP anytime, because he is so good. He has that balance of being competent as well caring and values me as a patient.*

[Participant 18 – patient]
In summary, data that emerged from the positively evaluated doctor experiences of participants captured the essence of what it meant for a doctor to be ‘patient-centred’ (identified as ‘unit of meaning’ 3.1.1 in the data analysis structure outlined in Table 3, section 3.3.5.2). This ‘unit of meaning’ was further analysed into ‘sub-unit’ (a) that focused on doctors ‘ensuring patient safety’; ‘sub-unit’ (b) that focused on doctors ‘showing genuine concern’ and ‘sub-unit (c) that focused on doctors ‘combining competence with caring’. The method revealed data that were not only idiographic (distinct and detailed) in nature but were found to converge around the doctor-patient relationship. Data emerged from a broad representation of stakeholders (participants who identified as patients, as health professionals, as medical educators, as senior academics, as health executives and as medical students).

4.1.2 Interpretive analysis of what ‘being a good communicator’ meant for selected participants (identified in the data-analysis structure, Table 3, section 3.3.5.2)

The second ‘unit of meaning’ identified in the data that emerged from participants’ positively evaluated doctor’s experiences was that of doctors being ‘good communicators’. This phenomenon was captured by one of the ‘signature’ stakeholders (a medical educator who was also an experienced intensive care nurse) who set the scene as follows:

*On a clinical note: in intensive care, we deal with a lot of trauma, a lot of tense situations; but ‘the dying patient’ is always one of the more difficult times in the intensive care because things are inclined to be very rapid and unexpected …*

[Participant 3.4 – medical educator]
This participant went on to seek positive meaning from his doctor experience by expressing relief at being able to rely on a junior doctor to respond to such a crisis situation:

> I've had interactions with an ex-[medical] student from here [names a local medical school] who was a resident at the time, who came into a room when I was having a conversation about a patient who had seriously deteriorated. The family were very anxious; they were very distressed; they were asking lots of questions. Y'know, he [the junior doctor] was literally just walking past and I managed to ‘grab’ him and bring him in to assist me in handling the situation.

[Participant 3.4 – medical educator]

Whilst his recognition of a family-in-crisis (from his expressions of ‘the family were very anxious; they were very distressed; they were asking lots of questions’) was expected, his expression of surprise at how willingly a junior doctor had come to his aid was unexpected. This participant’s choice of the words ‘I managed to grab him’ conveyed feelings of urgency, expressed in the context of an ICU environment when ‘things are inclined to be very rapid and unexpected’.

This participant’s experience provided deeper meaning when focus shifted to how effectively this junior doctor had communicated in the family crisis situation:

> I was so impressed with his ability to connect with the family straight away. He managed to de-escalate the situation, bring all the emotion down to a level where he could communicate what he had to do about the facts of
the matter and really provide a lot of information very quickly [and] with the least amount of drama; the least amount of ‘pomp and ceremony’. It was all very matter-of-fact and very personable and it’s exactly what the family needed to hear and it backed me up professionally and personally in a very difficult situation …

[Participant 3.4 – medical educator]

On further exploration of this positive doctor experience in the second hermeneutic, it is clear that the participant experienced feelings of admiration for a junior colleague’s ‘good’ communication, particularly in a crisis situation. These meanings were interpreted from his use of the words ‘connect’, ‘de-escalate’, ‘a lot of information very quickly’ and ‘least amount of drama’. The participant recognised how valuable doctors being ‘good communicators’ were in times of crisis, not only for patients and their families, but also for their colleagues.

I just found it very comforting and reassuring to see someone with that ability who was reasonably young in their experience of death and dying, let alone medical practice … he [the junior doctor] obviously had that ability at that stage to realise what he had to do. He was less about coming from a medical standpoint, but more about connecting with the family and giving them the information that they needed whilst still maintaining professionalism.

[Participant 3.4 – medical educator]

The focus of this participant’s experience had shifted at this point from a micro- to a macro-level. His meaning-making valued doctors who communicated
effectively, not only in particular (crisis) situations, but also in the broader context of doctor-patient relationships (by being ‘comforting and reassuring’); of the medical practice journey (by ‘having the ability … to realise what he had to do’ and by ‘maintaining professionalism’) and of end-of-life matters (although being ‘reasonably young in their experience of death and dying …’). Of equal significance was the dissonance that was evident in the second hermeneutic when the participant attempted to reconcile what he had witnessed (a junior doctor whose actions were impressive) with this doctor’s relatively young age and limited experience.

This ‘unit of meaning’ (positively evaluated doctor experiences in relation to doctors being ‘good communicators’) was further analysed into the following three ‘sub-units’ of meaning:

d) **Being a good listener** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

For this ‘sub-unit of meaning’, one of the ‘signature’ stakeholders was a patient who encapsulated what ‘being a good listener’ meant for her when she interacted with her doctor:

> My GP has a really warm and personal approach: she makes me feel that I’m being listened to and she gives me eye contact. She is very thoughtful and considers my opinions, which makes me feel important and valued as her patient … The reason I keep going back to her is because she is one of the few people I know who is a genuinely good listener … doctors cannot be passive! They need to be proactive if they are going to be good communicators and earn the respect of their patients.

[Participant 18 – patient]
Although at first glance this may appear to be a formulated opinion, the details provided make it clear that the participant’s meaning-making was based on particular experiences. This patient’s choice of the words ‘eye contact’, ‘makes me feel important and valued’ and ‘a genuinely good listener’ conveyed a deeper understanding and admiration, in the second hermeneutic for a doctor ‘being a good communicator’.

A ‘supporting’ stakeholder similarly expressed how she came to positively evaluate her doctor’s listening skills:

[Referring to her GP] He’s practical, he’s competent, he’s a good listener, he’s relaxed [smiles] … he’s just trustworthy. I trust his judgment and I know that it’s more than a conversation or a transmission of information with him … doctors need to have an understanding of the place of health in allowing a good life. If you can ‘get’ that, then you understand what’s at stake for someone if their health is failing … it’s also their ability to have a good life that’s failing … if you [as a doctor] can understand that, you can actually engage and connect with people.

[Participant 30 – senior academic]

This participant attached further meaning to her doctor’s listening skills that related to key elements identified for positive ‘doctor-patient relationships’ (such as trustworthiness, understanding, engaging and connecting) (Anderson, 2012; Australian Medical Council, 2009; Best, 2011; Blease, 2011; Crisp, 2015). These drew strong parallels with participants whose doctor experiences were interpreted as being ‘patient-centred’ (identified as unit of meaning 3.1.1 in Table 3, section 3.3.5.2). Another participant, a doctor herself, related how her
experience of a close family member’s acute hospital admission had brought home the importance of effective doctor communication for her:

Reinforcing the importance of just listening to people and sometimes recognising that patients don’t always expect answers, but they do expect to be listened to and to be given time … that was a good lesson for me [as a doctor].

[Participant 13 – practising doctor]

Meanings around this participant’s focus on ‘just listening’ deepened when she interpreted this as a personal lesson for improved communication with her own patients. She deepened her understanding when she emphasised ‘good listening’ as part of a ‘duty of care’ for doctors to communicate effectively for medico-legal and patient safety reasons:

We have a duty of care to keep our patients informed, just as we have a duty of care to keep them safe … if you do something that’s technically inaccurate or is not evidence-based … if you communicate that to the patient … if you’ve done that in good faith and with open communication … you’ll be forgiven.

[Participant 13 – practising doctor]

Another participant or ‘supporting’ stakeholder related an experience of what a doctor’s listening skills meant for her:

We were treated with the greatest respect … when you go to him you know that he’s listening; so listening for me is a really important attribute.

[Participant 38 – private nurse practitioner]
As a clinician herself, she highly valued listening skills for healthy doctor-patient relationships, using a personal experience to illustrate this:

\[ I \text{ recently took my elderly mother to see him … he sat there and he never took his eyes off her and he touched her hand … He’s just ‘got it’ … a real ‘gem’ … one of the nicest, most professional, interested and caring doctors I’ve come across … } \]

[Participant 38 – private nurse practitioner]

Interpretation of this participant’s doctor experience deepened understanding of what a doctor being a ‘good communicator’ meant for her. I drew parallels between her expressions of admiration for a doctor (as ‘one of the nicest, most professional, interested and caring’ doctors I’ve come across’) and humanistic medical practice. Her doctor experience emphasised the importance of not only ‘extrinsic’ or observable skills such as displaying eye contact (expressed as ‘he never took his eyes off her’); and tactile communication (expressed as ‘he touched her hand’), but also of ‘intrinsic’ qualities (expressed as ‘nicest, most professional, interested and caring’) for ‘good’ medical practice.

(e) **Allowing sufficient time**

(identified in the data-analysis structure, Table 3, section 3.3.5.2)

This ‘sub-unit’ of meaning took on significance for participants whose experiences related to doctors being ‘good communicators’, not only in terms of their ‘listening skills’ but also in terms of the time that doctors were willing to spend with them. According to one ‘signature’ stakeholder:
When I went to see him at the very beginning, he sat with us … my sister and me … for two hours! He went through every aspect of my cancer, he explained it in layman’s terms and he didn’t continue until he was sure that I understood the procedure, the cancer itself, what was going to happen and he wanted me to ask as many questions as I needed to know and he answered all of my questions.

[Participant 16 – patient]

For this participant, the time taken by her doctor had a significant and positive impact on the way that she was able to cope with her difficult situation. Her expressions of gratitude were mirrored in words such as ‘explained it in layman’s terms’; ‘didn’t continue until he was sure that I understood the procedure’; and ‘he answered all of my questions’. The meaning she made of a doctor ‘allowing sufficient time’ deepened as she continued to share her experience:

So, he was amazing! He was very good … my oncologist … it was just his manner: he was a gentle person, but confident and he made you feel confident in him. He gave you the feeling of confidence because he wasn’t pushy, he wasn’t short, he wanted them [her family] to know that I was in good hands and he convinced my brother … so there you go! He just gave you that feeling that everything was going to be okay.

[Participant 16 – patient]
Her experience highlighted key elements of effective communication she judged to be important from the experience, such as ‘inviting and answering questions’; ‘gentle and confident manner’; ‘not being pushy or short’; and ‘giving the feeling that everything was going to be okay’. On the second hermeneutic we can discern both a sense of calm and of confidence engendered by positive meaning she found in the doctor’s capabilities. Her experience also drew parallels with meanings related to ‘patient-centredness’ and ‘ensuring patient safety’ that had emerged from my earlier analysis of other participant experiences (participants 37, 16, 18, 1, 7.2, 9.1, 2.6, 9.7, 6, 9.3, 7.4, 32 and 39).

Another ‘supporting’ stakeholder’s experience strengthened what it meant for a doctor to be an effective communicator when she witnessed a doctor ‘allowing sufficient time’ to reassure a patient and his/her family:

_A doctor that I’ve had some experience with is someone who came in to see a patient out of time to discuss an operation that they were very concerned about and they had to wait for a son to come in to have the information given to them. And he sat there and drew a drawing and spent over an hour and a half with them, so that they understood what was going on._

;/*Participant 2.6 – medical educator*/

This participant’s experience conveyed a deep sense of caring, created by her narrative of a doctor ‘coming out of time’, ‘waiting for the son’ and taking additional time and steps (including ‘a drawing’) to reassure the patient and the family ahead of surgery.
Another ‘supporting’ stakeholder’s experience supported this ‘sub-unit’ of meaning of ‘allowing sufficient time’ by demonstrating the value of doctors spending time with their patients, particularly those who were vulnerable:

*I think time is a massive factor: Not just feeling that they are in there [the doctor’s surgery] for ten minutes and then they’re out because obviously, homelessness has a massive impact on them psychologically as well as physically and emotionally … that’s why time with a doctor to explore all of these is important.*

[Participant 8.6 – health consumer representative]

(f) **Being respectful** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

For one ‘signature’ stakeholder, the experience of a doctor’s effective communication skills involved not only ‘being a good listener’ and ‘allowing sufficient time’, but also ‘being respectful’:

*[Names the doctor] was in his suit quicker than I could get changed and his shoes were buffed up again and his waistcoat was tight and he went down to see them as though he was going to the Queen of England.*

[Participant 2.8 – medical educator]

At this point the participant’s experience focused on a doctor ‘being respectful’ by the way he presented himself, giving a detailed description of what may have been an expected dress code for doctors at the time. The meaning of ‘being
respectful’ made from this experience deepened when his focused changed to the doctor’s encounter with a patient and the family:

*He squatted down in front of them because they were sitting there shattered … his face was on their level and it was still on their level three quarters of an hour later when he finished talking to them … He was respecting them and as [was] obvious from his dress and his behaviour and what have you, was respecting himself as well. That’s [names the doctor]!* 

[Participant 2.8 – medical educator]

The words used by this participant convey deep and powerful meanings related to a doctor’s show of respect not only for himself by, for example, taking pride in the way he dressed (wearing a ‘suit’, ‘waistcoat’ and ‘buffed’ shoes) but more importantly, for a patient and a family in distress (‘they were sitting there shattered’). This participant’s experience lent strong support to those shared by others, focusing on doctors’ communication capabilities: creating an equal partnership (‘squatting down on their level’), giving eye contact (‘his face was on their level’) and giving time (‘three quarters of an hour later’).

A ‘supporting’ stakeholder’s experience of doctors ‘being respectful’ was shared from a different angle:

*We see professionalism in doctors and it still boils down to respect. They are willing to participate [in their education courses], they’re respectful to the nurses in their allocated teams … they recognise and respect that we have knowledge and skills that they can benefit from … for us respect permeates everything, particularly when there is a*
power differential ... these doctors have humility enough to know that what we are teaching is not their specialty but they show respect in their teamwork with the other health care professionals.

[Participant 38 – private nurse practitioner]

This participant’s use of the words ‘power differential’ and ‘humility’ support the experience of participant 2.8 that emphasised a doctor communicating effectively with a patient and family in distress by ‘squatting down’ in front of them ‘because they were sitting there shattered’.

The concept of an equal partnership that was highlighted by participant 2.8 evokes parallels with data that emerged from the first ‘unit of meaning’ that focused on stakeholder experiences of doctors being ‘patient-centred’ (identified in the data-analysis structure, Table 3, section 3.3.5.2). The positive impact of this concept was reinforced by two ‘supporting’ stakeholders’ as follows:

My doctor is older than me but we speak the same language, we have that equal respect for each other. We talk about all sorts of things that build our rapport. I value that he listens to what I’m saying ... we are on the same page ... we sing from the same hymn sheet.

[Participant 4.6 – patient]

I feel listened to, I feel that my doctor responds to where I’m at and to what I’m saying. She’s friendly and is a great communicator! [remarks of affirmation from the participant group] ... it’s so lovely and so relaxed to be treated like that and to be communicated to on a normal level instead
of ‘they’re up there’ and you’re ‘down here’ [gestures with her hands] or you [the doctor] are ‘God’ and I’m just a ‘pleb’! [referring to herself, with strong affirmation from the participant group].

[Participant 5.6 – patient]

The concept of a ‘power differential’ that emerged from the experience of participant 38 highlighted the value that both professionals and patients placed upon doctors ‘being respectful’.

For other ‘supporting’ stakeholders, meanings around doctors ‘being respectful’ related to their emphasis on cultural safety for ‘good’ medical practice:

Quite recently I’ve been caring for my 90-year-old dad and I’ve had to call the afterhours [doctors] on a couple of occasions. We’ve had three Indian doctors who just blew us away with their respect for him. You could just feel it from their body language, the way they spoke to him and their thoroughness … it was just lovely to see him treated with so much respect.

[Participant 5.7 – patient]

I’ve worked with a lot of Indigenous and non-Indigenous people and basically, Indigenous people are interesting to manage in health care: because they don’t like being directed, doctors need to work with them to do it their way. They respond when we [as Indigenous health workers] are very respectful of their culture and when we recognise that our way is not how everyone does it … The doctors we work with respect that some clients have a belief system and culture which is very different from their own.

[Participant 36 – Indigenous health worker]
This ‘unit of meaning’ (positively evaluated doctor experiences related to doctors ‘being good communicators’) can be summed up in the words of two participants:

There’s two guys [doctors] I work with currently now: both are very different in their fields of medicine, but they are people who stand out … It’s picked up by relatives … by staff … by visiting doctors. And it’s simple, simple things like basic communication skills …

[Participant 2.4 – medical educator]

I think at the moment things are starting to shift in the way that doctors interact with patients and I think that we’re starting to see doctors who understand that they need to sit at the bedside: level with the patient and level with the family, physically, as well as on a communication level. So, the nature of the doctor-patient relationship is changing and evolving and doctors need to adjust their communication skills to suit that.

[Participant 33 – health executive]

In summary, data that emerged from the positively evaluated doctor experiences of selected participants captured the essence of what it means for a doctor to be a ‘good communicator’ (identified as ‘unit of meaning’ 3.1.2 in the data analysis structure outlined in Table 3, section 3.3.5.2). From this this broad ‘unit of meaning’ data were analysed further into ‘sub-units’ (d) ‘being a good listener’, (e) ‘allowing sufficient time’ and (f) ‘being respectful’ from experiences shared by study participants (including a health executive, two medical educators, three patients, a private nurse practitioner and an Indigenous health worker).
My IPA commentary had thus far informed medical selection and education by linking stakeholder experiences to capabilities required for ‘good’ medical practice. These capabilities emerged from the positively evaluated experiences of diverse stakeholders and focused on doctors being ‘patient-centred’, which included ‘ensuring patient safety’, ‘showing genuine concern’ and ‘combining competence with caring’. These capabilities also focused on doctors ‘being good communicators’, which included ‘being good listeners’, ‘allowing sufficient time’ and ‘being respectful’.

As advocated by Smith et al. (2009) my IPA commentary had thus far represented a dialogue with participants that was ‘reflected in the interweaving of analytic commentary and raw extracts’ (p.110). As anticipated, this dialogue culminated in the first phenomenological theme of ‘positively evaluated doctor experiences’. This theme was most strongly portrayed by the extracts of ‘signature’ stakeholders, which were selected for being the most deeply experiential and which were supported by ‘supporting’ stakeholder extracts.

The initial coding of raw data for this ‘good doctor’ phenomenon revealed some interesting patterns. The most notable was that the majority of references for the ‘good doctor’ were linked to patients – 93 references; compared with nurses and midwives (33), medical educators (30), doctors (29), health executives (28), medical students (22), allied health practitioners (11), community organisation representatives (9) and alternative health practitioners (3). This patient-dominated pattern was significant in that it confirms that my study will inform medical selection and education from a more inclusive perspective. Of perhaps, greater interest, however, were the unsought and unanticipated data that emerged to define a second phenomenological theme around ‘negatively evaluated doctor experiences’.
4.2 NEGATIVELY EVALUATED DOCTOR EXPERIENCES

Within an IPA paradigm, the flexibility of my data collection method facilitated fuller exploration of participants’ experiences with doctors. Given the large and diverse study sample, I was able to ‘capitalise on IPA’s ability to explore unanticipated and unexpected findings’ (Smith et al., 2009, p. 70). True to the IPA approach, data for this second theme emerged from participant-led interviews that went beyond the core question of ‘what does the good doctor mean to you?’

As with the first phenomenological theme, I applied an ideographic (distinct and detailed) approach to single out ‘signature’ stakeholders whose experiences with doctors had yielded the most deeply experiential data. To establish credibility and transferability of the data, I then selected ‘supporting’ stakeholders who had made sense of their experiences in similar ways, thus building the analytical outcomes layer by layer. This process was repeated for this second theme as follows.

4.2.1 Interpretive analysis of what ‘being unprofessional’ meant for participants

(identified in the data-analysis structure, Table 3, section 3.3.5.2)

The first ‘unit of meaning’ identified from participants’ ‘negatively evaluated doctor experiences’ relates to their perceptions of being treated ‘unprofessionally’ when vulnerable. This was expressed by a ‘signature’ stakeholder in the following way:

*I’ve personally seen some very good doctors but I’ve had this personal experience with a person who was dreadful! When I was about 32, I had a perforated appendix. I was a first-year consultant at the time and was admitted to the teaching hospital where I was working. Although it was*
early morning I didn’t get operated on for the next twelve hours as the surgeon was in meetings all day.

[Participant 26 – senior academic]

This participant’s vivid recall of his experience evoked strong feelings: he described his surgeon as ‘a person who was dreadful!’ and recalled the ‘twelve hours’ he had to endure before he was operated on, trying to make sense of how the surgeon’s choice to be ‘in meetings all day’ had taken priority over his needs as an acutely ill patient. Even at this early stage of the dialogue, his experience conveyed two remarkable messages: the first was how vivid his recollection was, given that almost ten years had passed since this traumatic event. The second was the stark contrast he drew between his own standards of professionalism (as a ‘consultant’) and those of a colleague entrusted to care for him when he was at his most vulnerable as a patient.

I remember distinctly that at two or three in the afternoon my appendix burst! I had a sore tummy and I can still remember going into the operating theatre; and then afterwards I wound up having a terrible course! For three to four days I sat there getting worse and worse and I had this awful feeling … When one of the interns remarked ‘Oh you’re just so sick!’, I asked them to call the surgeon.

[Participant 26 – senior academic]

His feelings of vulnerability and helplessness in this situation were conveyed through the words ‘wound up having a terrible course!’ and ‘I had this awful feeling’. The time delay as well as the recognition by a junior colleague of how ill he was, conveyed further feelings of fear and dread about his situation.
He [the surgeon] came in and yelled at me: ‘This has to stop!’ … and then he asked the liaison psychiatrist to come and see me to manage my ‘tummy pain’!

[Participant 26 – senior academic]

On the face of the story, this participant’s description of his surgeon’s reaction strongly suggests unprofessional behaviour in relation to a patient in distress; yet he continued to relate his experience with a sense of calm and in a ‘matter-of-fact’ manner:

After the psychiatrist had seen me I heard him saying: ‘He is so tachypnoeic [breathing rapidly]! Are you sure he doesn’t have a pulmonary embolism? I then started to vomit and I had seven litres of bile come up out of me … When I finally recovered, I came to see him [the surgeon] as an outpatient. I politely said: ‘Y’know, I wasn’t too impressed with how long it took to get to the operating room, and also I was a bit upset with how you managed that’ and he replied: ‘there’s no evidence that delaying surgery for appendicitis makes any difference! I might have made the wrong call there, but we got you better!’

[Participant 26 – senior academic]

At this point and in spite of how poorly he felt treated in the hospital where he worked at the time, this participant continued to express the expectation that his surgeon would at least acknowledge him. As his understanding of this shocking experience deepened, the tone deepened, his expression changed – suggesting on the second hermeneutic, a move from failed expectation and shock to feeling defeated and (paradoxically) sarcastic:
I couldn’t even speak! All I did was make a complaint to him [the surgeon] and then basically got my head bitten off! And then I thought: ‘I just can’t be bothered!’ I got as far as writing a letter but never sent it … I felt like: ‘Hey, look, I couldn’t be bothered. I lived! I survived! I’ve had my key-hole surgery for my appendectomy!’ [laughs sarcastically]

[Participant 26 – senior academic]

These feelings of passive resignation appeared to change again as he reflected upon his experience:

… Even ‘though I helped him [his surgeon] when his son was a patient, even ‘though he was my colleague and a peer, there is no way he would ever admit that he’d made a mistake. He was a highly competent surgeon but he had that cold inability to just say ‘sorry’ … so if that’s how he treats somebody who is a colleague, God knows what he’d be like with his other patients!

[Participant 26 – senior academic]

His expressions of disappointment in a ‘colleague’ and ‘peer’ who had failed him professionally and personally; as well as of concern for other patients were compelling.

Two participants who appeared to make sense of their negative doctor experiences in similar ways serve as ‘supporting’ stakeholders. Parallels can be drawn between the experience of the previous participant (26) and the following
patient who was rendered equally helpless and vulnerable prior to undergoing major surgery:

When I went in for my breast cancer surgery a doctor on the early morning round came with about twelve other people and said: ‘You don’t mind if I have some med[ical] students here?’ That was just before I was due to go into surgery and he [the doctor] was ignoring me and saying: ‘She’s going to have this, she’s going to have that, can I have a quick look?’ I remember thinking: ‘I don’t want all these people here’, but I was too scared to say anything.

[Participant 17 – patient]

This participant’s experience resonated clearly with that of the previous participant (26), though, perhaps, from an even less powerful position. Apart from experiencing fear and helplessness, she expressed feeling depersonalised when her feelings were disregarded and her privacy further invaded:

I wasn’t given enough warning, I was just put ‘on the spot’, I was not in a good place to have twelve people come and ogle me like a prize chicken! The curtains [around her bed] got thrown open with all these strange faces peering at me!

[Participant 17 – patient]

As her understanding of her fragile situation deepened, she attempted to make sense of this ‘bad’ experience in new ways:

I know it’s difficult, because how are they going to learn? I understand that, but it could have been broached differently … none of my needs were taken into account at
that point in time. It was all about their ward round and not really about me.

[Participant 17 – patient]

Whilst expressing an awareness and understanding of doctors’ expectations of patients in teaching hospitals, her experience points to care that was clearly doctor-centred rather than patient-centred.

The second ‘supporting’ stakeholder shared her experience of a doctor ‘being unprofessional’ during a consultation with her daughter:

I saw an ENT [ear, nose and throat] specialist, who was probably in his fifties. He was just totally wrapped up in himself, but in a charming kind of way, but which turned out to be sort of a slimy, sleazy way. Initially we thought he was just being friendly, but then he started talking about himself and then he took a call from his son in front of us. Then we were told all about his son, a whole long story! And I just thought: ‘I’m paying for this! I don’t want to have to listen to this!’

[Participant 18 – patient]

This participant’s expression of indignation turned to one of amazement and then to one of disbelief when she related the degree of ‘unprofessionalism’ that she believed to have been metered out to them by this doctor:

He [the specialist] started telling us all about one of his patients! I can’t remember what but it made us feel so uncomfortable. Then he turned to [names her daughter]
and said: ‘You haven’t had Botox have you?’ We just sat there speechless and I’m thinking ‘What sort of a question is that, and besides, I’m meant to be the patient here!’ She [her daughter] was so taken aback and when she eventually answered ‘no’, he said: ‘Well good, because you’re beautiful enough without it’ and then he went onto a big story about somebody else, some other woman and Botox! Anyway, I cancelled my next appointment and never went back there.

[Participant 18 – patient]

This participant’s vivid recall of what she and her daughter experienced during a single consultation with a medical practitioner was compelling and shocking. Her experience resonated with those of the two previous participants, with clear senses of helplessness and vulnerability coming through in the second hermeneutic.

This ‘unit of meaning’ (‘negatively evaluated doctor experiences in relation to doctors being unprofessional’) was further analysed into the following two ‘sub-units’ of meaning: ‘being disrespectful’ and ‘being arrogant’.

(g) Being disrespectful (identified in the data-analysis structure, Table 3, section 3.3.5.2)

For this ‘sub-unit of meaning’, one of the ‘signature’ stakeholders, a midwife, related what ‘unprofessionalism’ had come to mean for her in the context of her experiences with ‘disrespectful’ doctors:

That was one of the biggest things that I found when I came to Australia. In the UK, it’s quite respectful amongst midwives and doctors, you know. There’s quite a level of respect there for midwives as the guardians of ‘the normal’ and the doctors looking after ‘the abnormal’ and we all
practiced on this even plain, but when I came to Australia, it was like [laughs]: ‘Well, who are you?’ So I think there still is a power difference between doctors and midwives in Australia, compared with the UK.

[Participant 37 – midwife]

Her drawing these comparisons pointed to parallels with what doctors ‘being respectful’ had meant for other participants, particularly in terms of a perceived ‘power differential’ between some doctors and their patients. This participant’s concept of doctors ‘being disrespectful’ related not only to differences in interprofessional care models per se, but also to how an individual doctor’s perceived lack of respect could impact negatively on others:

I came across a doctor who women stopped accessing because they felt that he put them down, that he was disrespectful. On one occasion, he came into the birthing room without even addressing the woman and he then examined her without even speaking to her! You know, without even saying ‘hello’ to her, let alone getting her consent!

[Participant 37– midwife]

For this midwife, a doctor’s ‘unprofessionalism’ manifested in what she appears to make sense of as ‘objectification’ of a patient in a particularly vulnerable situation around birth.

I heard this doctor say, after this woman had had a particularly difficult birth: ‘Oh what’s wrong with her? She’s got her baby, her baby’s okay!’ He was not able to respect what she had gone through and that it could affect her for the rest of her life. He could not validate any of that! All he did was be dismissive with
no regard for the impact that a birth experience can have on a woman and her loved ones.

[Participant 37 – midwife]

In the second hermeneutic, the tone of this quotation and particularly the words ‘no regard for the impact that a birth experience can have on a woman and her loved ones’ convey a sense of quiet anger that manifest as powerful advocacy for a vulnerable client in distress. Her interpretation of witnessing a doctor being ‘dismissive’ resonates with participant 26’s experience (section 4.2.1), when he related being dismissed by his doctor after raising concerns over his treatment.

Other participants or ‘supporting’ stakeholders related experiences in which the meaning of ‘disrespectful’ is evident, for example:

*He [the doctor] rang for the ambulance and whilst I was lying there, all I could see was the dirty blinds on the window of his surgery. He started putting some dressings on my tummy and then I watched in amazement as he dropped one and then nonchalantly bent down, picked it up off the floor and placed it on my burn! I couldn’t help thinking that I must be in some sort of comedy and if I wasn’t in so much pain and shock I would probably have said something and I’m talking ‘big time’ pain!*

[Participant 23 – patient]

This participant made sense of her distressing situation and evident sense of vulnerability through dark humour (‘I couldn’t help thinking that I must be in
some sort of comedy’) to convey the extremity of her doctor’s ‘nonchalant’ behaviour that she had ‘watched in amazement’.

Another participant recounted using humour to manage a situation that she had come to understand as an absence of respect during her interaction with a doctor when her young child was hospitalised:

The first time I took him [her son] to [names a local hospital] one of the doctors asked me where I lived, so I said: [names a Gold Coast suburb]’ … and then he asked: ‘What do you live in?’ and I looked at him and said: ‘Well, I live in a house … doesn’t everybody live in a house?’ ‘Oh no!’ he said. ‘Some people live in caravan parks’ and I said: ‘or what … a hole in the side of a hill or something? What are you saying?’ Now, is this because I am ‘dark’? Did he think I was being a neglectful mother and just wanted to get rid of my child for a couple of nights? So, yeah … that was appalling!

[Participant 16 – patient]

Yet another participant’s experience acquired a negatively evaluated meaning related to feeling disrespected and ‘objectified’, similarly to participants 17 and 37 (in section 4.2.1):

And I remember this day, going in for the colonoscopy: I was lying on the bed in this ward full of people when he [her doctor] walked in and didn’t even say: ‘good morning’ or ‘good afternoon’ or ‘I’m doctor so-and-so’ or anything. He picked up my file and said in a loud voice: ‘why are you here today having this?’ And I said that I’d had a series of polyps and that I’d been advised to have colonoscopies
every six months. And he replied again, in a loud voice: ‘absolutely no need for that!’ And he turned his back on me and left without saying another word! I was so embarrassed, I can never forget that!

[Participant 14 – patient]

Issues around interprofessional respect, referred to earlier (by participants 37 and 23 in section 4.2.1), were borne out by another stakeholder’s negatively evaluated experience:

I rang him [the doctor on call] at 2 am for a patient who was deteriorating. When he ordered a particular drug for the patient, I asked him to please repeat it to one of my colleagues [another registered nurse] as per our legal guidelines. To which he replied: ‘no, I won’t!’ When I asked him a second time, he yelled at me saying: ‘are you a moron or something? Don’t you understand English?’ There’s been numerous similar incidents with doctors over the years, but I’ll always remember that … it’s stuck in my brain!

[Participant 38 – nurse practitioner]

This ‘sub-unit’ of meaning of ‘being disrespectful’ can be summed up, from different points of view, in the sense-making of these three participants:

It’s that kind of toxic problem that we’ve got and we see in ‘bad doctoring’. I think all sorts of bad things: I think just disrespect and lack of professionalism. The way some people talk about their patients is just shocking! And, look, everyone knows there is a humour that we all have but it’s just so obvious [laughs] where that line is. And then I
guess people who … I think, increasingly, junior doctors aren’t modelled enough to involve patients in their care. There’s a lot of handovers and discussions in rooms and then there’s the telling the patient what’s going to happen. And that’s become more and more prevalent over time: People are removing themselves from the bedside.

[Participant 27 – senior academic]

If they [doctors] are teaching [medical] students something during a ward round, it’s good for them to have the ability to say, if we don’t know the answer: ‘It’s okay … this is the answer …’ rather than by embarrassing us by saying ‘Oh, you don’t know the answer? Well, you’re idiots!’ [laughter accompanied by laughter from participant group]. There’s a fine line between respect and ridicule.

[Participant 9.11 – medical student]

I believe that a lack of respect lies at the root of a lot of problems we see in hospitals and in the community, including a lack of respect for the other people in a team. I think that a lack of respect goes hand-in-hand with arrogance: ‘I’m smarter than you … I am ‘this’ and you are only ‘that.’

[Participant 38 – nurse practitioner]

(h) Being arrogant (identified in the data-analysis structure, Table 3, section 3.3.5.2)

The ‘arrogance’ to which participant 38 referred (above) is the focus for the next ‘sub-unit of meaning’ for stakeholders’ negatively evaluated doctor experiences.
This second aspect of doctors ‘being unprofessional’ focused on stakeholder experiences that were perceived to be doctor- rather than patient-centred; and that related to the ‘power differential’ (referred to earlier) between doctors and their patients, as well as others. According to another ‘signature’ stakeholder:

*In the Queensland hospitals that I’ve managed there’s too much of a ‘prima donna’ mentality amongst the specialists and patients are suffering as a result of consultants who are ego-driven and very territorial. Some of the senior doctors also have big egos and think they’re the best doctor in the world: ‘I’m king of the jungle, I know best, I’m the leader and I’m God!’ They often lack team skills and I’ve seen them denigrate nurses and allied health people.*

[Participant 39 – health executive]

The meanings that emerged for this participant focused on what she believed to be doctor behaviours that were both ‘ego-driven’ and linked to their positions of power in an organisation. Her use of the words ‘specialists’, ‘senior doctors’, ‘big egos’, ‘prima donna mentality’, ‘think they’re the best doctor in the world’, ‘king of the jungle’, ‘I know best’, ‘I’m the leader’ and ‘I’m God’ richly expressed what doctors ‘being arrogant’ meant for her. Her reference to particular hospitals (in ‘Queensland’) implied her belief that these doctor behaviours were tolerated more in some hospitals than in others.

Of equal significance was the quiet sadness evident in the second hermeneutic in her emphasis on the negative impact that doctors ‘being arrogant’ had on patients (expressed in the words ‘patients are suffering’); as well as on other health professionals (expressed in the words ‘denigrate nurses and allied health
people’). A more detailed and shocking account of what doctors ‘being arrogant’ meant for her, emerged from more deeply exploring her experiences:

*I have encountered various doctors who can’t work as part of a team, who compromise everyone with their egotistical attitude. They engage in all sorts of unprofessional behaviour like surgeons who yell and throw things in [the operating] theatre or consultants who publicly humiliate junior colleagues in front of their patients. It’s always all about them!*

[Participant 39 – health executive]

The experience of another participant supports that related by participant 39 by placing a darkly humorous interpretation on what doctors ‘being arrogant’ meant for him:

*It used to amuse me when I was lying in hospital some years back now: I used to look forward to the ‘big wigs’ coming in because the doors would be literally flung open and the leading doctor would ‘swan in’ with all the others shuffling in behind him. They were too self-absorbed to pay any attention to me … it reminded me of one of those ‘Carry-On’ [comedy] movies!*

[Participant 21 – patient]

This participant’s use of the words ‘big wigs’, ‘swan in’ and ‘self-absorbed’ added richness to meanings that focused on ‘arrogance’ for the ‘signature’ stakeholder (participant 39).

For another stakeholder, a doctor ‘being arrogant’ was interpreted in a more overtly serious light:
We visited a specialist who was by all accounts at the top of his field, but his sheer arrogance made me refuse to ever go back there again. His attitude towards myself, and most particularly to my elderly parents was appalling, even ‘though he was an expert. Because my parents are elderly, I was trying to ask questions and he was even putting his hand up at me to be quiet while he was ‘so busy’ and such ‘an important a person’! He was the biggest prat who ever breathed!

[Participant 38 – nurse practitioner]

This participant made further meaning of her experience that had not only caused her to feel outraged, but that prompted her to seek to understand the reasons for this doctor ‘being arrogant’:

I believe that it’s not only related to his narcissism but also to society’s expectations that elevate him to a position where his ego is allowed to take control, to the point where us lesser folk should not be questioning or challenging him.

[Participant 38 – nurse practitioner]

This ‘sub-unit’ of meaning of ‘being arrogant’ was summed up by other participants, from multiple viewpoints, as follows:

I think arrogance breaks down the doctor-to-patient relationship and doctor-to-doctor relationships. It’s where mistakes happen as well because no-one’s willing to share decisions.

[Participant 6.6 – medical student]
I’ve seen a doctor’s arrogance around ‘I’m right, I don’t need to continue learning’. That sense of entitlement does not foster learning, teamwork, collaboration and creates all those barriers to good patient care.

[Participant 34 – senior hospital manager]

I think arrogance is a very dangerous quality to have particularly for doctors who are perhaps a bit ‘gung-ho’, who stretch beyond their capabilities and who push boundaries with inevitable consequences for their patients’ safety.

[Participant 13 – doctor]

I remember a doctor at a place where I’ve worked who was a consultant. He would not speak to his interns. He would only speak to his interns through his registrar. I think that’s one of the worst things: That sense of self-importance, of entitlement. We know from patient safety literature that can lead to patients dying … and not only is that what he [the consultant] did, but he told everyone that’s what he did so he should have been sacked!

[Participant 27 – senior academic]

In summary, data that emerged from the negatively evaluated doctor experiences of some participants captured the essence of what it meant for a doctor to be ‘unprofessional’ (identified as ‘unit of meaning’ 3.2.1 in the data analysis structure, Table 3, section 3.3.5.2). This ‘unit of meaning’ was further analysed into ‘sub-unit’ (g) that focused on doctors ‘being disrespectful’ and ‘sub-unit (h) that focused on doctors ‘being arrogant’. The method revealed data that were not only idiographic (distinct and detailed) in nature but that
converged around power differentials in the doctor-patient relationship and in interprofessional interactions. These were informed by a broad representation of stakeholders (participants who identified as patients, as health professionals, as senior hospital managers, as senior academics, as health executives and as medical students).

4.2.2 Interpretive analysis of what ‘compromising the safety of self and others’ meant for participants (identified in the data-analysis structure, Table 3, section 3.3.5.2)

The second ‘unit of meaning’ that emerged from selected participants’ negatively evaluated doctor experiences related to their experiences with doctors whom they came to believe had compromised their own safety or the safety of others. For one ‘signature’ stakeholder, this was focused on her birth experience some 30 years ago:

*He [her obstetrician] was such a horrible, cold fish! He had absolutely no bedside manner. He was very arrogant, didn’t listen to questions, didn’t even want us [she and her husband] to ask any questions and when we did, he totally put us down. [Names her daughter]’s birth was the most awful experience!*

*[Participant 18 – patient]*

Even at this early stage, this participant’s experience resonated with interpretations around doctors ‘being arrogant’. As the story progressed, her meaning-making emerged in ways that were increasingly vivid and powerful:
Because it was a public holiday and he [her obstetrician] wanted to go and play golf and I was interfering with that. So, he just stuck his hand up and ripped her [baby] out because it was taking too long for him. He kept sending [names her husband] out of the room, so you can imagine how distraught we felt … it was really horrible!

[Participant 18 – patient]

The meanings that emerged from this participant’s experience relayed a powerful and horrific sense of the trauma that she seemed to have suffered at the hands of a specialist doctor. These meanings not only highlighted those that had emerged from other participants’ negatively evaluated doctor experiences, but revealed deeply-seated impacts of how a doctor was believed to have compromised the safety and wellbeing of a mother, a baby and a couple for his own ends. Of further significance was not only the period of time that had elapsed for this participant, but of how vividly the emotional impact found expression in the words that she chose such as ‘horrible’, cold fish’, ‘absolutely no bedside manner’, ‘arrogant’, ‘totally put us down’, ‘awful experience’, ‘wanted to go and play golf’, ‘stuck his hand up and ripped her out’, ‘you can imagine how distraught we felt’.

This participant went on to relate her experience further:

The whole experience was just like: ‘You’ve got to do this’ and [to her husband] ‘You … get out! He [her obstetrician] was yelling at me to ‘p-u-s-h’ and then he started to pull her [baby] out. I was in such agony! I wasn’t even aware that she was out until they told me … I’ll never ever forget that day!

[Participant 18 – patient]
The seemingly shocking impact of this experience for this participant was reinforced by her repetition of the words ‘you … get out!’ and ‘he started to pull her out’. Her references to ‘being in agony’, ‘I wasn’t even aware that she was out …’ and ‘I’ll never forget that day’ suggest that her safety had been severely compromised not only physically (in the short term) but emotionally (in the long term) as well.

‘Supporting’ stakeholders related similar situations in which they had come to believe that doctors had compromised either their own safety or the safety of others. For example, for one participant it was in the context of his role as a junior doctor many years previously:

*He [a surgical registrar] thought that he should be just ordering us [junior doctors] around with that sense of entitlement, which was hard to manage. He met with a whole series of problems where he undoubtedly … well, in front of my eyes … led to someone being seriously ill when they need not have been.*

[Participant 31 – senior academic]

Parallels are evident with previous interpretations of doctors ‘being arrogant’ and this participant’s use of the of the words ‘sense of entitlement’. In the second hermeneutic, we can see him make sense of the experience as he focuses on how ‘unsafe’ medical practice had not only unnecessarily compromised a patient, but had also compromised him as a witness to such practice. His use of the words ‘in front of my eyes’ gave a sense of foreboding to what followed:
Then he [the registrar] tried to implement something that was actually going to make one of our patients very significantly worse. Thankfully, I ‘twigged’ what was happening, because he’d done the same thing once before and I’d been told about it, so I was watching out for him. Despite having been told the error of his ways, he was trying to do the same thing again!

[Participant 31 – senior academic]

The participant made sense of this experience in new ways. Firstly, he expressed confidence in his own clinical judgement of the situation through his use of the words ‘make the patient significantly worse’ and ‘thankfully, I twigged what was happening’. Secondly, his sense of foreboding materialised when the ‘unsafe medical practice’ continued to further and more seriously compromise another patient (expressed in his use of the words ‘was trying to do the same thing again!’).

Another time we nearly lost a patient because of his mismanagement and his ignoring advice and counsel, which was obviously very dangerous. The bosses involved actually tried to flag him and fail him for a term in his training … it got very messy … he got into surgical training but he didn’t last very long.

[Participant 31 – senior academic]

For this participant, the outcome of his negative experience was expressed with a mixture of concern about complexities around regulation (expressed in his words ‘it got very messy’) and relief that the doctor had not been able to pursue
a career as a specialist surgeon (expressed in his words ‘he got into surgical training but didn’t last very long’).

Another ‘supporting’ stakeholder experience echoed that of the previous participant’s, linking ‘unsafe medical practice’ to ‘poor role-modelling’ by senior doctors and sharing a reference to complexities around regulation processes in Australia:

One of the surgeons at the hospital I was managing at the time was teaching junior doctors inappropriately and being a really bad role-model. I had to refer him to the New South Wales Medical Board et cetera … he’s now exiled overseas and he’ll be going to jail as soon as he steps his foot back in the country.

[Participant 35 – senior hospital manager]

Another two ‘supporting’ stakeholder experiences focused on doctors who had compromised patient safety when their own physical, mental and emotional health became compromised:

Another disaster I came across was one of my [doctor] colleagues who had never had a problem but he ended up with personal problems and started making clinical mistakes. He could not cope and literally fell apart in front of us.

[Participant 31 – senior academic]

I remember when I was working as a senior registrar I was dealing with one junior medical officer who became involved with one of the patients he was looking after and I
said to him that that was really a very unethical thing to be doing as she was already in a vulnerable position.

[Participant 1 – doctor]

This participant's focus shifted as what initially appeared to be a matter of misconduct was afforded a subtly different meaning related to the doctor's health:

I don't know what happened, but I do know that he was actually found to be stealing drugs from the drug cupboard … eventually he came up before the coroner because he had lost his job at the hospital, had found a job at the locum agency and was actually going to do house calls. While he was under the influence of drugs he misdiagnosed a patient who subsequently died from a bowel obstruction. He was deregistered. So obviously that's quite a startling example ... so he obviously ... despite counselling went down the wrong path.

[Participant 1 – doctor]

A patient participant's experience as the mother of a sick infant resonated with that of the 'signature' stakeholder for this 'unit of meaning' of 'compromising safety' (participant 18, section 4.2.2):

When my son was small and got sick with 'gastro', our GP referred us to [names a local hospital]. The A&E doctor who saw him sent us home, saying that he wasn't dehydrated … by the next night he was passing 'black tar' [bowel motions] every 20 minutes. When I took him back to my GP, he was appalled! He wrote a letter to the registrar at the same [local] hospital to complain and
referred us straight to [names a Brisbane hospital] where he was isolated for two weeks. All his veins had shrunk ... he was actually in a bad way ... he could have died!

[Participant 16 – patient]

This participant’s negatively evaluated experience also suggests impaired medical judgment, which is the focus for the next ‘sub-unit’ of meaning (i) and which relates to the broader ‘unit’ of ‘negatively evaluated doctor experiences around safety’.

(i) Having impaired judgement (identified in the data-analysis structure, Table 3, section 3.3.5.2)

Parallels can be drawn between a previous ‘signature’ stakeholder’s negatively evaluated doctor experience around birthing (participant 18, section 4.2.2) and this participant. She found meaning in a particularly intense experience, by concluding that a doctor ‘having impaired judgment’, had compromised her safety:

When my first baby was due, I requested a caesarean as my mother had had a very bad [perineal] tear when she had given birth to me. The doctor took no notice of my history and refused … my birth ended very badly with a third-degree tear [extensive trauma to the muscles surrounding her birth canal and anal sphincter] [expressions of shock from the participant group]. When the doctor saw me afterwards he dismissed me, saying that none of his patients had ever had a third-degree tear and that it was ‘nothing’. I went back to see him after a few months as I couldn’t control my bowels and sex was almost unbearable … it was shocking and frightening …
life was just terrible! [outpouring of expressions of sympathy from the participant group]. He just said: ‘You should be like the old cow in the paddock … relax more and you’ll be alright’ [gasps and expressions of shock from the participant group].

[Participant 5.4 – patient]

Of significance here, was that a group interview participant (a woman in her seventies), was courageously sharing the intimacy of her long-term suffering with eight co-participants. In the second hermeneutic, we find an understandable sense of anger that has softened, only a little, with the passing of many years. The emotional pain connected with this experience is expressed in words such as ‘took no notice of my history’, ‘refused’, ‘dismissed me’, ‘it was nothing’, ‘couldn’t control my bowels’, ‘sex was almost unbearable’, ‘it was shocking and frightening’, ‘life was just terrible!’, ‘be like the old cow in the paddock’. The meaning that she had made in relation to the incident and the doctor’s ‘impaired judgment’ and compromise of her safety was expressed further:

It was never really properly fixed … I ended up going to another specialist for my other children and had caesareans. I’ve had two more [perineal] repairs since, which haven’t really worked. None of that would have happened if he’d listened … his pigheadedness has wrecked my life! [further expressions of sympathy from the participant group].

[Participant 5.4 – patient]
Meanings that emerged as this participant continued to evaluate her doctor experience deepened to a sense of extreme and prolonged suffering that elicited strong emotional reactions from her group. These meanings also drew parallels with participants’ negatively evaluated experiences of what doctors ‘being unprofessional’ meant for them (analysed in the previous ‘unit of meaning’, section 4.2.2). This particular participant’s belief that her life had been ‘wrecked’ by a doctor’s ‘pigheadedness’ was also mirrored in participant experiences of doctors ‘being disrespectful’ (analysed in ‘sub-unit’ g, section 4.2.2) and ‘being arrogant’ (analysed in ‘sub-unit’ h, section 4.2.2).

Other ‘supporting’ stakeholders shared what doctors ‘having impaired judgement’ meant for them. The first was a medical student participant whose experience resonated with the narrative around patients being ‘objectified’ by doctors, particularly when vulnerable:

*The nurses had asked the reg[istrar] to do the cannulation as they couldn’t get a vein. He just came up to me and started patting my right lower arm without saying anything. When I told him that the phlebotomists had advised before to use my left arm he continued to ignore me, saying: ‘I’ll find a vein, I do this a lot’.*

[Participant 9.1 – medical student]

At this stage of the dialogue, the participant conveyed a sense of trust in his doctor’s clinical ability. As the story progressed, we can discern in the second hermeneutic a sense of, helplessness, fear and panic:

*He stuck the needle in and started digging around for a vein in my right arm. After a coupla minutes I grimaced*
and wanted to pull away with the pain. He persisted, making excuses that the vein ‘kept moving’ and by now it was really hurting. He then moved to my left arm where he dug around and finally found a vein.

[Participant 9.1 – medical student]

The participant attempted to make sense of his situation on the one hand, by vividly expressing the intense pain inflicted upon him (by using the words ‘by now it was really hurting’); and on the other hand, by making an effort to disassociate himself (referring to his ‘left arm where he dug around and finally found a vein’). New meanings emerged as he continued to make sense of his experience, which resonated with earlier stakeholder accounts of doctors ‘being disrespectful’ and ‘being arrogant’ (section 4.2.1):

All the time he hardly said a word and to add insult to injury, he never apologised, let alone acknowledged that he’d made a mistake! He just would not listen and was trying to prove me wrong. I remember him as being over-confident, egotistical and rigid … trying to show-off that he had superior skills at my expense.

[Participant 9.1 – medical student]

Another medical student participant shared what a doctor ‘having impaired judgement’ meant for him:

We had a consultant who basically did not listen to anyone other than himself and while it was funny for us as medical students, it wasn’t really funny for the allied health people working with him. I remember there was a question about a
patient being in a delirious state and the social worker had said that she thought it was a delirium and all were fine with that; but the consultant contradicted her in front of everyone and then announced around the ward that that social worker was never going to work on the Gold Coast again …

[Participant 9.6 – medical student]

At this point his experience resonated with other participant accounts of ‘doctors being disrespectful’ and ‘being arrogant’ (section 4.2.1). His attempts to make sense of his experience portrayed a tension between a negative ‘hidden curriculum’ effect (in this case a hierarchical medical work culture) and collegiality in health care teams. As he made sense of the experience in the first hermeneutic, his focus shifted to recognising the consequences of ‘impaired medical judgement’ for doctors personally, as well as for the medical profession generally:

I think it’s more of an ego thing as well and while it was entertaining to watch him perform, it happened at the social worker’s expense. It was so unprofessional and put him in a very poor light. I don’t think he realised how he came across to people and the image that he was portraying, not only for himself but for our profession as a whole [remarks of affirmation from the participant group].

[Participant 9.6 – medical student]

His focus shifted again when he acknowledged how this doctor’s ‘poor role-modelling’ had affected him. In the second hermeneutic, we can see a subtle
but definite shift in the participant’s world view that suggests a resolution to do better than this in his own future medical practice:

His behaviour just feeds the stereotype that some doctors think that they are above the rest and can do and say what they want. I didn’t think that he was being a very good role-model either. He was a really smart consultant whom I admired, but I had no respect for him after that incident.

[Participant 9.6 – medical student]

This ‘sub-unit’ of meaning of doctors having ‘impaired judgement’ was summed up in the accounts of the following two participants:

You can be a poor doctor because of impaired judgement for whatever reason. Impaired judgement relates either to a mental health problem or to an addictive personality where other things overtake their lives. So, they may not necessarily be bad people but their judgement is impaired for whatever reason … often people who lack insight become ‘poor’ doctors because they make incorrect decisions, both in medical/technical aspects as well as in interpersonal, communication type-of-things.

[Participant 5 – doctor]

The doctors that are the most difficult for us to manage are those that lack insight. They have personality traits that limit their effectiveness, either in terms of their patient care or their team relationships … It relates mainly to a sense of entitlement that does not foster learning, team work or collaboration. It creates all those barriers to safe patient care like not taking the time to ensure that the patient
really understands what’s happening and making false assumptions.

[Participant 34 – senior hospital manager]

These participant understandings (that focused on ‘interpersonal, communicational type of things’ and to ‘safe patient care like not taking the time to ensure that the patient really understands what’s happening and making false assumptions’) can be linked to the analytical commentary of the next ‘sub-unit’ of meaning that focuses on doctors ‘being poor communicators’.

(j) Being a poor communicator (identified in the data-analysis structure, Table 3, section 3.3.5.2)

Stakeholders’ negatively evaluated doctor experiences for this ‘sub-unit’ drew parallels with those that were focused on what doctors ‘being unprofessional’ had meant for them (section 4.2.1). These experiences were linked to ‘doctors being disrespectful’ (‘sub-unit’ g) and ‘being arrogant’ (‘sub-unit’ h). For one ‘signature' stakeholder, a doctor being ‘a poor communicator’ was expressed in the following way:

I thought I had a good doctor until one day he kept me in the waiting room for two hours!!!! Talk about being a ‘patient patient’! He walked past me several times as though I was invisible! Other people were coming in and got to see him straight away, so by the time I finally saw him I was pretty stressed! He was coming in and out of the room, barely talking to me, tapping away on his computer and looking at his watch.

[Participant 3.11 – medical educator]
Meanings that emerged from this encounter for this participant highlighted a sense of disappointment in, and failed expectations of, a doctor whom she had previously evaluated as being ‘good’. Her expressions of humour and sarcasm (‘talk about a patient patient!’ and ‘as though I was invisible’) further highlighted the negative impact that her doctor’s ‘poor communication’ seemed to have had on her:

*He was very distracted. At one point, he left me sitting there with the blood pressure cuff really tight around my arm … and when he came back into the room he said: ‘All’s okay’ and handed me the piece of paper to pay at reception. It was like all he cared about was to get me out of there and to pay his bill, so there was no empathy, he had no people skills.*

[Participant 3.11 – medical educator]

The meaning that this participant made from her experience was that a previously ‘good’ relationship with her doctor had been unexpectedly breached by his poor communication and treatment of her, related to what seemed to her to be his lack of empathy, coupled with being time-poor and money-driven.

Perceived failed expectations that related to doctors’ communication skills were similarly expressed by other ‘supporting’ stakeholders. For the first of these it was in the context of a specialist consultation:

*I took my son to see an orthopaedic surgeon who I’d worked with professionally for fifteen years. I’d probably sent him a coupla million dollars’ worth of work in that time. His manner was really rude and abrupt, he talked down to me as though I knew ‘zip’ and then he charged me the full amount for the*
consultation! I actually spoke to him afterwards about that and it didn’t even occur to him that he might have offended me, so I thought then that there’s something wrong here … there’s a bypass happening.

[Participant 7.3 – allied health clinician]

This participant’s understanding of his doctor ‘being a poor communicator’ was expressed in his use of the words ‘didn’t even occur to him’ and ‘there’s a bypass happening’. His experience resonated with other participants who had focused on doctors ‘being disrespectful’ and ‘being arrogant’ when he referred to his doctor as being ‘rude and abrupt’ and ‘talked down to me’.

The second ‘supporting’ stakeholder experience focused on ‘poor communication’ in doctor-patient relationships, linking it to a lack of medical empathy in ways that were similarly expressed by the ‘signature’ stakeholder (participant 3.11):

On my GP rotation, I observed a doctor who was very quick to whip his patients into categories. I mean, I understand that he has had years of experience and is used to seeing the same things over and over again but he was very quick to dismiss them, oftentimes cutting them off when they were talking and not listening to them. I think that he was lacking in empathy, it was just becoming routine for him. It was like this ‘super-clinic’ type of situation they were numbers on a conveyor belt and he was just very like ‘next … next … next!’

[Participant 9.7 – medical student]
For this medical student participant, a doctor ‘being a poor communicator’ was expressed in his use of the words ‘very quick to dismiss’, ‘cutting off’ and ‘not listening’. His experience resonated with other participants who had expressed feeling objectified as patients (section 4.2.1), expressed in his case as a doctor who treated patients as ‘numbers on a conveyor belt’.

Parallels can be drawn between the experience of a third ‘supporting’ stakeholder and that of the ‘signature’ stakeholder (participant 3.11) when she linked ‘poor communication’ to an over-reliance on technology:

*I’ve been to doctors where they don’t even look at you, they give you no eye-contact because they are too busy typing on their computer instead of just listening, or they’ll pretend to listen. And the consultation lasts just ten minutes and then you’re out!*

[Participant 37 – midwife]

For this participant, doctors ‘being poor communicators’ was expressed in her use of the words ‘no eye-contact’ and ‘pretend to listen’. As she made sense of the experience in the first hermeneutic, her focus shifted to the impact that doctors ‘being poor communicators’ had on vulnerable patients, particularly in the context of maternity care:

*I think that patients are very intuitive and see through that, particularly women seeking maternity care when they often feel very vulnerable … if a woman feels that we’re not listening and supporting her, then she won’t disclose vital information that often leads to a whole breakdown in communication with the associated risks for both mother and baby.*
Her experience as a midwife validated the experiences shared by other stakeholders around ‘patient safety’ issues for this second ‘unit of meaning’.

Further parallels can be drawn between the ‘signature’ stakeholder’s experience of doctors being ‘poor communicators’ and a third ‘supporting’ stakeholder, in the context of doctor-to-doctor communication:

\begin{quote}
I had a patient who I felt needed a scan, but the senior registrar did not want the scan to happen. It was for a DVT [deep vein thrombosis] and he just didn’t listen and the patient ended up having a DVT. So, it’s the listening skills amongst each other and it was quite disheartening not to be listened to as well as having your clinical judgement not taken seriously. Just because someone is more senior … yes, they have more knowledge than you, but you should still be able to listen to your co-workers.
\end{quote}

This participant’s sense-making of a doctor being a ‘poor communicator’ was expressed in his use of the words ‘he just didn’t listen’ and ‘disheartening not to be listened to’. In the second hermeneutic, we can again find a sense of dismay leading to a sense that the doctor had learned from this experience in a way that would impact his own practice (‘you should still be able to listen to your co-workers’). His experience resonated with the previous participant’s when his understanding deepened to portray how a doctor being a ‘poor communicator’ had compromised the safety of his patient.
Within the overall theme of ‘negatively evaluated doctor experiences’, these participant experiences had so far illustrated links between doctors ‘being unprofessional’ (associated with ‘disrespect’ and ‘arrogance’) and ‘compromising the safety of self and others’ (associated with ‘impaired judgement’ and ‘poor communication’). Further IPA yielded a third ‘sub-unit of meaning’ from participant experiences that focused on how doctors ‘being incompetent’ compromised their own safety and that of others.

(k) **Being incompetent** (identified in the data-analysis structure, Table 3, section 3.3.5.2)

Meanings around this concept highlighted different interpretations of what doctors ‘being incompetent’ meant for participants. A ‘signature’ stakeholder shared her experience as follows:

*Probably the worst doctor experience I ever had: I was on placement at [names a hospital in rural Australia]. I was working with a junior doctor who was very lovely and we were seeing a patient who hadn’t slept in two days ‘cos she’d had a motorbike accident and she had what seemed to me to be a pretty obvious scaphoid fracture [of the wrist]. She was in tears, you’d touch her and she’d just cry. The consultant came and when she saw the scratches on her hand he said, ‘she’s got an infection of her hand … that’s it, that’s what’s causing her pain’, even ‘though there were no clinical signs of infection that we could see, just a few grazes.*

[Participant 6.2 – medical student]
Meanings that emerged for this participant were expressed through her vivid recollection and recognition of what she saw to be a patient in distress (‘hadn’t slept in two days’, ‘was in tears’, ‘you’d touch her and she’d just cry’). In the second hermeneutic, we can see what appears to be an initially comfortable disposition in the training hierarchy, which was favourably expressed in her use of the words ‘I was working with a junior doctor who was very lovely’; until she went on to relate how she believed a senior doctor’s involvement came to adversely affect their situation:

*The consultant refused our requests for a scan and told us to send the patient home on antibiotics before taking herself off to lunch. When we relayed this to our patient she became so distraught, I’ve never seen someone so distraught in my life! So, I asked the junior doctor whether we could organise a scan before sending her home, given that we were both concerned about a possible fracture. She [the junior doctor] replied: ‘we can’t just do that, otherwise I will get into so much trouble from [said consultant]!*

*[Participant 6.2 – medical student]*

As the story deepens, we can sense the participant’s conflicted situation and the profound impact of the patient’s understandable distress (‘I’ve never seen someone so distraught in my life!’). Fortunately, the story takes a providential turn:

*Luckily, a different consultant walked by, saw the patient crying and ordered a scan. It turned out that she not only had a scaphoid fracture but it was so displaced that she required surgery that afternoon [expressions of shock from the participant group]. It was just so dreadful that she had*
to suffer! When we saw the consultant, who had misdiagnosed the pain in her wrist, all she said was: ‘Oh well!’ and then she just walked away! [further expressions of shock from the participant group]. What made it worse was her huge ego, so it was really difficult to respect her after that.

[Participant 6.2 – medical student]

Of significance for this study was a participant whose negatively evaluated experience linked the concept of a doctor’s ‘incompetence’ (‘misdiagnosis’) with concepts identified earlier that related to doctors ‘compromising the safety of others’ (‘it was just so dreadful that she had to suffer’); being ‘poor communicators’ (‘and then she just walked away’); ‘being unprofessional’ (‘it was difficult for us to respect her’) and ‘being arrogant’ (‘her huge ego’). In the second hermeneutic, we likewise gain a sense that the experience impacted on the participant’s world view and served to shape her own professional values (‘so it was really difficult to respect her after that’).

‘Supporting’ stakeholders shared what doctors ‘being incompetent’ had meant for them. The first of these experiences involved a doctor who had been compromised in a ‘shared care’ situation with a junior doctor colleague:

*I came across someone in my medical career who was a real problem because he was not only inept but lazy, which was a real nightmare! Basically, there were three of us who were equivalent in the [medical] team, and he was the one who did next-to-nothing and just casually assumed that we would run around and cover for him. Back then it was ‘shared care’ and we were worried that he was making us all look stupid! Fortunately, the senior
guys were astute enough to act as he was becoming downright dangerous.

[Participant 31 – senior academic]

As this participant’s understanding of his experience deepened, his assessment shifted from a doctor who was not only ‘inept’ and ‘lazy’ to one who was ‘becoming downright dangerous’.

Parallels can be drawn between the experience of a second ‘supporting’ stakeholder and the negatively evaluated experiences of other participants, particularly around medical error:

We reported a senior obstetrician who failed to diagnose complications in our daughter, which led to renal failure and a whole range of other problems. It made me realise that even doctors who are at very senior levels still make mistakes.

[Participant 32 – senior academic]

At this point, this participant reflected passively that ‘even doctors who are at very senior levels still make mistakes’. As he attempted to make sense of a doctor experience that had impacted seriously on his daughter, his perspective shifted to one of strong criticism:

I believe it’s because they become complacent, they get too busy, they stop listening to the patient, they don’t spend enough time on the particular issue, they can no longer be available when they are really needed. So, there
are lots of reasons why even very senior doctors from time to time can harm patients.

[Participant 32 – senior academic]

His experience also resonates with participant experiences that had focused on doctors ‘being poor communicators’ (expressed in his words ‘they stop listening to the patient’); and which were linked to doctors who perceived themselves to be ‘time-poor’ (expressed in his words ‘they get too busy’ and ‘they don’t spend enough time’). His rationalisation that ‘there are lots of reasons why even very senior doctors … can harm patients’, was sobering.

A third ‘supporting’ stakeholder experience raised further concerns about doctors ‘being incompetent’:

I’m seeing many ‘near misses’ since I’ve been on the wards, which are often just covered up. I think that this is why young doctors are probably making mistakes ‘cos they’re learning ‘on-the-job’ and often have poor role-models. Often the reg’s [registrars] are telling you information that is incorrect because they’ve learnt ‘on-the-job’ and haven’t taken the time or trouble to keep their knowledge and skills up to date. That’s a huge problem for patient safety …

[Participant 10 – doctor]

As this participant made sense of his experience, parallels could be drawn with other participant experiences, particularly in relation to negative hidden curricula effects of poor role-modelling for junior doctors. New meanings emerged when
this one doctor participant shared the gravity of ‘hidden risk’ for patients by doctors ‘making mistakes’ and causing ‘many near misses’ which were often ‘just covered up’:

There are a few people [doctors] who should not be here, especially the ones that are continuously having a ‘bad week’ and continuously getting growled at! It makes me think ‘how did you get here? You really should not be here!’ and I really cannot see a safe avenue for this person practising as a doctor.

[Participant 10 – doctor]

The gravity of risk to patients seemed compounded by this participant’s pessimism, expressed in her use of the words ‘I really cannot see a safe avenue for this person practising as a doctor’.

For a fourth ‘supporting’ stakeholder, ‘doctors being incompetent’ related to doctor-centred rather than to patient-centred care:

The worst doctors I see have a mix of either being over-confident and under-competent or they have a degree of arrogance and ego, and the problem with that is that that often comes before patient care, so your decision-making is skewed by the fact that you’re trying to get something out of it for yourself or you’re trying to improve or ‘up’ your ego.

[Participant 2 – doctor]

This participant’s experience resonated with other negatively evaluated doctor experiences that had focused on medical care being doctor- rather than patient-driven (expressed in his words ‘trying to get something out of it for yourself’); as
well as on doctors being ‘arrogant’ (expressed in his words ‘they have a degree of arrogance and ego’ and ‘trying to improve or ‘up’ your ego’).

His sense-making in the first hermeneutic raises serious concern for patient safety:

> So, I think they’re really dangerous sorts of doctors who can’t ‘see the patient for the trees’, so people’s own agendas taking priority over the needs of the patients.

[Participant 2 – doctor]

Meanings that emerged from the experience of a fifth ‘supporting’ stakeholder were in the context of direct patient care:

> While he [her doctor] was doing my injections, he kept looking at his medical manual all the way through to see how to do it! I felt so uncomfortable! It was like someone bringing a car manual in to work on your car!

[Participant 15 – patient]

This participant’s account emphasised a lack of confidence in her doctor’s ability to carry out a procedure on her, which she likened with dark humour to ‘bringing a car manual to work on your car!’ As she made sense of the experience, we gained an impression of her vulnerability, fear, distrust and distress:

> It also made me feel really scared because I was like: ‘You’re supposed to be the doctor!’ I put my trust in him … I was in and out of hospital every six months and he stuffed every operation up!

[Participant 15 – patient]
As her sense making deepened, her distress became tinged with understandable frustration and anger:

\[ I \text{ was like his human guinea pig! Every operation that we thought would help me, he stuffed up and now other doctors are still picking up the pieces today, trying to fix the problems that he created.} \]

[Participant 15 – patient]

A sixth ‘supporting’ stakeholder similarly shared what a ‘doctor being incompetent’ had meant for him:

\[ \text{He [the orthopaedic surgeon] has basically said that they [the other orthopaedic surgeons] should never have taken the plate out [when managing complications of his fractured ankle]. Once they take it out, it's not like he can put it back in at the moment because of the infection. So he [the orthopaedic surgeon] comes into play if this [points to his bandaged leg] doesn’t work. I’ll have to then have more surgery, and go through more pain and … yeah … I feel like ‘specimen A’ in ‘bed B’!} \]

[Participant 19 – patient]

This participant’s experience also resonated with the previous ‘supporting’ stakeholder, particularly in relation to their vulnerability as patients and to their sense of feeling ‘objectified’ by their doctors.

This ‘sub-unit of meaning’ of ‘being incompetent’ was summed up in the words of one participant as follows:

\[ \text{The worst doctors I've seen and come across are the ones that are completely egotistical. They are not able to see} \]
another perspective; they are self-absorbed, are not able to pick up on the cues that something’s amiss: ‘hang on a minute … I’m getting these negative messages here …’ Like, most people would have a degree of self-awareness or reflectiveness or insight where they would actually question, they wouldn’t just assume that the rest of the world is wrong! Most people would think: ‘well, what was my part in creating that situation?’ The ‘bad’ doctors don’t pick up on that cue, they don’t ‘get’ the cues that others are giving them. It’s not only a lack of insight and of humility, it’s actually narcissism! As I say to the students: ‘there’s narcissists everywhere. The problem in medicine is the narcissist who’s [also] incompetent.

[Participant 30 – clinical ethicist]

This participant’s experience echoes issues raised by others over negative aspects of medical practice (such as ‘poor communication’, ‘arrogance’, a ‘lack of insight and accountability’). Most significantly, she took these concerns to a deeper and more serious level by emphasising the risk to patients from the combination of ‘narcissistic’ and ‘incompetent’ medical practice (or malpractice).

4.3 SUMMARY OF FINDINGS AND INITIAL CONCLUSIONS

In summary, data that emerged from ‘negatively evaluated doctor experiences’ of selected participants captured the ‘essence’ of meanings around doctors ‘compromising their own safety as well as that of others’. From this broad ‘unit of meaning’ data were analysed further into ‘sub-units’ of (i) ‘having impaired judgement’, (j) ‘being a poor communicator’ and (k) ‘being incompetent’. These experiences were shared by participants including five doctors, five patients,
four medical students, two senior academics, two senior hospital managers, a medical educator, an allied health clinician, a midwife and a clinical ethicist.

Consistent with the IPA that culminated in the first phenomenological theme of ‘positively evaluated doctor experiences’, the second theme of ‘negatively evaluated doctor experiences’ was most strongly portrayed by the extracts of ‘signature’ stakeholders, which were selected for being the most deeply experiential and which were supported by ‘supporting’ stakeholder extracts. In contrast to the first phenomenological theme that linked stakeholder experiences to capabilities desired for ‘good’ medical practice, the second phenomenological theme linked stakeholder experiences to ‘poor’ medical practice. One focus on doctors ‘being unprofessional’ was linked to experiences that were related to doctors ‘being disrespectful’ and to ‘being arrogant’. Another focus on doctors ‘compromising their own safety as well as that of others’ was linked to experiences that were related to doctors ‘having impaired judgement’, ‘being poor communicators’ and ‘being incompetent’. In contrast to the first phenomenological theme, IPA that culminated in the second was unexpected, confirming the scholarly prediction that ‘analysis will have taken you into new and unanticipated territory’ (Smith et al., 2009, p. 113).

As noted for the first phenomenological theme, initial coding of raw data for the second theme revealed similarly interesting patterns. The most notable was that the majority of references to ‘poor’ medical practice were linked to patients – 107 instances; compared with medical educators (56), doctors (44), health executives (32), medical students (28), nurses and midwives (28), allied health practitioners (17), community organisation representatives (10) and alternative health practitioners (3). This patient-dominated pattern points to success in my
attempt to inform medical selection and education from a more inclusive perspective.

In conclusion, my choice of methodology and methods had refined and then addressed the research question of ‘how the experiences of stakeholders with doctors could inform medical selection and education’. Guided by my planned analytical sequence of concurrent data collection and analysis, data that were initially descriptive and focused on participant perceptions of doctors, became more deeply experiential as the ‘good doctor’ phenomenon was explored in greater depth. Mapping a data analysis structure facilitated a fluid process of moving between the ‘parts’ (individual participant experiences) and the ‘whole’ (shared participant experiences). IPA focused on the more deeply experiential data, balancing the idiographic (distinct and detailed) nature of the data obtained from individual participants with commonalities that emerged from their shared doctor experiences (Smith, 2004).

These analytical findings linked stakeholder experiences with capabilities desired for ‘good’ medical practice in uniquely compelling ways. These capabilities were multi-dimensional and embraced a broad range of concepts. The first focused on ‘patient-centredness’ that included ‘ensuring patient safety’, ‘showing genuine concern’ and ‘combining competence with caring’. The second focused on ‘good communication’ that included ‘being a good listener’, ‘allowing sufficient time’ and ‘being respectful’. Of equal significance were analytical findings that linked ‘experience’ to ‘poor medical practice’. This included ‘unprofessionalism’ (related specifically to ‘being disrespectful’ and ‘being arrogant’) as well as ‘compromising the safety of self and others’ (related specifically to ‘having impaired judgement’, ‘being a poor communicator’ and ‘being incompetent’).
These findings were critical to informing medical selection and education on two levels: firstly, by linking ‘experience’ to ‘capabilities’ required for ‘good’ medical practice and secondly, by informing these processes from a uniquely inclusive perspective. The significance of these findings will be discussed in greater detail in the following chapter.
CHAPTER 5 DISCUSSION

In this chapter, I discuss the significance of my findings for informing medical selection and education in light of the existing literature. Two broad gaps were identified from my exploration of the literature in Chapter 2. Firstly, of the many and varied attempts to better inform medical selection and education models, research to link capabilities identified for effective long-term medical practice to ‘real-life doctor experiences’ was found to be relatively lacking.

Secondly, although there was evidence in the literature of stakeholder contributions to medical selection and education decision-making, such contributions had generally favoured ‘privileged’ viewpoints. My study, therefore claims a unique contribution to the body of medical selection and education research by linking ‘capabilities’ to the positively and negatively evaluated experiences of diverse and multiple stakeholders in ways that have not previously been evidenced in the literature.

Smith’s phenomenological paradigm was adapted to accommodate a larger-than-usual participant sample to capture the ‘essence’ of the ‘doctor experience phenomenon’ from these multiples perspectives. IPA facilitated refinement of my research question for addressing the relative gaps identified in my literature search.

In the following discussion, I explore comparisons between my key findings and those in the literature to establish the significance of my findings. In order to achieve this comparison optimally, I have elected to include a small number of participant quotations in this discussion chapter. Whilst I recognise that this practice is unconventional, I believe that it serves to make these connections more easily for the reader.
5.1 COMPARING FINDINGS TO STAKEHOLDER-BASED LITERATURE

This comparison related to key findings that were mapped in the schematic representation of my study data (outlined in Table 3, section 3.3.5.2) and my review of the stakeholder based literature (in section 2.5). Comparisons focused on ‘patient-centredness’, ‘communication’, ‘doctor and patient safety’ and ‘professionalism’.

5.1.1 Patient-centredness

Analysis of what doctors ‘being patient-centred’ meant for my study participants supported research that advocated for patient-focused, as opposed to systems-focused or doctor-focused models of selection and education (Rana, 2017; Simpkin et al., 2017; Stewart, 2005; University of California, 2004; Weston et al., 1989). My findings lent support to the University of California recommendations for ‘patient-student encounters’ that increase the amount of time between medical students and patients. These findings emerged to focus on ‘allowing sufficient time’, which were mapped in Table 3 (section 3.3.5.2) and explored more deeply with stakeholders in section 4.1.1.

Research-based recommendations to balance ‘humanism’ with ‘science’ aligned closely with these recommendations and were further supported by my findings. These findings emerged to focus on ‘combining competence with caring’, which were mapped in Table 3 (section 3.3.5.2) and explored more deeply with stakeholders in section 4.1.1. Parallels with the literature were found in the University of California (2004) guidelines for ‘good medical practice’:

There is a groundswell in medicine today – coming from both sides of the examination table – to bring the human dimension back into medicine as evidence grows that the
interaction between a doctor and a patient can be as important in health as a physician's technical competence.

(p. 1)

Whilst some studies shared my participants’ focus on doctors combining ‘competence’ with ‘caring’ (Rana, 2017), others advocated ‘patient-centred care’ as the ‘cornerstone of good medical practice’ (Simpkin et al., 2017, p. 434). These authors’ recommendations informed medical education models by stating that ‘health technology and humanistic patient care should be implemented throughout medical curricula at the undergraduate, graduate, and continuing medical education levels’ (p. 434).

Further comparisons can be made between my findings and discourses around ‘patient-centredness’ in the literature. For example, I found that what my study participants had referred to as doctors ‘showing genuine concern’ and ‘combining competence with caring’ is consistent with discourses around doctors being ‘compassionate’ (Cameron et al., 2013; Carmel & Glick, 1996; Green, 2013; Lown et al., 2011); ‘altruistic’ (Burks & Kobus, 2012; Jones, 2002); ‘caring’ and ‘benevolent’ (MacLeod, 2011); ‘sympathetic’ (Lown et al., 2011) and ‘empathic’ (Ahrweiler et al., 2014; Eikeland et al., 2014; Hegazi & Wilson, 2013; Hojat et al., 2013; Howick et al., 2017; Tavakol et al., 2012).

My study findings mirror the juxta position between the ‘art’ versus the ‘science’ of medicine embedded in the medical selections and education literature (Benbassat, 2014; Bloom, 1963; Boelen et al., 2016; Dobkin & Laliberté, 2014; Fadiman, 1997; George & Green, 2017; Haidet et al., 2002; Jeffrey, 2016; McNair et al., 2016; Safran et al., 2006; Stewart, 2005; University of California,
2004). More specifically, my study participant experiences that reflected doctors combining the ‘art’ with the ‘science’ of their medical practice resonated with stakeholder-based studies cited earlier in the literature review (Chapter 2, section 2.5.1) that emphasised humanistic traits as necessary, alongside those of academic ability, for ‘good’ medical practice (Fones et al., 1998). The essence of this aspect of the ‘good doctor’ phenomenon is captured in two of my study stakeholder responses as:

[His specialist] is a very caring person. I have complete trust in him … to be a good doctor you not only have to be good at what you do, but you have to be a good ‘people person’ and a caring person [emphasis added].

[Study participant 19 – patient]

I get to work with compassionate doctors who have these [good] characteristics of insight, of integrity, of proactively seeking out a complex answer to a complex question so I’m dealing with ‘the thinkers’ [emphasis added].

[Study participant 30 – clinical ethicist]

Whilst acknowledging leading scholars’ attempts to address selection and education challenges by focusing on medical empathy (including psychometric testing and hidden curricula effects), research that demonstrated the positive effects of empathy-focused learning for patients, resonated more strongly with my findings. For example, Shapiro et al. (2016a) focused on medical student empathy, particularly in the context of the ‘student-patient relationship’. Using a CAQDAS approach similar to mine, the authors illustrated their findings with verbatim extracts such as:
I heard her crying out, in search of an answer, and I tried to take some of her suffering upon myself [emphasis added] (P10).

She was a difficult patient because she put up a wall. However, walls are meant to be broken, it just takes some time. Maybe at a future appointment, she and I will finally make that connection [emphasis added] (P20).

(p. 5)

My findings contribute to scholarly discourses around whether medical empathy needed to be assessed as part of a selection process or whether it could be acquired during training. For example, Saunders (2015) questioned whether virtue, which was interpreted as compassion, empathy, genuine concern and caring, could be taught. Stakeholder sense-making from my study suggests that participants considered these capacities to be largely determined by a person’s nature when they said ‘[y]ou either have it or you don’t’ [patient participant 5.4] and ‘[h]e just has this intrinsic compassion’ [nurse clinician participant 38].

To sum up, where discourses in the literature had linked ‘patient-centredness’ with doctors being ‘compassionate’, ‘altruistic’, ‘caring’ and benevolent’, ‘sympathetic’, and ‘empathic’, my findings added to this body of knowledge on two levels. Firstly, they deepened our understanding of this ‘good doctor’ phenomenon from the novel perspective of first-person accounts of experiences with doctors. Secondly, they were more inclusive of stakeholder representation that could better inform how we might select and educate ‘patient-centred’ doctors.
Apart from my study’s contribution to research on ‘patient-centredness’, my findings also concurred with other key elements of ‘good medical practice’ identified in the literature. For example, there was strong concordance between my study and Lupton’s (1997) Sydney-based study of ‘60 lay people and 20 medical practitioners’ for whom ‘good doctors’ meant ‘being patient-centred’ and ‘being good communicators’, as in this quotation from the paper:

_I think good doctors are good listeners and they genuinely are interested in people and their welfare_ [emphasis added] (Kristin).

(p. 489)

Lupton’s (1997) study further supported my findings by concluding that:

>[t]he doctors typically articulated the importance of practising a medicine that was empathetic and involved good communication between patient and doctor, including the doctor being able to listen to the patient and being genuinely interested in the patient’s feelings and symptoms [emphasis added].

(p. 490)

My study added to Lupton’s findings by confirming them with a broader range of stakeholders in a different region of Australia.

5.1.2 Communication

Alongside ‘patient-centredness’, ‘being a good communicator’ was found to be at the centre of the meaning derived from my study participants’ positively-evaluated doctor experiences. Key elements of doctors ‘being good
communicators’ focused on those who were ‘good listeners’, who ‘allowed sufficient time’ and who were ‘respectful’. These elements were schematically represented in Table 3 in section 3.3.5.2 and formed part of my analytical commentary in section 4.1.2. These results were useful for informing future medical selection and education models, given the volume of evidence-based support for selecting and educating doctors to communicate effectively across all stages of their careers.

My findings resonated with a large range of studies that had placed ‘communication’ at the centre of healthy doctor-patient relationships. In this context, I drew parallels between my study findings and other stakeholder-based research focused on effective doctor-patient communication. For example, evidence that suggested that ‘doctors who can communicate effectively with patients will be more effective in many ways … patients value clear and courteous communication; unsurprisingly, it makes them feel better’ (Smajdor et al., 2011, p. 383).

Apart from ‘communication’ being prescribed for ‘good medical practice’ (Australian Medical Council, 2012; Frank et al., 2010a, 2010b, 2015), parallels were evident between my study’s stakeholder-led focus on doctors ‘being good communicators’ and other recent stakeholder-based evidence that had prioritised ‘communication’ for ‘good’ medical practice’ (Fürstenberg & Harendza, 2017; Furstenberg et al., 2017). Other stakeholder-led research that had prioritised ‘respect’, ‘care for patients’ and ‘communication’ as key elements for ‘good medical practice’ resonated further with my study findings when it focused on the importance of cultural safety for effective communication (Fadiman, 1997; Ojuka et al., 2016). Such concordance is illustrated by one of
my study stakeholders who emphasised the importance of cultural safety for ‘good’ medical practice:

\[
\text{[t]he doctors we work with respect that some clients have a belief system and culture which is very different from their own.}
\]

[Participant 36 – Indigenous health worker]

My study adds to the body of knowledge that has attempted to better inform how doctors could be selected and educated to be ‘good communicators’. It does so by linking ‘communication’ to ‘being a good listener’, ‘allowing sufficient time’ and ‘being respectful’ and by connecting these dimensions of ‘good’ medical practice to ‘experience’ in uniquely compelling ways. This novel approach was inclusive of a broader range of stakeholders than could be identified in the prior literature.

Important to note are the compelling findings that emerged from my study’s stakeholder experiences of doctors ‘being poor communicators’, regarding the issue of compromising safety. Parallels are evident between such negative impacts of ‘poor’ doctor communication and evidence in the literature, including research that had linked ‘poor communication’ with disciplinary action against doctors (Abadel & Hattab, 2014). Apart from evidence of the negative impacts of doctors ‘being poor communicators’, equally concerning parallels can be identified in the areas of ‘poor professionalism’ and doctors who had compromised their own safety as well as that of others.
5.1.3 Professionalism

The ‘negatively evaluated doctor experiences’ of my study participants resonated with stakeholder-based research on ‘professionalism in medicine’ (referred to in section 2.5.6 of the literature review). Findings from my study that relate to stakeholder experiences of doctors ‘being unprofessional’ were linked more specifically to ‘being disrespectful’ and to ‘being arrogant’. The schematic representation in Table 3 (section 3.3.5.2) is useful for highlighting an important tension between these key ‘negative’ elements and the elements of ‘being respectful’, ‘showing genuine concern’ and ‘combining competence with caring’ that were analysed as part of stakeholders’ ‘positively evaluated doctor experiences’ (in section 4.1).

It is interesting to note how my study findings resonate with discourses around doctors ‘being disrespectful’ in the literature (Arora et al., 2010; Chang et al., 2015, 2017; Ebrahimi et al., 2012; Scott et al., 2015). More specifically, the two recent studies by Chang et al. (2015, 2017) evidenced a lack of respect from the personal experiences of junior doctors in a Korean hospital. My study’s broader representation of stakeholders supports this research on two levels: firstly, with regard to focusing on a ‘lack of respect for patients’ and secondly, on a ‘lack of respect for colleagues’.

1) A ‘lack of respect for patients’ (emphasis added) was cited thus by a junior doctor in Chang et al.’s (2015) study:

   In the ER, I saw a resident conduct an EKG [electrocardiogram] on a young female patient with the curtains not entirely shut … I can imagine how she felt when taking that EKG even unhooking her bra. I don’t think the resident had done it intentionally, but the
Resident should have been able to see the situation from the patient’s perspective [emphasis added].

(p. 375)

Findings from my study, similarly, included expressions of what doctors ‘being disrespectful’ (emphasis added) had meant for some participants, for example:

I can remember once hearing a clinician talk about a patient as ‘the stroke’ [emphasis added].

[Study participant 34 – health service manager]

I wasn’t given enough warning … I was not in a good place to have twelve people come and ogle me like a prize chicken! The curtains [around her hospital bed] got thrown open with all these strange faces peering at me! [emphasis added].

[Study participant 17 – patient]

2) A ‘lack of respect for colleagues’ (emphasis added) was cited thus by a junior doctor in the same study by Chang et al. (2015):

There are repetitive and boring tasks that require us to organize the data during clinical research. We called it “plowing a field.” Some senior residents order juniors to plow the seniors’ field for nothing, not putting the juniors’ name on the paper or giving them money. Sometimes they pretend it’s supposed to be the juniors’ job, or maybe they really think so [emphasis added].

(p. 375)
Findings from my study, similarly, include expressions of what doctors ‘being disrespectful’ (to people other than patients) meant for some participants:

*If they* [doctors] *are teaching [medical] students something during ward round, it’s good for them to have the ability to say, if we don’t know the answer: ‘It’s okay … this is the answer’ rather than by embarrassing us by saying ‘Oh, you don’t know the answer? Well, you’re idiots!’* [laughter accompanied by laughter from the participant group]. *There’s a fine line between respect and ridicule* [emphasis added].

*Study participant 9.11 – medical student*

Equally interesting to note is the congruence between my findings and evidence of how doctors ‘being disrespectful’ and ‘being arrogant’ had impacted on others, particularly patients (Courtenay, 1993; Dunbar et al., 2011; Hall, 2015; Jager, 2013; LeFanu, 2009). Discourses around doctors ‘being arrogant’ in the literature aligned with what doctors ‘being arrogant’ had meant for my study participants (Buntine, 2011; Hall, 2015; Katz & Vinker, 2014; Lombard et al., 2012; Mendelsohn, 1991; Powis, 2015; Reeve-Johnson, 2013; Robins et al., 2002). Although my study placed a similar emphasis on the negative impacts of ‘doctors being arrogant’, my findings add two distinct contributions. Firstly, they deepen our understanding of the complex phenomenon of ‘poor professionalism’ in medicine; and secondly, they add a ‘less privileged’ perspective to that understanding that might inform medical selection and education decision-making. For example, the following quotations capture the negative impacts of ‘disrespect’ and ‘arrogance’ on two of my patient participants:
[The obstetrician] **was very arrogant** ... totally put you down. [Her daughter]'s **birth was the most awful experience** ... [Names her husband] kept on being sent out of the room; so you can imagine how distraught we felt ... it was really horrible! The whole experience was just like: ‘You’ve got to do this and [to her husband] ‘You … get out! **He was yelling at me** to ‘p-u-s-h’ ... I wasn’t even aware that she was out until they told me ... I’ll never ever forget that day! [emphasis added].

[Study participant 18 – patient]

*The doctor took no notice of my history and refused* ... my birth ended very badly ... afterwards **he dismissed me**, saying ... that it was ‘nothing’. I went back to see him after a few months ... He just said: ‘**You should be like the old cow in the paddock** ... relax more and you’ll be alright’ [gasps and expressions of shock from the participant group] ... **his pigheadedness has wrecked my life!** [emphasis added].

[Study participant 5.4 – patient]

5.1.4 **Safety**

Alongside ‘being unprofessional’, ‘compromising the safety of self and others’ was found to be key to my study’s ‘negatively evaluated doctor experiences’. Apart from ‘poor communication’ (alluded to in an earlier comparison in section 5.1.2), doctors ‘having impaired judgement’ and ‘being incompetent’ were found to have substantially negative impacts on their personal safety as well as on the safety of others. The term ‘safety’ encompasses physical, mental and emotional wellbeing. These three ‘negative’ elements are schematically represented in
Table 3 in section 3.3.5.2 and formed part of my analytical commentary in section 4.2.2. These findings demonstrated the negative and far-reaching impacts of ‘unsafe medical practice’ on many stakeholders, including patients.

My study’s evidence of concerns expressed over ‘doctors compromising the safety of self and others’ resonates with concerns identified in the existing literature. These include studies that have linked unsafe medical practice to hidden medical school curricula and to poor workplace cultures. More specifically, similarities are evident between my findings and evidence of the negative impacts of poor role-modelling (George & Green, 2017; Rentmeester et al., 2007; Roberts et al., 2014; Symonds & Talley, 2013); of tensions between university policies, medical schools and the profession (Alldridge et al., 2014; Hays et al., 2013; Hays & Worthington, 2012) and of discourses around medical empathy (Hegazi & Wilson, 2013; Hojat et al., 2004, 2009; Roff, 2015; Singh, 2005). Where most of this research had attempted to inform medical selection and education from ‘privileged’ viewpoints, my study adds to this body of research from ‘less privileged’ viewpoints and in novel ways by linking ‘unsafe medical practice’ to experiential data that are unique and powerful.

Whilst maintaining a focus on ‘poor professionalism’ in medicine, further concordance was found between the literature and findings from my study. Where ‘positively evaluated doctor experiences’ align with research focused on ‘patient-centredness’ and ‘healthy’ doctor-patient relationships, ‘negatively evaluated doctor experiences’ align with research that has linked ‘poor professionalism’ with unhealthy and disrupted doctor-patient relationships. Examples include the negative experiences of doctors as patients (McKevitt & Morgan, 1997); asymmetry in doctor-patient relationships attributed to power
imbalances (Nimmon & Stenfors-Hayes, 2016); and distrust resulting from increasingly litigious medical practice (Wang, 2015).

Up to this point, my discussion has focused on how my findings concur with the existing literature and how they add to it, particularly in relation to the novel and compelling ways in which my findings can better inform medical selection and education. I accomplished this by linking ‘capabilities’ identified for ‘good’ medical practice with the ‘doctor experiences’ of those most affected by medical practice and malpractice. These ‘positively’ and ‘negatively’ evaluated ‘doctor experiences’ found expression in ways that are uniquely powerful and more inclusive of stakeholders, particularly of patients. Comparing this inclusivity of my study with others warrants further discussion of how my attempts to ‘give a voice to stakeholders’ adds to the existing literature.

5.1.5 **Giving a voice to stakeholders**

From the perspectives and experiences of the 107 participants in my study, key meanings that involve doctors’ ‘patient-centredness’, ‘communication’, ‘professionalism’ and ‘safety’ emerged to impact on their future selection and training. Identifying these key elements gives a voice to stakeholders, not only from ‘privileged’ positions in medical education, academia, health executive management and the professions of medicine, nursing, midwifery, rural health, alternative health and allied health; but also from ‘less privileged’ positions as medical students, as patients and as members of community-based groups.

My study’s focus on diverse stakeholders has parallels with few other research attempts to better inform medical selection and education. For example, Stewart (2005) emphasised the importance of combining ‘the student voice’ with the ‘patient voice’ (p. 800); whilst Walsh et al. (2016) called for the patient’s voice to
be ‘formally embedded in the reality of medical education’ (p. 4); and Luxford (2011) demonstrated benefits of ‘partnering with patients to hear their stories’ (slide 29). My research went further by giving a voice to participants whose negatively-evaluated doctor experiences (focused on doctors ‘being unprofessional’), resonated with scholars who recognised the significance of ‘giving a voice’ to patients:

*As the patient voice becomes better informed and louder, the professionalism of all clinicians faces greater scrutiny.*

(Hays et al., 2013, p. 64)

By far the greatest support for how my findings ‘gave voice’ to patients was provided by scholars who undertook IPA-based research amongst vulnerable stakeholder groups, with the aim of informing changes to the delivery of their health care (Harris, 2015). Their claim to be ‘breaking new ground in demonstrating how the "voice of the patient" can directly influence healthcare design to centre on the needs of those using them, rather than those delivering them’ (Harris, 2015) aligned strongly with my stakeholder-led research approach.

When compared with other stakeholder-focused attempts to better inform medical selection, my study’s contribution is noteworthy on two accounts: firstly, by increasing our understanding of the phenomenon of ‘experience with doctors’ from multiple perspectives and secondly, by demonstrating the positive and negative impacts of such experiences in uniquely powerful ways.

To sum up, this part of the discussion explored a range of capabilities for ‘good’ medical practice that could be derived from the sense-making of my
participants, based on their experiences with doctors. This range of capabilities included ‘patient-centredness’, ‘communication’, ‘professionalism’ and ‘safety’. Although parallels were drawn between these findings and the literature, my study adds to prior work from the individual and shared perspectives of diverse stakeholders who had prioritised these capabilities differently. In the discussion that follows, it will be important to establish how the range of capabilities identified for ‘good’ medical practice on the basis of my stakeholders’ experiences, aligns with key existing ‘capability’ or ‘competency’ frameworks in the literature.

5.2 COMPARING FINDINGS TO ‘CAPABILITY’ FRAMEWORKS

From earlier comparisons between my study findings and the literature, general agreement over the range of capabilities important for informing medical selection and education was established. For example, I drew parallels between discourses in the literature focused on stakeholder perspectives of the ‘good’ doctor, healthy doctor-patient relationships, patient-centredness and professionalism (in section 2.5) on the one hand; and the range of capabilities important to my study stakeholders, based on their experiences, on the other.

To evaluate these claims, I mapped my findings to three important existing capability frameworks. In doing so, I have considered my earlier reference to ‘capability’ (in section 2.4) as an overarching term to encompass descriptions of areas of ability that might variously be described as ‘learning outcomes’, ‘graduate attributes’, ‘competencies’ or a wider range of other descriptors.

The first framework to which I compared my findings focuses on ‘domains of attributes’ for medical selection (Wilkinson & Wilkinson, 2016), the second focuses on ‘Graduate Outcome Statements’ for medical students (Australian
Medical Council, 2012) and the third focuses on ‘physician competency’ (Frank et al., 2015). These frameworks were previously discussed in the review of the existing literature presented in sections 2.3.5 and 2.4.

5.2.1 ‘Domains of attributes’ for medical student selection

My findings, summarised in Table 3, section 3.3.5.2 map to the ‘domains of attributes’ evidenced by Wilkinson and Wilkinson (2016) as follows (emphasis added):

- Domains of attributes for ‘logical reasoning and problem solving’ and knowledge of ‘biomedical science’ (p. 3) (emphasis added). These domains align with a range of capabilities that my study participants’ sense-making prioritised for ‘ensuring patient safety’, as well as for practising the ‘science of medicine’ (referred to as ‘competence’ or ‘hard skills’ in my analytical commentary in section 4.1.1). These ‘domains of attributes’ were also visible ‘in the negative’, as deficiencies in the ‘safety’ concerns prioritised in the meanings made by my study participants in section 4.2.2. My findings evidenced links between participant concerns over ‘safety’ and negatively evaluated experiences that focused on doctors’ ‘having impaired judgement’, ‘being poor communicators’ and ‘being incompetent’.

- A domain of attributes relating to ‘understanding people’ (Wilkinson & Wilkinson, 2016, p. 3) (emphasis added), aligns with capabilities prioritised by my study participants for doctors ‘being patient-centred’ and ‘being good communicators’. My findings can be mapped more closely to this domain by linking to participant sense-making focused on doctors ‘showing genuine concern’; ‘combining competency with caring’; ‘being
good listeners’; ‘allowing sufficient time’ and ‘being respectful’ (evidenced in section 4.1). This domain was also evident ‘in the negative’ in concerns over ‘unprofessionalism’ and ‘safety’ prioritised by my study participants in section 4.2. These were found in meanings that focused on doctors ‘being disrespectful’, ‘having impaired judgement’ and ‘being poor communicators’.

My findings resonate strongly with the ‘domain of attributes’ evidenced for ‘communication skills’ (emphasis added) by Wilkinson and Wilkinson (2016, p. 3), particularly when linked to the previous domain of ‘understanding people’. The key elements prioritised by my study participants for doctors to be ‘good communicators’ can similarly be mapped for this domain. Focus on ‘good communication’ reflected deeper dimensions of what doctors ‘being good listeners’, ‘allowing sufficient time’ and ‘being respectful’ had meant for diverse stakeholders.

This ‘communication skills’ domain is again evident ‘in the negative’ in concerns over ‘unprofessionalism’ and ‘safety’ prioritised by my study participants in section 4.2. These concerns were expressed in ways that focused on doctors ‘being disrespectful’, ‘having impaired judgement’ and ‘being poor communicators’ in section 4.2.2 of my analytical commentary.

In addition to mapping my findings to Wilkinson and Wilkinson’s (2016) four broad evidence-based ‘domains of attributes’, they can also be mapped to the finer capabilities prioritised by these authors and evidenced in the literature. For Wilkinson and Wilkinson (2016) these capabilities were prioritised as ‘professionalism, probity [fairness and honesty], empathy [and] teamwork …’ (p. 5).
My findings that focused on the ‘positively evaluated doctor experiences’ of participants, are generally congruent with the capabilities identified for ‘professionalism’ (emphasis added) in the Wilkinson and Wilkinson (2016, p. 4) framework. This congruence of capabilities is evident in the ways my study participants had prioritised doctors who were ‘patient-centred’ and ‘good communicators’. Dimensions of this range of capabilities were expressed as ‘ensuring patient safety’; ‘showing genuine concern’; ‘combining competence with caring’ and ‘being respectful’ (in section 4.1 of my analytical commentary).

The ‘negatively evaluated doctor experiences’ of my study participants also map, ‘in the negative’, to this ‘professionalism’ domain (Wilkinson & Wilkinson, 2016, p. 4). This is evident in the ways my study participants had made sense of their experiences with doctors as them having been ‘unprofessional’ and having ‘compromised their safety as well as that of others’. My findings evidenced broader links between participant concerns over ‘safety’ and ‘unprofessionalism’. These dimensions converged around participant expressions of doctors ‘being disrespectful’, ‘being arrogant’, ‘having impaired judgement’, ‘being poor communicators’ and ‘being incompetent’ (in section 4.2 of my analytical commentary).

My findings can be mapped to capabilities that Wilkinson and Wilkinson (2016) prioritised for ‘probity’, ‘empathy’ and ‘teamwork’ (p. 5) (emphasis added). These three capabilities resonate with ways in which my study participants had prioritised doctors ‘being patient-centred’ and ‘being good communicators’. My analytical commentary in section 4.1 demonstrated how these two dimensions had converged around more
detailed participant expressions of doctors’ ‘being safe’, ‘showing genuine concern’, ‘combining competence with caring’, ‘being a good listeners’, ‘allowing sufficient time’ and ‘being respectful’.

Overall, mapping my findings to the ‘domains of attributes’ proposed by Wilkinson and Wilkinson (2016) provided independent confirmation to my findings, regarding principles that should inform medical selection and education, particularly from a stakeholder perspective. Comparing my findings with the Wilkinson and Wilkinson (2016) framework confirms my results on two accounts: firstly, by clarifying a range of capabilities that could be assessed at different levels and stages of a medical career; and secondly, by evidencing how diverse stakeholders had prioritised these capabilities differently, based on their experiences.

5.2.2  ‘Graduate outcome statements for medicine’

Having mapped my findings to Wilkinson and Wilkinson’s (2016) capability framework for medical student selection, I will now continue further comparison with the framework of ‘Graduate Outcome Statements’ that require a range of capabilities for entry to professional medical practice in Australia and New Zealand (Australian Medical Council, 2012). The AMC (2012) comparison involves mapping my findings to graduate outcomes for ‘science and scholarship’, ‘clinical practice’, ‘health and society’ and ‘professionalism and leadership’ (p. 7) (emphasis added) as follows:

- Parallels can be drawn between the graduate outcomes for ‘science and scholarship’ (emphasis added) in the AMC framework (2012, p. 2) and the domains identified by Wilkinson and Wilkinson (2016) for ‘logical reasoning and problem solving’ and knowledge of ‘biomedical
science’ (p. 3) (emphasis added). This concordance facilitates mapping my findings in similar ways to the AMC (2012) framework. Examples are that elements of the capabilities prioritised by my study participants for ‘patient-centred’ medical practice (in section 4.1.1) resonate with the AMC (2012) ‘science and scholarship’ graduate outcomes; particularly in relation to the ways in which my study participants had focused on doctors who made them feel ‘safe’, who showed ‘genuine concern’ and who were ‘competent as well as caring’.

An important consideration is how the ‘negatively evaluated doctor experiences’ of my study participants provided a negative contrast with the AMC (2012) graduate outcomes for ‘science and scholarship’ (p. 2). This is evidenced (in section 4.2.2 of my analytical commentary) by the ways in which my study participants had focused on doctors who were ‘unprofessional’ and ‘unsafe’. The impact of my findings intensifies when the focus of participant concerns over ‘professionalism’ and ‘safety’ narrowed to expressions of doctors ‘being disrespectful’, ‘being arrogant’ ‘having impaired judgement’, ‘being poor communicators’ and ‘being incompetent’. Excerpts of these expressions were captured as raw text in my analytical commentary.

Graduate outcomes identified for ‘clinical practice’ (emphasis added) in the AMC framework (2012, pp. 2-3), align with my study findings in positive and negative ways, based on the doctor experiences of my study participants. Mapping is positive for the ways in which participants prioritised doctors who were ‘patient-centred’ and ‘good communicators’ (evidenced in section 4.1). Dimensions of this range of capabilities were expressed as ‘ensuring patient safety’; ‘showing genuine concern’;
‘combining competence with caring’ (in section 4.1.1); ‘being a good listener’; ‘allowing sufficient time’ and ‘being respectful’ (in section 4.1.2).

As demonstrated earlier, it is important to note how the ‘negatively evaluated doctor experiences’ of my study participants compare as negative expressions of ‘clinical practice’ graduate outcomes in the AMC (2012) framework. This is evidenced by the ways in which participants focused on doctors ‘being unprofessional’ and ‘compromising their own safety and that of others’ (in section 4.2 of my analytical commentary). These negative dimensions were found to converge around participant experiences that were focused on doctors ‘being disrespectful’, ‘being arrogant’, ‘having impaired judgement’, ‘being a poor communicator’ and ‘being incompetent’ (in sections 4.2.1 and 4.2.2). These findings were important for highlighting ways in which doctors had failed to meet the range of capabilities prescribed for sound ‘clinical practice’ in the AMC (2012) framework.

- Parallels can also be drawn between the AMC (2012) framework’s domain of ‘health and society’ (pp. 3-4) (emphasis added) and the range of capabilities prioritised by my study participants. This congruence is particularly relevant for shared participant experiences around doctors ‘being patient-centred’ and ‘being good communicators’; as well as for shared medical educator discourses around medical student selection and education in my pilot study. For example, recognising the diversity of capabilities required for a career in medicine was evidenced in section 3.3.1 of the analytical commentary for my pilot study:

  "we have a responsibility to produce graduates who are equipped to practice in a variety of places ..."
[Study participant 1.3 – medical educator]

You’ve got to train people for the real world … it depends on the context. So if you’re training a doctor for the hospital environment with support, with graduated responsibility … that’s different to a community experience.

[Study participant 1.7 – medical educator]

- Although the Wilkinson and Wilkinson (2016), framework had identified ‘professionalism’ as one of the ‘domains of attributes’ for good medical practice (p. 5), the AMC framework (2012) outlines graduate outcomes for ‘professionalism and leadership’ (p. 4) (emphasis added) in greater detail. The AMC framework (2012) emphasises the importance of this range of capabilities by linking this domain to ‘codes of conduct’ for doctors in Australia and New Zealand (Australian Medical Council, 2009). As evidenced earlier, ways in which my study participants had prioritised doctors ‘being patient-centred’ and ‘being good communicators’ resonates with key elements identified for ‘professionalism and leadership’ in the AMC framework (2012, p. 4). For example, parallels can be drawn between capabilities such as ‘compassion, empathy and respect for all patients’ (p. 4) and my study participant expressions of doctors ‘showing genuine concern’; ‘combining competence with caring’ and ‘being respectful’ (in sections 4.1.1 and 4.1.2 of my analytical commentary).

As demonstrated earlier, it is important to note how the ‘negatively evaluated doctor experiences’ of my study participants are reflected in
the AMC frameworks’ (2012) graduate outcomes for ‘professionalism and leadership’ (p. 4), but in the negative. This dichotomy is evidenced by the ways in which my study participants had focused on doctors ‘being unprofessional’ and ‘compromising their own safety and that of others’ (in section 4.2 of my analytical commentary). These broader dimensions of ‘unprofessionalism’ and ‘safety compromise’ were linked to participant experiences that had focused on doctors ‘being disrespectful’, ‘being arrogant’, ‘having impaired judgement’, ‘being poor communicators’ and ‘being incompetent’ (evidenced in sections 4.2.1 and 4.2.2 of my analytical commentary).

In summary, mapping my findings to the AMC ‘Graduate Outcome Statement’ framework (2012) that guides the accreditation of medical education programs reveals ‘domains’ similar to those identified by Wilkinson and Wilkinson (2016) for medical student selection (in the previous section 5.2.1). Capabilities are similar in the areas of ‘scientific knowledge’, ‘communication’, ‘empathy’ and ‘professionalism’. The AMC framework (2012) describes these areas in more detail and links them to ‘codes of conduct’ for ‘good medical practice’ in Australia and New Zealand (Australian Medical Council, 2012, p. 4). Capabilities prioritised by my study participants are congruent with these domains but are expressed somewhat differently.

Noteworthy is that earlier distinctions I have drawn between the prioritisation of capabilities for ‘good medical practice’ and the ‘negatively evaluated doctor experiences’ of my study participants were deepened by the AMC framework (2012) comparison. This mapping strengthens my attempts to improve our understanding of the impacts of medical practice and ‘malpractice’ in unique
ways and from multiple perspectives. I will now map my findings to a capability framework for ‘physician competency’ that was noted in section 2.4 of the literature review.

5.2.3 ‘Physician competency’

The findings of my study (as summarised in Table 3, section 3.3.5.2) will also be compared with the CanMEDS capability framework for ‘physician competency’ (Frank et al., 2015; Royal College of Physicians and Surgeons in Canada, 2017). Important for my study is that this framework has been linked to a larger ‘Competency by Design’ initiative to identify competencies for different stages of a medical career (Frank et al., 2010a, p. 12). Parallels are evident between the domains identified in the two previous frameworks (Australian Medical Council, 2012; Wilkinson & Wilkinson, 2016) and the CanMEDS role of ‘medical expert’ that integrates the domains of ‘communicator’, ‘collaborator’, ‘leader’, ‘health advocate’, ‘scholar’ and ‘professional’ (Frank et al., 2015; Royal College of Physicians and Surgeons in Canada, 2017) (emphasis added).

These similarities enable merging of these ‘communicator’, ‘collaborator’, ‘leader’, ‘health advocate’, ‘scholar’ and ‘professional’ domains into three areas of capabilities for this comparison as follows:

- The CanMEDS (2015) domains of ‘communicator’, ‘collaborator’ and ‘health advocate’ (pp. 16,18,22) (emphasis added) can be combined for this purpose as they are mirrored in similar domains for the two previous capability frameworks. These are the Wilkinson and Wilkinson (2016) ‘domains’ of ‘understanding people’ and ‘communication skills’ (emphasis added) in section 5.2.1 (p. 3); and the domains of ‘clinical practice’ and ‘health and society’ (emphasis added) in the AMC framework (2012, pp. 2-4) in section 5.2.2. Given this shared focus, my
findings can be mapped to the CanMEDS (2015) domains in similar ways, demonstrating how the three domains of ‘communicator’, ‘collaborator’ and ‘health advocate’ (pp. 16,18,22) (emphasis added) align with my study findings in positive and negative ways, based on the doctor experiences of my study participants.

Once again, there was clear alignment with the ways in which my study participants prioritised doctors who were ‘patient-centred’ and ‘good communicators’ (in section 4.1 of my analytical commentary); particularly through ‘ensuring patient safety’, ‘showing genuine concern’, ‘combining competence with caring’, ‘being a good listener’; ‘allowing sufficient time’ and ‘being respectful’ (in sections 4.1.1 and 4.1.2).

As demonstrated earlier, it is important to note the negative alignment between my participants’ ‘negatively evaluated doctor experiences’ and the CanMEDS (2015) domains of ‘communicator’, ‘collaborator’ and ‘health advocate’ (pp. 16,18,22) (emphasis added). This negative alignment is reflected in ways participants’ meaning-making had prioritised a range of capabilities around doctors ‘being unprofessional’ and ‘compromising safety’ (in section 4.2 of my analytical commentary). Important to emphasise is how my findings have linked ‘poor communication’ to ‘unsafe’ practice in impactful ways and from multiple perspectives (evidenced in section 4.2.2 of my analytical commentary).

Similarities can be identified between the CanMEDS (2015) domain of ‘scholar’ (p. 24) (emphasis added) and the ‘domains of attributes’ identified in the Wilkinson and Wilkinson (2016) framework for ‘logical reasoning and problem solving’ and knowledge of ‘biomedical
‘scientific’ (p. 3) (emphasis added) in section 5.2. Key elements of this ‘scholar’ domain are also found in the AMC framework (2012) graduate outcomes for ‘science and scholarship’ (p. 2) (emphasis added).

Once again, these congruent domains facilitate mapping my findings to the CanMEDS (2015) framework in ways that were similar for the two previous capability frameworks (Australian Medical Council, 2012; T. M. Wilkinson & Wilkinson, 2016). For example, capabilities prioritised by my study participants for doctors being ‘patient-centred’ (in section 4.1.1 of my analytical commentary) resonated with the CanMEDS (2017) integrated role of ‘medical expert’ in Table 4. As this table shows, ‘scholar’ (emphasis added) is the (fundamental) role that aligns most closely with this ‘patient-centred’ dimension, particularly when linked to participant experiences that focused on doctors ‘ensuring patient safety’ and ‘combining competence with caring’, (evidenced in section 4.1.1 of my analytical commentary).

Yet again, the negative contrast between my participants’ ‘negatively evaluated doctor experiences’ and the CanMEDS (2017) integrated role of ‘medical expert’ (emphasis added) is noteworthy. This contrast was evident in ways participants expressed concerns over their safety and that of others, as captured in verbatim extracts in my analytical commentary in section 4.2.2. The impact of this evidence is intensified when the focus on ‘unsafe’ medical practice was analysed into specific types of participant expressions of doctors ‘having impaired judgement’, ‘being a poor communicator’ and ‘being incompetent’ (in section 4.2.2 of my analytical commentary).
The CanMEDS (2015) domains of ‘leader’ and ‘professional’ (pp. 20-21, 26-27) (emphasis added) were combined for this comparison as they are mirrored in similar domains for the two previous capability frameworks (Australian Medical Council, 2012; Wilkinson & Wilkinson, 2016). These include the graduate outcomes for ‘professionalism’ (Australian Medical Council, 2012, p. 4; Wilkinson & Wilkinson, 2016, p.5); the domains for ‘probity’ and ‘teamwork’ (Wilkinson & Wilkinson, 2016, p. 5), as well as graduate outcomes for ‘leadership’ (Australian Medical Council, 2012, p. 4).

As anticipated, ways in which my study participants prioritised ‘doctors being patient-centred’ and ‘being good communicators’ resonate with the two CanMEDS (2015) domains of ‘leader’ (pp. 20-21) and ‘professional’ (pp. 26-27) (emphasis added). For example, parallels can be drawn between the CanMEDS (2015) ‘physician competencies’ around ‘patient safety’ and ‘time management’ (p. 26) and my study participant’s expressions of ‘ensuring patient safety’ and ‘allowing sufficient time’ (in section 4.1.1 of my analytical commentary).

As demonstrated earlier, it is important to note how the ‘negatively evaluated doctor experiences’ of my study participants reflect the range of capabilities identified for these two CanMEDS domains, but in the negative. This is evidenced by the ways in which my study participants had focused on doctors ‘being unprofessional’ and ‘compromising their own safety and that of others’ (in section 4.2.) and in my analytical commentary around doctors ‘being disrespectful’; ‘being arrogant’ (in
section 4.2.1); ‘having impaired judgement’; ‘being poor communicators’ and ‘being incompetent’ (in section 4.2.2).

Mapping my findings in this way, highlights key parallels between deficiency in ‘physician competencies’ identified for ‘leadership’ and ‘professionalism’, and the ‘negatively evaluated doctor experiences’ of my study participants. For example, extracts from my analytical commentary (in section 4.2) illustrated participant expressions of doctors ‘being unprofessional’ in diverse ways:

*He was a highly competent surgeon but he had that cold inability to just say ‘sorry’ … so if that’s how he treats somebody who is a colleague, God knows what he’d be like with his other patients!*  

[Participant 26 – senior academic]

*He [the specialist] started telling us all about one of his patients … it made us feel so uncomfortable … I cancelled my next appointment and never went back there.*  

[Participant 18 – patient]

*[h]e came into the birthing room without even addressing the woman and he then examined her without even speaking to her … without even saying ‘hello’ to her, let alone getting her consent!*  

[Participant 37 – midwife]
When I asked him [the doctor on call] a second time, he yelled at me saying: “Are you a moron or something? Don’t you understand English?” There’s been numerous similar incidents with doctors over the years, but I’ll always remember that … it’s stuck in my brain!

[Participant 38 – nurse practitioner]

They engage in all sorts of unprofessional behaviour like surgeons who yell and throw things in [the operating] theatre or consultants who publicly humiliate junior colleagues in front of their patients …

[Participant 39 – health executive]

To clarify the general comparison between my study findings and the three capability frameworks (Australian Medical Council, 2012; Frank et al., 2015; Wilkinson & Wilkinson, 2016), an integrative analysis of this comparison is presented in Table 4 below:
Table 4 Comparison of study findings to three capability frameworks
(Australian Medical Council, 2012; Frank et al., 2015; Royal College of Physicians and Surgeons of Canada, 2017; Wilkinson & Wilkinson, 2016)

<table>
<thead>
<tr>
<th>Domains of attributes for medical student selection (Wilkinson &amp; Wilkinson, 2016)</th>
<th>Graduate Outcome Statements (Australian Medical Council, 2012)</th>
<th>Physician Competencies (Frank et al., 2015; Royal College of Physicians and Surgeons of Canada, 2017)</th>
<th>Capabilities prioritised by my study participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logical reasoning, problem solving, knowledge of biomedical science</td>
<td>Science and scholarship</td>
<td>Medical Expert *Scholar</td>
<td>Ensuring patient safety</td>
</tr>
<tr>
<td>Understanding people</td>
<td>Clinical Practice</td>
<td>Collaborator Communicator Health advocate</td>
<td>Being patient-centred (being safe, showing genuine concern, being competent &amp; caring)</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Clinical Practice</td>
<td>Communicator Collaborator Health advocate</td>
<td>Being a good communicator (being a good listener, allowing sufficient time, being respectful)</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Clinical Practice Health and society Professionalism and Leadership</td>
<td>Professional Leader</td>
<td>Being patient-centred (being safe, showing genuine concern, being competent &amp; caring)</td>
</tr>
<tr>
<td>Probity Empathy Teamwork</td>
<td>Clinical practice</td>
<td>Collaborator Leader Health advocate</td>
<td>Being a good communicator (being a good listener, allowing sufficient time, being respectful)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Being patient-centred (being safe, showing genuine concern, being competent and caring)</td>
</tr>
</tbody>
</table>

*While knowledge and its application are specifically referred to in the ‘medical expert’ integrated role, ‘scholar’ is the fundamental role most closely aligned because it refers to life-long learning for keeping medical knowledge up-to-date and a questioning approach to problems.*
Table 4 is useful for comparing my study findings to the three capability frameworks to summarise how the capabilities prioritised by my study participants aligned positively and negatively with the capabilities recommended for medical student selection (Wilkinson & Wilkinson, 2016); for medical school graduates (Australian Medical Council, 2012) and for practising physicians (Frank et al., 2015). Despite these different approaches, capabilities recommended for ‘good’ medical practice converged around the areas of academic competence (‘science and scholarship’), effective communication (‘collaboration, teamwork and health advocacy’), professionalism (‘health and society’, leadership), and ‘clinical practice’ (including ‘empathy’ and ‘probity’). These capability domains, graduate outcomes and physician competencies are illustrated in Table 4.

Useful comparisons in Table 4 are the positive alignments between my study participants’ focus on ‘patient-centredness’ and ‘communication’ and the capability framework areas of ‘understanding people’; ‘clinical practice’; ‘health and society’, ‘collaborator’, ‘communicator’; ‘health advocate’; ‘professionalism’; ‘leadership’; ‘probity’, ‘empathy’ and ‘teamwork’. However, as Table 4 illustrates, my study findings capture the ‘essence’ of what ‘patient-centredness’ and ‘good communication’ meant for participants, based on their experiences. Compared with the framework capabilities, the capabilities prioritised by my study participants for ‘patient-centred’ doctors focused more distinctly on ‘being safe’, ‘showing genuine concern’ as well as ‘being competent and caring’. Likewise, the capabilities prioritised by my study participants for ‘good communication’ focused more distinctly on doctors ‘being good listeners’, ‘allowing sufficient time’ and ‘being respectful’.
Table 4 illustrates further positive alignment between my study findings and the three capability frameworks (Australian Medical Council, 2012; Frank et al., 2015; Wilkinson & Wilkinson, 2016). The capabilities prioritised by my study participants for doctors to ‘ensure safety’ and to be ‘competent as well as caring’ aligned positively with framework capabilities that converged around ‘logical reasoning’, problem solving’, ‘knowledge of biomedical science’, ‘science and scholarship’ and ‘scholar’.

Noteworthy contrasts with previous frameworks are also illustrated in Table 4 in the column headed negative alignments, which presents the negative features identified by study participants that appear to be the negative aspects of doctor performance (Australian Medical Council, 2012; Frank et al., 2015; Wilkinson & Wilkinson, 2016). For example, study participant experiences that focused on doctors ‘being unprofessional’ and ‘being unsafe’ aligned negatively with framework capabilities that converged around ‘professionalism’, ‘clinical practice’, ‘health and society’, ‘leadership’, ‘probity’, ‘empathy’, ‘teamwork’, ‘collaborator’ and ‘health advocate’. Equally important to consider is the distinct and detailed emphasis given by my study participants for ‘unsafe’ and ‘unprofessional’ medical practice, based on their doctor experiences. As Table 4 illustrates, participants focused on doctors ‘being disrespectful’; ‘being arrogant’; ‘being unsafe’; ‘having impaired judgement’ and ‘being poor communicators’.

Illustrating negative alignments between my study findings and the three capability frameworks is important for evidencing deficiencies in capabilities recommended for medical student selection, for medical school graduates and for practising physicians, based on the negatively evaluated doctor experiences of my study participants.
To summarise, mapping my findings to three capability frameworks was useful for identifying convergence with as well as divergence from, a range of capabilities identified for ‘good’ medical practice. As anticipated, the ‘positively evaluated doctor experiences’ of my study participants generally aligned with key elements of the three frameworks. Parallels were drawn between a positive focus on doctors who were ‘patient-centred’ and ‘good communicators’ and a range of capabilities identified for ‘effective’ medical practice at various stages of a medical career.

It is important to note the divergence between the ‘negatively evaluated doctor experiences’ that my study participants provided, unbidden, with key elements identified for these capability frameworks. This contrast raises serious concerns over the ways in which participants had been impacted by experiences that had evidenced doctors’ deficiencies in key capabilities; made sense of by my participants as their ‘being unprofessional’ and ‘compromising their safety as well as that of others’.

Mapping my findings to the three frameworks (Australian Medical Council, 2012; Frank et al., 2015; Wilkinson & Wilkinson, 2016) connects the capabilities they describe to the ‘experiences’ of my study’s multiple stakeholders, including patients. Comparing my findings to these three capability frameworks underlines the contribution of this study to medical selection and education research on two accounts: firstly, by finding commonalities between the range of ‘desirable’ capabilities outlined in each framework and my findings (both in terms of the presence and absence of the capabilities in my participants’ experiences); and secondly, by establishing that the viewpoints expressed in these capability frameworks had remained privileged.
The capabilities emerging from my participants’ responses reflect the sense they made of their experiences with doctors. Much of what emerged was already contained within the three frameworks analysed, providing mutual confirmation for the frameworks as well as my findings. What my study adds, however, is an appreciation of the negative aspects of these capabilities, as well as guidance on which of the range of identified capabilities selectors and educators should prioritise. For my participants, capabilities focused around ‘patient-centredness’, ‘communication’, ‘professionalism’ and ‘safety’ should take precedence over other capabilities that may be more valued by ‘privileged’ stakeholders. My findings also provide rich examples to help selectors, educators and students to understand and guide how they operationalise these key capabilities in practice, both when they are present and when they are deficient. For instance, the ‘real-life’ doctor experiences of my study participants would be valuable for informing scenarios for selection SJTs and MMIs as well as for communication skills and case-based learning (CBLs) in medical school curricula.

It is important to note that these capability frameworks (Australian Medical Council, 2012; Frank et al., 2015; Wilkinson & Wilkinson, 2016) have not been previously linked in quite this way in the medical selection and education literature. However, a proposal that linked the CanMEDS capability framework to a larger ‘Competency by Design’ initiative for physicians to identify competencies for different stages of a medical career (Frank et al., 2010a, p. 12), facilitates further comparison between my findings and other relevant discourses in the medical selection and education literature.

The first relevant discourse relates to attempts to strengthen the nexus between medical selection and education models (Monash University, 2016; World
Federation for Medical Education, 2015). My findings generally support this exhortation to manage selection, education and career development of future doctors along a continuum. The approach focuses on the range of capabilities required for ‘effective’ medical practice over the course of a lengthy and diverse career. Within this ‘continuum dimension’, parallels can be seen between my study findings and views that emphasise the long-term implications of admissions decisions. For example, leading scholars have cautioned that ‘[s]electing the wrong person for a job can have serious consequences for an organisation, the employee involved and, perhaps of most importance in medicine, the patient’ (Patterson et al., 2014, p. 404). Similarly, one of my study participants made sense of their experiences through a focus on ‘a continuum of assessment’, expressing that:

*Universities should move away from putting ‘all their eggs in the selections basket’ … selection should be the initiation of an assessment pathway for the entire curriculum and possibly even beyond that. This continuum of assessment should provide the ‘checks along the way’ that are required to identify and to manage poor medical student performance, be that on an academic or on a professional level.*

[Study participant 39 – health executive]

A second relevant discourse is an unresolved debate around the extent to which the key ‘capabilities’ can be learned or are primarily related to temperament and, thus, relatively immutable (Hays et al., 2013; Kelm et al., 2014; Lim et al., 2016; Patterson et al., 2014; Wündrich et al., 2017). Although my study findings were similarly inconclusive, they are important for linking
‘capabilities’ to ‘doctor experiences’ in novel ways and from multiple perspectives. In general, my participants appeared to have made meaning of their experiences in a way that assumed relative immutability of the capabilities they valued, as illustrated in the following participant quotations (from sections 3.3.1, 4.1 and 4.2):

You either have it [empathy] or you don’t … [emphasis added]

[Study participant 5.4 – patient]

He [her doctor] just has this intrinsic compassion … [emphasis added]

[Study participant 38 – nurse clinician]

[On admission] we get between four and six students who are ‘criminal’, ‘unethical’, ‘amoral’ … who really just should not be there … [emphasis added]

[Study participant 1.6 – medical educator]

[w]e’ll never be able to weed out the personality disorders because they’re so smart … the narcissistic ones especially have no insight … [emphasis added]

[Study participant 1.13 – medical educator]

[On admission] we … get a handful of what you could call ‘sociopaths’… we also have a responsibility to produce graduates who are equipped to practice in a variety of places [emphasis added].
Comparison between my study findings and discourses related to whether ‘capabilities’ can be learned or are primarily related to temperament, are important for informing medical student selection and education from a stakeholder perspective in three ways. Firstly, it helps to inform decision-making over for what capabilities we should select in a ‘good’ doctor. Secondly, it may inform decisions for assessing capabilities on entry and at critical career stages. Thirdly, it supports the value of determining whether ‘desirable’ capabilities should be required at the time of entry or whether they might be learned during training and thereafter.

A third relevant discourse concerns the hidden curricular effects of positive and negative role-modelling for trainee doctors (Bombeke et al., 2010; Butani et al., 2013; Byszewski et al., 2012; McNair et al., 2016; Passi & Johnson, 2016b; Tagawa, 2016). Important to note are the ways in which my study participants’ sense-making identified these effects, based on their experiences. For example, the impacts of ‘negative’ role-modelling were captured in the following extracts from my analysis in section 4.2:

*She [the junior doctor] replied: ‘We can’t just do that [seek help for a deteriorating patient]; otherwise I will get into so much trouble from [said consultant]!* [emphasis added]

[Participant 6.2 – medical student]
He [a senior doctor] just **would not listen** and was trying to prove me wrong … trying to **show-off that he had superior skills at my expense** [emphasis added].

**[Participant 9.1 – medical student]**

*If they [doctors] are teaching [medical] students something during ward round … embarrassing us by saying ‘Oh, you don’t know the answer? Well, you’re idiots!’* [emphasis added]

**[Study participant 9.11 – medical student]**

[b]ut the consultant **contradicted her in front of everyone** … I didn’t think that he was being a very **good role-model** … [emphasis added]

**[Participant 9.6 – medical student]**

A fourth relevant discourse focuses on research attempts to link ‘capability’ with ‘specialty’ for ‘effective’ medical practice (Hojat & Zuckerman, 2008; Hojat et al., 2005; Mehmood et al., 2013); as well as for medical ‘malpractice’ (Bismark et al., 2011a, 2011b; Courtenay, 1993; Roberts et al., 2014). Mapping my findings to these attempts was inconclusive. Although some participants had linked their ‘doctor’ experiences’ to medical specialties, they did so in ways that were inconsistent with the literature. For example, my findings demonstrated mixed expressions of study participant experiences that were linked to the specialities of surgery and obstetrics. These were illustrated by the following extracts from my analysis in sections 4.1 and 4.2:
He [the surgeon] came in to see a patient out of time to discuss an operation that they were very concerned about … [emphasis added]

[Study participant 2.6 – medical educator]

He was a highly competent surgeon but he had that cold inability to just say ‘sorry’ … [emphasis added]

[Study participant 26 – senior academic]

She [the obstetrician] was extremely supportive of the woman’s wishes … she facilitated all that happened and that woman had a beautiful birth [emphasis added]

[Study participant 37 – midwife]

He [her obstetrician] kept sending [names her husband] out of the room, so you can imagine how distraught we felt … it was really horrible! [emphasis added]

[Study participant 18 – patient]

A fifth dimension that warrants comparison with my findings, in the light of initiatives related to a ‘continuum’ from medical selection to education referred to earlier (Frank et al., 2010a, 2010b), relates to challenges identified in the medical selections and education literature review (in section 2.3). Pertinent to this comparison was research related to attrition or drop-out rates (Arulampalam et al., 2007; Fortin et al., 2015; Maher et al., 2013; O’Neill et al., 2011); to a ‘failure to fail phenomenon’ (van Mook et al., 2015; Yepes-Rios et al., 2016);
and most importantly, to the consequences of selection error or failure, particularly for patients (McGurgan et al., 2010; Roach & Dorling, 2000; Patterson et al., 2014).

Although my findings are generally consistent with the predominant discourses around these difficulties, my study participants expressed them differently, based on their experiences. For example, two study participants acknowledged these dilemmas and recommended thus:

*Resources for remediation of poorly-performing students should include opportunities for alternative career pathways for students who are clearly not suitable for medicine. At the moment the stakes are so high that a ‘blanket of resistance’ against exclusion seems to take over at every level: from the university bureaucracy at the top, to the academics and clinicians in the middle; down to the families of students and finally to the students themselves [emphasis added].*

[Study participant 39 – health executive]

*We may have a brilliant student who’s passing academically and there’s no way that we can fail him; but we must have measures in place to fail students like this who are clinically weak. We should not ignore the cracks that appear during clinical assessment; because we do so at our peril when we put students ahead of patients [emphasis added].*

[Study participant 38 – private nurse practitioner]
In summary, I extended the comparison that I had made between my findings and the CanMEDS framework in the light of initiatives proposed to identify physician competencies for different stages of a medical career (Frank et al., 2010a; 2010b). With this focus in mind, I compared my findings to relevant research attempts to support selection and education of doctors to practise ‘effectively’ over the course of their medical careers. My findings concurred with attempts to link medical selection, education and career development models along a continuum. Based on the doctor experiences of my study participants, my findings mirrored discourses in the literature relating to the extent to which the capabilities required for effective medical practice could be learned or were related to temperament. This comparison was useful for informing medical selection, education and career development planning. Although mapping my findings to research that linked ‘desirable’ and ‘undesirable’ characteristics to certain medical specialties was inconclusive, the impactful ways in which capabilities were prioritised by my study participants makes some contribution to this body of research.

Overall, these comparisons were useful for underlining the contribution that my findings can make in informing medical student selection and education from a more inclusive perspective and linking ‘capabilities’ with ‘stakeholder experiences’ in unique and compelling ways.

5.3 METHODOLOGICAL CONSIDERATIONS AND LIMITATIONS

The focus of my discussion will now shift to methodological considerations, including the limitations of my project. Having compared my findings to the stakeholder-based literature, as well as to capability frameworks, a comparison between my chosen research approach and that of other attempts to inform medical student selection and education is warranted.
A fundamental difference between my study and the body of medical selections and education research, is the phenomenological hermeneutic method that I applied to explore participant experiences with doctors in a manner that could better inform how we select and train them. Only very few earlier phenomenologically-based studies could be found in this broad area related to medical school graduates’ experiences of their internships (Bearman et al., 2011); as well as to medical student and junior doctor experiences related to personal wellbeing and resilience (de Vries-Erich et al., 2016; Goodyear, 2014; Greenhill et al., 2015) No other phenomenological studies prior to mine appear to have focused on stakeholders’ experiences with doctors with the intention of informing medical selection and education.

Although stakeholder-based studies on this topic using other methodologies were noted (Butani et al., 2013; Moreau et al., 2016; Nimmon & Stenfors-Hayes, 2016; Poncelet et al., 2013; Rentmeester et al., 2007; Stewart, 2005), none of these achieved the scope of the current study in terms of its size (107 participants), range of stakeholders (health care professionals, patients, executive health and academic managers, medical educators, medical students, alternative health practitioners and health consumer representatives) or depth (IPA of richly experiential data). My study was the first to have linked the range of capabilities required for medical practice, as well as the capability deficiencies associated with ‘malpractice’, to stakeholder experiences with doctors. These capabilities and capability deficiencies were prioritised in impactful ways and from multiple perspectives.

Methodological considerations for this project focused on the planning, implementation and evaluation of my research role within the chosen framework of hermeneutics and IPA. Given the emphasis placed on the role of the
researcher in phenomenological research (Smith et al., 2009; Van Manen, 2001), it is useful to identify key elements of my role as a sole (though supervised) researcher for the project.

An early, exploratory part of my role was the essential task of reviewing the existing literature, which informed my initial research question of ‘how stakeholder perspectives of “good” doctors could inform medical selection and education’. Whilst the literature contained evidence of similar research attempts, gaps were identified related to medical selection and education models privileging certain stakeholders in their decision-making, as well as to a lack of recognition for how this decision-making had impacted on stakeholders as the ‘end-users’ of medical service delivery and on patients in particular.

Granted ethics approval, I was fortunate enough to have an opportunity to test my method in a pilot study. My role was then to design a semi-structured interview, informed by the existing literature and in consultation with experts in this data collection method. I also gained skills in planning, implementing and evaluating a semi-structured group interview that would encourage participant interaction and responses to yield the desired quality of ‘rich’ data for the main study. A key element of my role for the main study data collection stage was establishing good rapport with participants and engaging deeply with them in individual as well as group interviews, to explore their experiences with doctors.

Given the flexibility of my role, I conducted IPA in a hermeneutic cycle with selected ‘signature’ stakeholders, moving from the ‘idiographic’ (or ‘particular’) to capture the ‘essence’ of the phenomenon (the ‘doctor experience’) for all study participants (the ‘whole’). Although separately sequenced below, my research role was central to linking these elements together, referred to by
Pringle et al. (2011) as ‘the central role of the analyst in understanding the experiences of participants’ (p. 20). Key dimensions of my research role included:

- Undertaking a literature review to inform the initial research question, to identify leading scholars in the field, to identify gaps in this body of knowledge and to clarify the use of terms and abbreviations (referred to in Appendices A and B)
- Outlining semi-structured interview schedules for the pilot and main studies. The example illustrated in Appendix C evolved within a IPA method of concomitant data collection and analysis
- Devising a participant information and consent sheet, referred to in Appendix G
- Obtaining ethics approval for the pilot and main studies study, referred to in Appendices E and F
- Organising the pilot study semi-structured interview in a conference setting
- Collecting and analysing the pilot study data, which informed further development of the research question for the main study
- Initiating a coding book of field notes (extracted and referred to in Appendix D)
- Participant recruitment for the main study (referred to in Tables 1 and 2, section 3.3.3)
- Organising and conducting a further eight group interviews and 39 face-to-face interviews
- Concurrent collection and analysis of the main study data focusing on IPA for ‘signature’ stakeholders’ and the development of the data analysis structure (referred to in Table 3, section 3.3.5.2)
Outlining how my research role evolved during the course of this project is necessary for assessing how it measured up to well-established standards for conducting rigorous and robust qualitative research (Cleland, 2017; Commonwealth of Australia, 2008; Guba & Lincoln, 1989; Kafle, 2011; Morse et al., 2002; Ng et al., 2013; Tavakol & Sandars, 2014a, 2014b; ten Cate et al., 2017). In the next section I will discuss the limitations of my study and the ways in which I have attempted to address each of them.

5.3.1 Study limitations

The following sections include discussion of the limitations of the study in relation to the four key quality criteria for qualitative studies formulated by Guba and Lincoln (1989). These criteria for qualitative studies are ‘credibility’, ‘transferability’, ‘dependability’, and ‘confirmability’ (pp. 236-243).

5.3.1.1 Credibility

This criterion concerns whether my findings were a ‘true’ reflection of the doctor experiences of my study participants; described by Guba and Lincoln (1989) as ‘the match between the constructed realities of respondents (or stakeholders) and those realities as represented by the evaluator and attributed to various stakeholders’ (p. 237). Their definition was recently clarified by Korstjens and Moser (2017) as establishing ‘whether the research findings represent plausible information drawn from the participants’ original data and is a correct interpretation of that data’ (p. 2). I reviewed the credibility of my research in the light of enhancing strategies recommended by Guba and Lincoln (1989) as follows:

‘Prolonged engagement’ and ‘persistent observation’ (p. 237) (emphasis added): Combining data collection with analysis facilitated close interaction with
participants to capture the ‘essence’ of their ‘doctor experiences’. I remained immersed in the data by reading and re-reading interview transcripts and by checking participant responses directly (when possible) as well as indirectly (with interview observers and supervisors).

My choice of an IPA method facilitated a focus on the idiographic or detailed elements of individual participant experiences, evidenced by verbatim extracts in my analytical commentary. I also attempted to address these strategies by detailing how the research question had evolved as new and unanticipated data emerged.

‘Peer debriefing’ (Guba & Lincoln, 1989, p. 237) (emphasis added): I used this technique to a lesser degree, which may have limited the ‘testing out’ of my findings. With the exception of peer debriefing for my pilot study, I consulted experienced researchers, including my doctoral supervisors, on my research methods and discussion of my findings. Although this strategy supported key elements of my research role, it was not in the ‘neutral’ or ‘peer’ sense recommended by the authors (Guba & Lincoln, 1989, p. 237).

‘Negative case analysis’ (Guba & Lincoln, 1989) (emphasis added), was referred to as ‘the process of revising working hypotheses’ (p. 237), and so did not strictly apply to my phenomenological approach. However, in the process of translating the idiographic accounts to more generalised accounts of whole aspects of the phenomenon under study, the accounts of participants whose experience was at variance with the remainders were certainly considered carefully for their particular perspective on the phenomenon.

‘Progressive subjectivity’ (Guba & Lincoln, 1989, p. 238) (emphasis added): The authors linked this technique to their earlier recommendation for debriefing,
which they extended to regular self-scrutiny for any personal biases that could compromise credibility. I linked bracketing and reflexivity strategies to this criterion as they were particularly relevant to my IPA approach, particularly related to managing issues around subjectivity and personal bias. In a phenomenological context, I am confident that I was able to put aside or bracket any personal pre-understandings that might influence my interpretation of participant experiences. I utilised reflexivity by reflecting on personal ‘biases, preferences and preconceptions’ and by recognising how ‘the research relationship’ could influence participant responses (Korstjens & Moser, 2017, p. 2). For example, I disclosed and then put aside subjective perspectives resulting from my role as a health care professional and medical educator. I attempted to address any potential conflicts of interest with participants who were known to me professionally or personally, particularly if there might be seen to be power differentials in relationships with any medical student participants. I also needed to acknowledge how recruiting ‘volunteer instructional patients’ for some interviews may have affected ways in which they focused on their doctor experiences. Their motivations to volunteer for one of the local medical school programs may have biased their positive or negative expressions of these experiences, but no clear suggestions of such bias were evident on close examination of their transcripts.

I also needed to acknowledge how recruiting ‘volunteer instructional patients’ for some interviews may have affected ways in which they focused on their doctor experiences. Their motivations to volunteer for one of the local medical school programs may have shaped their positive or negative expressions of these experiences and the reader should bear this possibility in mind.
For example, of the 15 ‘volunteer’ patients recruited for two group interviews (allocated numbers 4 and 5), the transcript of one patient (referred to as ‘participant 5.4’) yielded deeply experiential data that focused on her childbirth experience with a doctor many years previous to my study that was evidently unrelated to her contemporary volunteer patient role though, of course, it is possible that the experience may have influenced her decision to undertake this work. Under a phenomenological framework, participants were recruited on the basis of their having experienced the phenomenon under investigation and being able to articulate that experience rather than with any attempt at ‘representativeness’.

A further limitation was created by my decision to exclude participants aged less than 18 years of age as members of this group. People less than 18 years of age are considered to be ‘minors’ under Australian legislation and consequently, recruiting participants younger than 18 years of age would have required special arrangements that would have substantially increased the challenge of this research. For example, interviewing minors raises the potential for issues arising that would have required independent reporting to medical authorities. In order to manage the demand of what was already an ambitious research project, these potential participants were excluded. However, future research would benefit from specifically interviewing minors to extend upon the findings reported here.

My study did not entirely measure up to the emphasis placed on ‘member checks’ (emphasis added) as ‘the single most crucial technique for establishing credibility’ (Guba & Lincoln, 1989, p. 239). This was partly due to time constraints for participants (particularly those who were working or studying fulltime) as well as to my being the sole researcher for a large-scale project.
Collecting and analysing data from 39 individual and nine group interviews was time-and-labour intensive, which posed limitations on meeting the highest standards for member checking (Cleland, 2017; Ng et al., 2013; Pini, 2017; Ringsted et al., 2011; Tavakol & Sandars, 2014b) and triangulation (Barbour & Barbour, 2003; Cleland, 2017; Ng et al., 2013; Pini, 2017; Ringsted et al., 2011). I attempted to mitigate this concern by inviting post-interview responses from participants, which were checked against transcriptions. Two group interviews were co-facilitated by my doctoral supervisors and transcriptions were checked with them when direct participant verification proved difficult.

Guba and Lincoln (1989) viewed member checking and triangulation as separate activities. However the credibility of my study was enhanced by employing triangulation techniques, as argued by Korstjens and Moser (2017). In this case, triangulation included ‘data triangulation (by using multiple data sources in time, place and person)’; ‘investigator triangulation’ (by consulting experts and doctoral supervisors on coding and IPA decisions); and ‘method triangulation’ (by using multiple methods of data collection) (p. 2). I undertook focused activities such as field notations to facilitate reflection and persistent observation for each of the 39 face-to-face and nine group interviews, as well as prolonged engagement with each transcript.

Further attempts to optimise the credibility of my findings included demonstrating transparency for each of my research steps. Transparency was demonstrated in field notes (including field coding for the initial organisation of data) and in engagement with participants, supervisors, colleagues and peers as well as in the management of scarce resources such as time and money for undertaking the project (Clancy, 2013; Hefferon & Gil-Rodriguez, 2011; Larkin, 2013; O’Brien et al., 2014; Pini, 2017; Reid et al., 2005; Smith, 2011; ten Cate
et al., 2017). Additional evidence of ‘being transparent’ included being accountable, for example, complying with doctoral candidature and ethics approval requirements. The latter was evidenced by my attempts to build respectful relationships with participants that included ensuring anonymity, being open about potential conflicts of interest and exercising beneficence (Alexandra & Miller, 2009; Bouma, 1996; Cohen et al., 2007; Guba & Lincoln, 1989; Kafle, 2011; Lindseth & Norberg, 2004; Neuman, 2011; Silverman, 2011; Starks & Brown-Trinidad, 2007; Tavakol & Sandars, 2014b; ten Cate et al., 2017).

5.3.1.2 Transferability

This criterion was defined as ‘the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents’ (Korstjens & Moser, 2017, p. 2). According to Guba and Lincoln (1989), the major technique for establishing the degree of transferability is ‘thick description’ (p. 241), which I demonstrated by weaving rich text through my analytical commentary in sections 4.1 and 4.2. The ‘essence’ of the doctor experience phenomenon was captured in ways that were meaningful to outsiders and that facilitated engagement with stakeholders around other phenomena.

My findings resonated with other stakeholder-led research, for example IPA projects that have informed health care delivery decisions in England (Harris, 2015). In addition, I attempted to satisfy a ‘transferability judgement’ (Korstjens & Moser, 2017, p. 3) by outlining my research steps in ways that others could follow for conducting similar projects. I detailed these steps in the methods section (3.3) by outlining the settings as well as sampling and recruitment methods for the pilot and main studies. The semi-structured interview process
was detailed for face-to-face as well as for group interviews, with an interview schedule excerpt provided in Appendix C.

The evolution of the research question was guided by the literature and detailed in section 3.3.2 as part of an iterative IPA process to yield rich accounts of participant experiences with doctors. One potential limitation related to keeping my literature review current, given the protracted duration of my project and the large volume of research on my topic. I attempted to keep abreast with scholarly developments in these areas by accessing published research through online journals and by participating in conferences and forums. One further limitation was posed by the larger than recommended size of my study sample for an IPA project. I attempted to mitigate this by demonstrating the merits of exploring the ‘doctor experience’ phenomenon from diverse and multiple stakeholder perspectives. For example, data saturation was reached when truly novel stakeholder experiences were no longer emerging from the 39 face-to-face and nine group interviews (detailed in section 3.3.4).

5.3.1.3 Dependability

The dependability criterion is focused on ‘the stability of the data over time’ (Guba & Lincoln, 1989, p. 243), which can be compared to ‘reliability’ judgments for quantitative research. My research, therefore, needed to reflect sound methodological decisions that could be tracked via an audit trail. One possible limitation relating to this strategy was that the ‘doctor experience’ phenomenon on which I was focused might have changed over time, given the influence of changing health care needs on the range of capabilities required for effective medical practice. I attempted to mitigate this by mapping my findings to evidence for capabilities that have been shown to have remained ‘stable’ over time, such as ‘genuine caring’ and ‘communication’ (evidenced in sections 4.1.1 and 5.1.1).
Another possible limitation on my study’s ‘dependability’ relates to the shift in focus of my research question as new and unanticipated data began to emerge from participants’ experiences with doctors. I attempted to address these concerns by compiling field notes and by documenting consultation outcomes with experienced researchers, including my doctoral supervisors. By documenting ‘the logic of process and method decisions’ that the authors referred to as ‘the dependability audit’ (Guba & Lincoln, 1989, p. 242), it is my belief that my project is likely to stand up to public scrutiny.

5.3.1.4 Confirmability

Guba and Lincoln (1989) linked the techniques required for a successful ‘dependability audit’ to those required for a ‘confirmability’ audit (p. 243). Where these authors had equated ‘dependability’ to ‘reliability’ in the previous section, they equated ‘confirmability’ to the ‘objectivity’ criterion for quantitative research. For Korstjens and Moser (2017), ‘dependability’ inferred ‘consistency’ (with research standards) whilst confirmability inferred ‘neutrality’ (by securing ‘the inter-subjectivity of the data’) (p. 3).

Similar to the steps outlined for meeting ‘dependability’ audit requirements in section 5.3.1.3, I added further steps to those outlined for establishing the credibility of my project in section 5.3.1.1. Of particular relevance was evidencing ways in which I had practiced bracketing, reflexivity and transparency. The latter was emphasised by Korstjens and Moser (2017) to ‘enable the auditor to study the transparency of the research path’ (p. 2).

This principle of confirmability is strategically aligned with that of reflexivity, which was highly relevant for my research role (Clancy, 2013). It required self-awareness and self-examination to acknowledge the potential influence of my
professional role-identity and years of medical education experience on my study participants and my analysis. For example, medical student participants took up my offers to use pseudonyms and I exercised transparency and respect around any potential conflicts of interest to defend the trustworthiness of my results. Equally significant for my research role was to balance reflexivity with bracketing, which required me to put aside (or ‘bracket’) any preconceptions that could affect my interpretation of participants’ doctor experiences. This strategy was particularly relevant for IPA that required me to remain close to, and fully immersed in the data. The principles of bracketing and reflexivity also relate to how I demonstrated ‘saturation’ within my phenomenological framework, where my role required me to be fully immersed in the ‘phenomenon’ of a participant’s doctor experience. As alluded to in section 3.3.3, saturation for my study was achieved when no new interpretations were emerging from stakeholder interviews.

On one hand, I achieved ‘confirmability’ by demonstrating that my findings were an accurate reflection of the data by, for example, weaving raw extracts into my analytical commentary in sections 4.1 and 4.2. On the other hand, my study’s ‘confirmability’ was potentially compromised by limited opportunities to check data with study participants or other researchers. I attempted to address these concerns by keeping a research diary, compiling field notes and documenting decision-making processes and outcomes with research experts, including doctoral supervisors. Journaling was particularly important as unanticipated data emerged to change the focus of the initial research question. Data checking was undertaken with participants and my PhD supervisors when possible. Enlisting colleague and PhD supervisor assistance for three of the
project’s nine group interviews facilitated immediate data checking and peer
debriefing for group interviews numbered 1 (pilot study) 2 and 3 (main study).

In addition to assessing how my study might measure up to the criteria
identified thus far (credibility, transferability, dependability and confirmability),
two further methodological considerations warranted further explanation:

The first methodological consideration relates to whether I might have
undertaken formal ‘between group’ comparisons of the experiences of the
different participant groups in my study. This consideration emerged early in
discussion with my research supervisors that led to the selection of the
analytical methodology. The objective of a phenomenological analysis is to
capture the essence of a phenomenon (in my case the practice of good and,
ultimately, bad doctors) through description and interpretation of the
experiences of multiple informants whose accounts provide different lenses on
its nature. Each account is first examined idiographically and then the different
experiences are utilised to triangulate an understanding of the phenomenon
under study. My novel modification to Smith’s interpretative phenomenological
analysis (IPA) to accommodate the large volume of data, focused on first
identifying a ‘signature stakeholder’ for each unit of meaning and then exploring
similar experiences identified by ‘supporting stakeholders’. This was also
purposefully developed to hold true to the nature of the phenomenological
approach. ‘Between-group’ comparisons at the analytical stage would have
been fundamentally at variance with this paradigm and were also judged not to
be critical to answering the research question. For these reasons they were not
undertaken.
The second methodological consideration relates to possible criticism that some of my participant experiences are now historical, although they have clearly had a profound and enduring effect on their lives. Negatively evaluated doctor experiences focused on historical events around childbirth (four participants); surgical procedures (six participants) and other diverse clinical encounters (16 participants). In spite of the time that had elapsed for these participants, my findings remain valuable as they underline the potential life-long impact of negatively evaluated experiences with doctors. It is acknowledged, however, that measures have been adopted in many settings in the interim to curb some of the excesses reported by my study participants.

In summary, methodological considerations for my research role outline strengths as well as limitations for the study. My strategies were measured against key criteria for establishing the ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’ of my findings (Guba & Lincoln, 1989). I demonstrated ‘credibility’ by prolonged engagement and persistent observation with participants and by triangulating my data with secondary data sources, as well as in shared decision-making. My study findings were ‘transferable’, having yielded sufficiently rich descriptions for researchers to conduct similar stakeholder-led research in other settings. Demonstrating a transparent and plausible research path that would give stability to my findings over time infers that my project was ‘dependable’. Whilst I satisfied requirements to balance bracketing with reflexivity to eliminate bias, the confirmability of my project was threatened by not being able to undertake member checking with all of the 14 pilot study and 107 main study participants. I mitigated these threats to some degree by undertaking data checks with participants who responded to post-interview communication as well as with PhD supervisors when possible.
To sum up, comparing the results of my research to stakeholder-based literature as well as to capability frameworks for effective medical practice was critical for supporting my claim to have added to the existing body of medical selections and education research. Although my findings identified capabilities that were already found in the range proposed for effective medical practice in the literature, they provided new information on which capabilities should be prioritised if medical selection and education is to fulfil its ultimate target of safe and effective patient care. This evidence is derived from the novel ways in which capabilities such as patient-centredness, communication, professionalism and safety were prioritised by my participants from multiple and diverse perspectives. My study also provides rich examples to inform selectors, educators and learners of how these key capabilities may be enacted in practice. However, the confirmability of my results could have been checked more closely with my study participants, had time and their availability allowed. It is also important to note that stakeholders in my study focused on their experiences with doctors who had already qualified as generalists and specialists. On one hand, this may have limited the scope of my study, yet on the other it was useful for informing not only the range of capabilities for which to prioritise in selecting and graduating doctors, but those that would be valued in effective medical practice over the longer term. Despite these limitations, the ways in which I have attempted to inform medical selection and education complements previous research that has privileged the viewpoints of selected stakeholders and focused on how, rather than for what to select and educate future doctors.

The final chapter will summarise the ways in which my study has contributed to the existing body of medical selection and education research, including
recommendations for informing future medical selection and education models and key implications for further research and practice.
CHAPTER 6 SUMMARY, RECOMMENDATIONS, FUTURE RESEARCH AND CONCLUSIONS

6.1 SUMMARY

The existing body of medical selection and education research is broad and complex. Although there is some agreement over ‘competency based’ medical education models, discourses in the medical selections literature remain divided. My exploration of this research revealed gaps related to the involvement of less privileged stakeholders in medical student selection and education decision-making and relatively limited evidence to support *for what* medical schools should be selecting and educating in order to graduate ‘capable’ doctors. My aim was, therefore, to focus on exploring this range of ‘doctor capabilities’ from a more inclusive and diverse stakeholder perspective.

Within an IPA framework, this exploration deepened, refining the focus of my research question towards a detailed analysis of how stakeholders had made sense of their experiences with doctors and what this could tell us about the doctor capabilities they most valued. The meanings they had drawn from these experiences, some of which were positively and some negatively evaluated were then compared with prior stakeholder-based research and with ‘capability frameworks’ for medicine. In spite of its limitations, my research addressed the gaps that had been identified by linking the meaning stakeholders had made from their experiences with doctors, to ‘capabilities’ in unique ways and from multiple perspectives. My findings add to the existing body of medical selections and education research by prioritising ‘capabilities’ from a unique, stakeholder-led perspective. Although the range of capabilities identified was not new to the literature, the unique and compelling ways in which ‘patient-centredness’, ‘communication’, ‘professionalism’ and ‘safety’ were prioritised in the meanings
derived from my stakeholders’ experiences, are critical for informing for what range of capabilities we should prioritise our selection and education efforts. The ways in which these capabilities were prioritised by my participants are also critical for informing how doctors are selected and educated for increasingly diverse career pathways.

The graphic in **Figure 3** below, summarises my project in four circular quadrants to illustrate the aims, methods, findings and implications in a circular pattern that captures the ‘essence’ of a positive doctor-patient encounter at the centre of the graphic.

The first quadrant in **Figure 3** below illustrates the aim of the project, which was to address the research question of *How can the experiences of stakeholders with doctors inform medical selection and education?* My literature review, which is outlined in sections 2.1 to 2.6 of chapter 2, was useful for informing the research question. The research question evolved and was refined during the course of the data collection and analysis phases of the pilot study (outlined in section 3.3.1 of chapter 3) and the main study (outlined in sections 3.3.2 to 3.3.5 of chapter 3).

The second quadrant in **Figure 3** below illustrates the method of the study within an IPA paradigm, including the time frame for the 8 group and 39 individual semi-structured interviews conducted as part of the main study. Participant recruitment for the semi-structured interviews for the main study is outlined in chapter 3 (section 3.3.3) and summarised in Tables 1 and 2.

The third quadrant in **Figure 3** below illustrates the findings of the main study, summarised as two phenomenological themes of the positively and negatively evaluated doctor experiences of my study participants. These findings are
outlined in chapter 4 (sections 4.1, 4.2 and 4.3) and are summarised in Table 3. A discussion of the findings follows in chapter 5, which includes comparisons with the stakeholder-based literature as well as with key capability frameworks. The latter comparison is summarised in Table 4.

The fourth quadrant in Figure 3 below summarises some preliminary research implications for better informing future medical selection and education. These are expanded upon in section 6.3 of this chapter.
FIGURE 3. Graphic representation of this project

How can the experiences of stakeholders with doctors inform medical selection and education?
6.2 RECOMMENDATIONS

My initial recommendations are outlined in the context of my research findings of the positively- and negatively-evaluated doctor experiences of multiple stakeholders. Subsequent recommendations are outlined in the context my contribution to the existing body of medical selection and education research.

6.2.1 Harmonise capabilities prioritised by medical schools with those of the communities they serve, particularly patients

My research findings, summarised in Table 3 (section 3.3.5.2), show that participants prioritised doctors who were ‘patient-centred’ (with an emphasis on ‘patient safety’, ‘showing genuine concern’ and ‘combining competence with caring’); as well as those who were ‘good communicators’ (with an emphasis on ‘being a good listener’, allowing sufficient time’ and ‘being respectful’).

When compared with other stakeholder-based research in the medical selections literature (in section 5.1) and with capability frameworks (in section 5.2), my findings support a scholarly focus on patient-centred models of medical selection and education, including improved ways of assessing and developing communication skills. However, my findings deepened our understanding of what doctors ‘being patient-centred’ and ‘good communicators’ had really meant for diverse stakeholders in diverse settings. Medical schools, therefore, need to prioritise this area of capability, in all of its complexity and diversity in order to provide good outcomes for doctors, for universities, for the profession and most importantly for patients. This strategy calls for shared decision-making between universities, the profession and communities and renewed commitments to resolve conflicted expectations.
Ways in which the meanings made by the stakeholders in my research prioritised the range of ‘desirable’ capabilities for already qualified doctors, support longer-term visions for medical selection and education. The need to design, implement and evaluate selection and training systems along a continuum, similar to that proposed by Patterson et al. (2016a) and outlined in Figure 1 (section 2.3.5) provides one example. Such a ‘continuum approach’ should be extended to a more seamless process that prioritises the graduation of ‘patient-centred’ doctors alongside ‘student-centred’ learning and desired outcomes for universities as well as the profession.

In a broader sense, recommendations to prioritise the needs of communities alongside those of universities and the profession align with calls to increase the social accountability of medical schools (Reeve et al., 2016). For example, the consensus statement and recommendations from the Ottawa 2010 Conference on the Assessment of Competence in Medicine and the Healthcare Professions recommended that:

The social accountability mandate of medical and health professional schools demands that social inclusion, workforce issues and widening of access are embedded in the principles of good assessment for selection.

(Prideaux et al., 2011, p. 215)

These scholarly recommendations resonate strongly with the results of my stakeholder-focused research, as does Patterson’s (2012) recommendation for changes that are ‘consistent with well-established patient expectations, have political backing, and are seen by doctors to be fair, proportionate and workable’ (p. 110).
Furthermore, the ways in which my research links positively-evaluated stakeholder experiences to the prioritisation of a particular range of ‘patient-centred’ capabilities for doctors, can inform such social accountability initiatives. These include transforming current medical education models (often labelled as paternalistic) to those that are more patient-and family-centred (Moreau et al., 2016); as well as ‘optimising patient outcomes in the face of changing health landscapes’ (McColl, 2010). Equally, my findings align with recent recommendations to connect the ‘social missions’ of medical schools to medical selection models, as argued by Ellaway et al.:

… more equity and inclusion in terms of the voices that are being heard … the perspectives of applicants and the communities they come from need to be heard, as do the voices of those whose unmet healthcare needs depend on who is admitted to medical school.

(Ellaway et al., 2017, p. 5)

Based on the evidence from my research, while it remains important to focus upon the how of selection, the primary emphasis should be towards what range of capabilities doctors require in order to practice effectively in ‘healthy’ doctor-patient relationships over the course of their medical careers. For the stakeholders in my research, key elements of ‘healthy’ doctor-patient relationships focused on doctors who practised safely, who showed genuine concern, who combined competence with caring, who were good listeners, who spent time with them and who were respectful. In the light of these findings, medical selectors and educators need to prioritise strategies that optimise patient-student encounters in a variety of clinical settings.
The ways in which my study participants prioritised a range of ‘desirable’ capabilities can be linked to broader recommendations for improvements in medical service delivery. For example, advocates for ‘humanism’ in the ‘art versus the science of medicine’ debate claim that, when doctors spend more time with their patients, the costs of health care delivery decrease (University of California, 2004). The need for a shift in focus, evidenced by the ways in which my study participants prioritised particular capabilities for doctors at various stages of their careers, is mirrored in the following recommendation from Patterson et al. (2016a):

*It is clear that indicators of competence for entrance to medical training and practice are likely to be different at different points in a medical career … This requires a clearer, theoretically relevant taxonomy of desirable outcomes which might range from academically oriented variables such as examination performance, through to variables relating to clinical practice and job performance indicators as judged by supervisors, peers and, ideally, patients … Hence, there is a need for more theoretically driven, future-oriented research aimed at identifying what a ‘competent’ physician is at the various stages of training and practice.*

(p. 49)

6.2.2 **Reconcile priorities of medical schools and the profession to mitigate the risks of ‘unprofessional’ and ‘unsafe’ medical practice, with those of the communities they serve, particularly patients**

With reference to my table of findings (Table 3, section 3.3.5.2), the negatively-evaluated doctor experiences of my study participants were made sense of as doctors ‘being unprofessional’ and ‘compromising their own safety as well as that of others’. These findings deepen our understanding of what doctors ‘being
unprofessional’ and ‘unsafe’ means, based on ‘real’ experiences with doctors in diverse settings. In contrast to the healthy stakeholder-doctor relationships evidenced in my study participants’ positively evaluated experiences, these negatively-evaluated accounts highlighted disrupted stakeholder-doctor relationships. Although attempts to address unprofessional and unsafe medical practice were apparent in the stakeholder-based literature, my research contributes to this body of knowledge from unique and multiple perspectives.

Although my study participant experiences focused on qualified doctors, my research offers an insight into the consequences of selecting and graduating doctors who lack the capacities to develop and maintain safe and professional practice over the course of their careers. In the light of these findings, medical schools should ensure that strategies to manage professionalism and safety issues are transparent, are in line with professional standards and can stand up to public scrutiny. Facilitating professional and safe medical practice requires reconciling university policies that tend to have a bias towards the benefit of students, with professional codes of conduct for doctors designed to protect all stakeholders, particularly patients (Alldridge et al., 2014; Hays et al., 2013; Hays & Worthington, 2012).

Given my research approach to linking ‘capabilities’ for ‘effective medical practice’ with the meaning made from ‘doctor experiences’, the unsought but informative evidence that emerged around ‘medical malpractice’ supports further recommendations for selecting and graduating ‘safe’ and ‘professional’ medical practitioners. Recommendations for practice embrace the following key elements:
(a) Assessment frameworks should address what scholars have referred to as ‘the failure-to-fail’ phenomenon, such as proposals to promote professionalism through learning, teaching and assessment (van Mook et al., 2015). My findings also support further recommendations to address issues related to clinical inertia by developing remediation and monitoring frameworks and by identifying barriers to and enablers for, attrition and failure rates (Yepes-Rios et al., 2016). Of significance is these authors’ acknowledgement that:

*Since no admissions system is perfect, it stands to reason that there will be trainees who will fail to meet expectations or standards of competency. Institutions can support assessors by offering faculty development aimed at preparing assessors for the inevitability of failing a student.*

(Yepes-Rios et al., 2016, p. 1097)

My findings align with recommendations from another IPA-based study that investigated ‘the complexity surrounding the failure experience from the student's perspective … to inform medical school remediation programmes’ (Patel et al., 2015, p. 9). Together, these two phenomenological studies may be usefully employed to inform the development of approaches that remediate students where possible, but in the end also ensure that they do not graduate without the key capabilities that stakeholders prioritise in the ‘good doctor’.

(b) A culture of respect and safety should be fostered and embedded in both the formal and informal curricula of medical schools (Doja et al., 2016; Ojuka et al., 2016; Park et al., 2017). Such a culture will partly address my study participants’ experiences of doctors being ‘disrespectful’ and
‘unsafe’. Stakeholder-based research evidence, which identified these as key elements for role-modelling strategies, aligns with this recommendation. For example, whilst medical students in a study by Byszewski et al. (2012) identified role-modelling as the single most important aspect of professionalism, Hays et al. (2013) advocated role-modelling as a powerful medium for teaching professionalism. These recommendations are more relevant to medical education reforms, given the limitations of assessing professionalism at the initial stages of the selection-education continuum, referred to earlier in section 6.2.1.

Further evidence-based strategies for medical educators to create opportunities for positive doctor role-modelling focus on the formation of a medical role-identity, particularly when transitioning from 'student' to 'doctor' (Passi & Johnson, 2016a, 2016b; Shapiro et al., 2016b). The evidence for these recommendations is strengthened by parallels between my findings and recent evidence of poor role-modelling for medical students, signalling the need for a more student-centred medical education culture (Scott et al., 2015). These positive role-modelling strategies were recently endorsed by Tagawa (2016), whose stakeholder-based research emphasised the value of positive role-modelling, claiming that ‘physicians develop an identity of “self” – starting with the student selection process, and that the overall process of medical education is important for their moral training’ (p. 8).

(c) Training programs should focus on increasing students’ critical reflective capacity, which has been identified as another key element for
developing more student-centred medical education models (Balint Society of Australia & New Zealand, 2016; Lelorain et al., 2013; Maxwell, 2012; Rogers et al., 2018; Shapiro et al., 2016a, 2016b; Young, 2010). This recommendation is supported by my findings of ‘doctors being patient-centred’ to link student-centred to more patient-centred approaches. For example, reflection was claimed to be ‘critical to the humanistic delivery of patient care’ (Simpkin et al., 2017, p. 433), whilst there was strong evidence to link reflective writing skills to other (hidden curricular) benefits such as increases in empathy, emotional intelligence and resilience (Eley & Stallman, 2014; Hancock et al., 2015; O’Callaghan, 2013; Shapiro et al., 2016a, 2016b; Smajdor et al., 2011; Tempski et al., 2012; Weng et al., 2008; Winston et al., 2010).

In the light of recommendations to foster positive role-modelling for trainee doctors, the ways in which poor role-modelling was evidenced in the negatively-evaluated experiences of medical student participants in my study, highlights an unresolved challenge for medical educators. My findings, therefore, support recommendations for medical educators to develop student-centred models of learning, alongside recommendations to strengthen patient-centred medical education selection and education models (emphasised earlier). For example, Stewart (2005), who recommended thus:

*Just as the doctor does not abdicate his or her expert role when attending to the patient’s voice, the teacher of medical students and trainees does not have to abdicate the role as teacher to listen more to the student’s voice, enter more the student’s world.*

(p. 800)
6.2.3 **Strengthen the focus on diversity in medical selection and education decision-making**

Equally important for informing stakeholder-led changes to medical selection and education were the key elements of diversity that were central to my research. Diversity was evidenced in my study’s broad participant pool, as well as in the diverse clinical settings and doctor profiles that contextualised participant experiences. This focus on diversity was important for informing the selection and education of doctors whose career profiles reflect population health care needs. In this way, my research adds to recommendations for medical schools to increase the diversity of their doctor applicant pools to match more closely those of the communities they serve. These recommendations relate to workforce planning initiatives (Gorman, 2017; Hudson et al., 2017; Murray & Wilson, 2017; Tiffin, 2017), as well as to strategies for increasing diversity and widening participation (Patterson & Price, 2017).

Recommendations to increase the exposure of trainee doctors to diverse clinical settings highlight the need to strengthen continuity between the admissions and subsequent learning and assessment stages of medical curricula. Although such recommendations are evident in medical selection and education discourses, they remain divided and ambiguous. Shared decision-making and increased collaboration within as well as between medical schools, is therefore required to strengthen the nexus between medical selection and education models.

6.2.4 **Strengthen the commitment of medical schools to workforce planning initiatives**

Given that medicine is a vocation like any other, the implications for future medical selection and education research and practice are significant.
Embedding workforce planning principles in medical selection and education models will address many of the problems typified by some of my participants’ negative experiences that may well result, at least in part, from traditional competitive and exclusive processes. This might also facilitate increased congruence between ‘input’ (students selected) and ‘output’ (vocationally suitable doctors graduated). Medical selectors and educators will, therefore, need to change their focus from short-term goals for medical student assessment performance to longer-term goals for patient-and-community-centred medical service delivery.

My findings also endorse recommendations to focus on diversity, widening access and realistic job preview for the initial phase of the medical selection process (Patterson et al., 2016a). Linked to these recommendations is increasing evidence to support proposals for medical selection centres where selection techniques are administered in combination to increase the predictive validity for the career performance of doctors rather than for the academic performance of students (Medical Schools Council, 2014a; Morrison, 2016; Patterson & Ferguson, 2012; Patterson et al., 2014; Sladek et al., 2016; Tiffin, 2017).

6.2.5 **Increased recognition by medical schools of the interplay between a candidate’s temperamental capabilities and those that are mutable for long-term, effective medical practice**

A further recommended strategy is for medical selectors and educators to focus on key elements prioritised for ‘patient-centredness’ and ‘good communication’ to seek consensus over selecting and graduating doctors who have the capacity to develop these capabilities. For example, recent stakeholder-based research evidence supports the value of empathy skills training (Wündrich et al., 2017).
and of promoting diversity amongst medical students in order to serve increasingly diverse populations (Mushtaq & Ratneswaran, 2015; Simmenroth-Nayda & Gorlich, 2015; Smajdor et al., 2011). The ways in which my study participants prioritised doctors ‘being good communicators’ were equally important for improving strategies to select and graduate doctors who communicate effectively in changing health care environments (Bombeke et al., 2010; Casey et al., 2014; Jeffrey, 2016).

Important for implementing this recommendation will be collaborative research efforts between medical selectors and educators to prioritise capabilities required upon entry, followed by shared strategies for supporting medical students’ capacities to develop capabilities required for effective, long-term medical practice. For example, my findings supported research-based attempts that had focused on doctor empathy to inform medical selection, education and subsequent medical practice. These included attempts to measure and to monitor predictors for empathy in medical selection and education models (Hojat, 2007, 2014; Hojat et al., 2002, 2005, 2013; Lim et al., 2016; Pedersen, 2009); as well as to identify and to address potentially negative hidden curricular effects on empathic doctor-patient relationships (Hegazi & Wilson, 2013; Hojat et al., 2004, 2009; Roff, 2015; Singh, 2005) and/or burnout (Hojat et al., 2015; Yuguero et al., 2016).

Important to these recommendations is Pederson’s (2009) call for more qualitative research that explores physician and patient experiences of empathy, particularly the context in which it is developed and practiced; as well as evidence for selecting and graduating doctors who can demonstrate emotional intelligence (Cherry et al., 2014; Johnson, 2015; Yen et al., 2011; Weng et al., 2008) and have sufficient resilience to manage the increasing
demands of medical training and practice (Greenhill et al., 2015; Ludwig, 2015; Dhingra, 2015; Van Dijk et al., 2017). Medical schools should consider applying interventions that have been shown to build resilience and increase empathy, such as mindfulness training (Krasner, 2009; Humphreys & Chan, 2017).

Overall, I have proposed a series of recommendations to improve the selection and education of future doctors, based on my research findings. These recommendations are supported to some extent by other contemporary medical selection, education and stakeholder-based literature, but differ in that they propose a prioritisation of particular areas of capability as the targets of selection and education. What sets my study apart from much of the literature is identifying a range of capabilities for enduring medical practice that is grounded in ‘real-life’ doctor experiences. My findings also provide rich examples to help selectors, educators and students to understand and operationalise these key capabilities in practice, both when they are present and when they are deficient. The ‘real-life’ doctor experiences of my study participants would be valuable for informing scenarios for selection SJTs and MMIs as well as for communication skills and case-based learning (CBLs) in medical school curricula.

My research findings offer a unique contribution to scholarly attempts to better inform medical student selection and education. These recommendations include strategies to reconcile priorities of medical schools to select and graduate doctors who are ‘patient-centred’ and ‘good communicators’ with those of the communities they serve, particularly patients; as well as strategies to reconcile priorities of medical schools and the profession to mitigate the risks of ‘unprofessional’ and ‘unsafe’ medical practice, particularly to patients. Furthermore, my research findings support evidence-based recommendations to increase diversity and widen access and participation, to strengthen
workforce planning initiatives and to increase consensus over determining which capabilities need to be assessed on admission or can be acquired before and beyond graduation. Although achieving consensus over the ‘nature versus nurture’ debate may be difficult, medical schools should strengthen attempts to address both approaches.

6.3 IMPLICATIONS FOR FUTURE RESEARCH

My research findings have important implications for future medical selection and education research. The unique and compelling ways in which hidden curricula effects were evidenced in my findings (for example, medical student experiences that focused on disrupted learning in clinical environments, as well as on poor doctor role-modelling) highlight the need for more research in this area to safeguard the wellbeing of students and ultimately of patients. A concerted research effort is, therefore, required to identify difficulties faced by medical students in today’s learning and clinical environments. Research that can identify such complexities and disparities is critical for informing medical student selection and education programs and for raising awareness of these issues.

Furthermore, the negative ways in which stakeholders in my research had been impacted by experiences to which they ascribed the meanings of doctors ‘being unprofessional’ and ‘unsafe’ appear to evidence instances of selection error and failure (explored as part of the medical selections literature review in section 2.3.3). My findings supported the need for further research to address some of these issues. For example, predictions that unsuitable students are likely to become unsuitable doctors (in section 2.3.5 of the earlier literature review), align with repetitive patterns of doctors ‘being unprofessional’ and unsafe’ in my analytical commentary (in section 4.2).
Although my findings are unable to inform judgements about the extent to which valued capabilities are ‘trainable’ or are related to temperament, the results clearly indicate the need to address this question. For example, calls for a paradigm shift from a traditional focus on ‘selecting in’ for positive doctor attributes to ‘selecting out’ candidates who could potentially harm patients (Powis, 2015) may have merit. The selections paradigm outlined in Figure 1 (section 2.3.5) supports this recommendation by identifying ‘selecting in’ and ‘selecting out’ strategies for the ‘pre-selection or screening stage of a selections process or continuum’ (Patterson et al., 2014, p. 52). These recommendations are aligned with medical workforce initiatives proposed earlier, particularly in relation to selecting and educating doctors for community-based outcomes. The following caution, therefore, has important implications for future selection research and practice:

*Selecting the wrong person for a job can have serious consequences for an organisation, the employee involved and, perhaps of most importance in medicine, the patient.*

(Patterson et al., 2014, p. 404)

Implications for future research are aimed at optimising outcomes for medical schools, for universities, for the profession and most importantly, for patients. It is important for future research to consider the utility of IPA-based studies to drive changes to medical practice delivery from broader stakeholder perspectives. My study highlights the need for more stakeholder-led research to better inform the selection and education not only of doctors, but of all future health care professionals.
Taking the limitations of my research into account, it offers a catalyst for changes to the scale of future IPA-based research, which would give a stronger voice to stakeholders in the medical selection and education decision-making process.

Although an increasing recognition for more qualitative-based research in this area is encouraging, qualitative studies remain lacking yet crucial to increasing our understanding of the complexities surrounding medical student selection and education.

6.4 **CONCLUSIONS**

My study has contributed to the existing body of medical student selection and education research in three ways. Firstly, by using a qualitative phenomenological approach to link stakeholder experiences with doctors to a range of capabilities (and absence of capabilities) in ways not previously evidenced in the literature. Secondly, whilst acknowledging that attempts to better inform medical student selection and education have involved stakeholders and identified such capabilities, my study involved stakeholders on a greater and more inclusive scale than could be found in the literature and analysed their experiences more deeply. Thirdly, the range of capabilities identified for enduring and effective medical practice was prioritised differently by my study stakeholders, contextualised not only by their unique experiences with doctors, but also by their relatively marginalised positions in medical student selection and education decision-making. This third contribution is particularly valuable for giving a voice to those most affected by medical practice and malpractice, which has implications for changing traditional medical selection and education approaches that may have favoured more privileged perspectives. This study is significant because it recruited a large
number of diverse participants whose shared doctor experiences carry powerful messages for catalysing medical selection and education changes on a global scale. It offers a valuable contribution to the body of medical selection and education research in that it is committed to optimising outcomes for universities, for the profession, for medical graduates and for the communities they serve.

My research offers a way forward for listening more closely to stakeholders at all levels of medicine, from selecting students, through the process of medical education to effective and long term medical practice. This research matters as it gives a voice to a broad representation of people, particularly to patients, who are the most affected by medical practice and malpractice.
APPENDICES

A. GLOSSARY OF TERMS
B. ABBREVIATIONS
C. SEMI-STRUCTURED INTERVIEW SCHEDULE (FINAL VERSION)
D. EXTRACT FROM CODING BOOK FIELD NOTES
E. ETHICS APPROVAL FOR PILOT STUDY
F. ETHICS APPROVAL FOR MAIN STUDY
G. PARTICIPANT INTERVIEW INFORMATION SHEET
<table>
<thead>
<tr>
<th><strong>GLOSSARY OF TERMS</strong></th>
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<tbody>
<tr>
<td><strong>Academic dishonesty</strong></td>
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<td><strong>A Level</strong></td>
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<tr>
<td><strong>Agreeableness (Big Five)</strong></td>
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<td><strong>Altruism</strong></td>
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<td><strong>At risk behaviour</strong></td>
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<tr>
<td><strong>Attitude–Social Influence–Self-Efficacy (ASE)</strong></td>
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<tr>
<td><strong>Autobiographical Screening Tool (ABS)</strong></td>
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<td><strong>Balint Group</strong></td>
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<td><strong>Behaviour</strong></td>
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<td><strong>Beneficence</strong></td>
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<td><strong>Benevolence</strong></td>
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<td><strong>Big Five</strong></td>
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<tr>
<td><strong>Bracketing (Husserl)</strong></td>
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<td><strong>Budner scale</strong></td>
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<td><strong>Burnout</strong></td>
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</tbody>
</table>
Computer-based Assessment for Sampling Personal Characteristics (CASPer)

An online Situation Judgment Test (SJT) designed to assess an applicant's personal and professional characteristics.

Cattell's 16PF test

A self-administered personality test, based on a model of 16 primary personality traits and the Big Five secondary traits.

California Psychological/Personality Inventory (CPI)

Used to measure those personal factors of temperament and character that are involved in everyday social living and constructive achievement.

CanMEDS

A framework that identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve.

Capability

Extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance.

Codes

Tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study.

Confirmability

The extent to which the findings are based on the study's participants and settings instead of researchers' biases.

Common personality trait

Shared in varying degrees by all members of the same culture, for example, self-esteem, intelligence and introversion.

Compassion

A person's ability to tolerate differences (regarding values and attitudes) between oneself and others, allowing them to show respect and appreciation for the human condition and a sense of kinship with all people.

Compassion fatigue

A response that those working in caring and helping roles may experience as a result of continued exposure to the traumatic experiences of those they care for. Linked to the experience of 'burnout', it can result in a reduced ability to feel empathic.

Competency-based medical education (CBME)

An outcomes-based approach to the design, implementation and assessment of medical education curricula using a structuring framework of competencies.

Competent

Possessing the required abilities in all domains in a certain context at a defined stage of medical education or practice.

Computer-based Multiple Sample Evaluation of Noncognitive Skills (CMSENS)

A pre-interview non-cognitive screening test.

Conscientiousness (Big Five)

The personality dimension that includes dependability, cautiousness, organisation and responsibility.

Content analysis

Research in which the content of a communication medium is systematically recorded and analysed.

Convergent interviewing (Bob Dick)

A procedure for collecting qualitative information on people's attitudes and beliefs through the use of interviews. Convergence occurs both within each interview and over a series of interviews.
Constructivism
Paradigm which states that knowledge and all meaning is not discovered but socially constructed. Meaning is not created but constructed out of the world that is already there (Illing 2007)

Credibility
The extent to which the study's findings are trustworthy and believable to others

Cultural effects
The shared behaviours and customs learned from the institutions in society

 Dependability
The extent to which the findings are consistent in relation to the contexts in which they were generated

Distress
A maladaptive response to the various factors influencing one's life

Doctors
Medical school graduates who gained license to practise at junior, senior or advanced levels in a variety of practice settings

Dyscompetent
The dysfunctioning of physicians in one or more competency domains

Emotional Intelligence
The ability to monitor one’s own and others’ feelings and emotions, to discriminate between them and to use the information to guide one’s thinking and actions

Empathy
A personal quality in the uncritical understanding of a patient's inner experiences and feelings. Is the essence of a meaningful doctor-patient relationship (Ability to sense and feel what others think and feel)

Epistemology
Theory of knowledge. What are the origin, nature, and limits of knowledge about reality?

Ethnomethodology
A social science approach that combines philosophy, social theory, and method to investigate ordinary social interaction in small-scale settings to reveal the rules that people apply to construct and maintain their everyday social reality

Eysenck's Personality Index/Inventory (EPI)
Measures personality as two biologically-determined types of temperament: Extroversion/Introversion and Neuroticism/Stability; and extended to a third type: Psychoticism/Socialisation

Existential phenomenology
Describes how phenomena present themselves in lived experience, in human existence

Extroversion (Big Five)
The personality dimension that includes enthusiasm, dominance, talkativeness, and sociability

Extroversion (Eysenck)
In Hans Eysenck biologically based theory, the term is used to describe the characteristic of being generally sociable, active and outgoing

Factor analysis
A statistical technique in which correlations among a number of simple scales are reduced to a few basic dimensions (a statistical tool for summarising and simplifying sets of variables)
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Focus group</td>
<td>A group of people informally 'interviewed' in a discussion setting that is participating in a qualitative research technique</td>
</tr>
<tr>
<td>Foundation doctor (FY1 or FY2)</td>
<td>A new graduate accepted into a two-year hospital training Foundation Programme in the United Kingdom, which forms the bridge between medical school and specialist/general practice training. Being a Foundation Doctor is compulsory for all newly qualified medical practitioners in the UK</td>
</tr>
<tr>
<td>Fiduciary relationship</td>
<td>The bond of trust between the patient and the physician, which is vital to the diagnostic and therapeutic process</td>
</tr>
<tr>
<td>Graduate Australian Medical Schools Admission Test (GAMSAT)</td>
<td>A cognitive test developed by ACER in conjunction with the Consortium of Medical Schools to assist with the selection of students into graduate-entry programs such as medicine since 1996 in Australia. It is undertaken annually in centres around Australia and a small number of overseas locations</td>
</tr>
<tr>
<td>Generalisability (G) Theory</td>
<td>A method within the medical education literature for assessments of the multiple mini interview type which offers a theoretical framework to manage unwanted variance.</td>
</tr>
<tr>
<td>Gold Coast stakeholders</td>
<td>People who represented the health professions, medical schools (including medical students), health care management, allied, alternative and rural health care, patients and the community of the Gold Coast, Australia as willing participants in my study</td>
</tr>
<tr>
<td>Grade Point Average</td>
<td>A numerical calculation of the mean of a student's tertiary education grades</td>
</tr>
<tr>
<td>Graduate entry program</td>
<td>Introduced in some Universities in Australia to encourage the enrolment of medical students from disadvantaged backgrounds. Students with any first degree from any university in Australia can apply.</td>
</tr>
<tr>
<td>Griffith University Multi-Station Admissions Assessment (GUMSAA)</td>
<td>A high stakes assessment of medical school applicants' personal and professional attributes which is being introduced in 2012 by the Griffith University School of Medicine</td>
</tr>
<tr>
<td>Health Rights Commission of Queensland, Australia</td>
<td>A statutory body empowered to investigate and resolve complaints about health services</td>
</tr>
<tr>
<td>Health Practitioners Tribunal, Queensland, Australia</td>
<td>A court in Queensland in which health care providers may be formally sanctioned and disciplined by a District Court judge after formal review of evidence</td>
</tr>
<tr>
<td>Hermeneutics</td>
<td>The theory and practice of interpretation; the concomitant production of meaning and meaning-making. A double hermeneutic is when the participant and researcher are both interpreting</td>
</tr>
<tr>
<td>Hermeneutic Circle</td>
<td>A metaphor for the dynamic and reciprocal relationship between the part and the whole, and between the researcher and the data</td>
</tr>
<tr>
<td>Hidden Curriculum</td>
<td>The set of influences that function at the level of organisational structure and culture including, for example, implicit rules to survive the institution such as rituals, customs and taken for granted aspects</td>
</tr>
</tbody>
</table>
Hogan Development Survey (HDS)  Designed to identify dysfunctional tendencies

Human Virtue  A relatively stable aspect of one’s character acquired by engaging in acts of kindness

Humanism in medicine  A respectful and compassionate relationship between physicians, other members of the healthcare team and their patients

Idiographic  Involved in the study of individual cases and/or focused on the particular

Imaginative empathy  An ability to imaginatively take the role of another so as to understand and accurately predict that person’s thoughts, feelings and actions

Inductive approach  An approach to psychology in which observations are systematically collected and concepts are developed based on what the data reveal

Intellectual curiosity  A desire for knowledge that leads to exploratory behaviour and consists of both an inherent trait and a context-dependent state

Interactionism  Represents the idea that we should pay more attention to how personality traits and situations interact with each other to influence behaviour

Interpersonal Reactivity Index (IRI)  An empirical scale developed to measure empathy in the general population (Davis)

Intern  A new graduate accepted into a two-year hospital training program (Australia)

International Personality Disorder Examination (IPDE)  A standard tool for the assessment of personality disorders

Interpretative explanation  A type of theoretical explanation about why events occur and how things work expressed in terms of the socially constructed meanings and subjective worldviews

Interpretative Phenomenological Analysis (IPA)  A qualitative research approach which aims to explore in detail the research participants’ personal lived experiences and how they make sense of those experiences

Intimacy  A person’s capacity to show deep love for family and close friends without jealousy or possessiveness

Introversion (Big Five)  this term is used to describe those who are low on the personality dimension of Extroversion; people who are introverted tend to be shy, submissive, retiring and quiet

Introversion (Eysenck)  In Hans Eysenck biologically based theory, the term is used to describe the characteristic of being generally quiet, reserved and thoughtful

Item Response Theory (IRT)  Designed to address interviewer bias in the mini multiple interview (MMI)
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Jefferson Scale of Physician Empathy (JSPE)</td>
<td>An empirical scale developed at the Thomas Jefferson University Hospital in Philadelphia to measure empathy in health care professionals</td>
</tr>
<tr>
<td>Jefferson Scale of Physician Empathy—Student Version (JSPE-S)</td>
<td>Jefferson scale of physician empathy (JSPE) adapted for students</td>
</tr>
<tr>
<td>Junior Doctor</td>
<td>Junior doctors are those who are in their 1st postgraduate year (internship), 2nd year (junior house officer - JHO) and 3rd year or more and who are not in training programs (senior house officer - SHO) in Australia</td>
</tr>
<tr>
<td>Key stakeholders</td>
<td>Those study participants recruited for individual interviews who identified as 'key' representatives of health care leadership, medical academia (including ethics); health professional practice (including nursing, midwifery, alternative health, allied and indigenous health) and rural health (including leadership and education)</td>
</tr>
<tr>
<td>Less privileged stakeholders</td>
<td>Those marginalised in medical student selection and education decision-making by virtue of lower socio-political, financial and/or academic status or as end users of medical services</td>
</tr>
<tr>
<td>Lexical hypothesis</td>
<td>The most salient and socially relevant personality differences in people's lives will eventually become encoded into language. By sampling language, it is possible to derive a comprehensive taxonomy of human personality traits</td>
</tr>
<tr>
<td>Locus of Control Scale (Rotter)</td>
<td>A self-evaluation tool that measures the extent to which individuals believe that they can control events that affect them (internal vs external)</td>
</tr>
<tr>
<td>Life Orientation Test-Revised (LOT-R)</td>
<td>An instrument for measuring Optimism</td>
</tr>
<tr>
<td>Maslach Burnout Inventory (MBI)</td>
<td>An instrument for measuring burnout, which includes three scales of Emotional Exhaustion, Depersonalization, and Personal Accomplishment</td>
</tr>
<tr>
<td>M-3 Checklist</td>
<td>A self-rated checklist for potential mood-anxiety symptoms</td>
</tr>
<tr>
<td>Medical education</td>
<td>An accredited program that facilitates the acquisition of knowledge, skills and attitudes for safe and competent practice for the duration of a licenced medical career</td>
</tr>
<tr>
<td>Medical student selection</td>
<td>An application process for undergraduate or postgraduate entry into an accredited medical program. Applicants are assessed and ranked according to specific requirements that usually include academic scores and/or aptitude tests. For some medical schools, such assessments are administered in combination with supplementary information, an interview-based method and/or psychometric test</td>
</tr>
<tr>
<td>Methodology</td>
<td>Strategic approach to answer the research question and to gain knowledge. What is the research design?</td>
</tr>
<tr>
<td>Meta-analysis</td>
<td>A statistical technique for combining the results of multiple research studies</td>
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<td>Term</td>
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<tr>
<td>Meyer-Salovey-Caruso Emotional Intelligence Test (MSCEIT)</td>
<td>An 'ability' measure of emotional intelligence (EI)</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory (MMPI)</td>
<td>A comprehensive self-report personality test that is focused on assessing psychopathology</td>
</tr>
<tr>
<td>Mojac scale</td>
<td>Measures moral orientation</td>
</tr>
<tr>
<td>Morphological (individual) personality traits</td>
<td>Those characteristics peculiar to the person that do not permit comparisons among people (personal dispositions)</td>
</tr>
<tr>
<td>Motives</td>
<td>Internal psychological forces that induce behaviour or push for expression</td>
</tr>
<tr>
<td>Multi-facet Rasch Modelling (MFRM)</td>
<td>A strategy to increase the reliability and validity of the multiple mini interview (MMI) by adjusting for interviewer stringency/leniency bias</td>
</tr>
<tr>
<td>Multiple abstract variance analysis (MAVA)</td>
<td>A statistical procedure which measures the influence of genetic and environmental influences on personality traits</td>
</tr>
<tr>
<td>Multiple Mini Interview (MMI)</td>
<td>Pioneered by McMaster University in Canada, is an admissions version of the objective structured clinical examination (OSCE), offering multiple short stations with different scenarios to measure the attributes of ethics, clinical reasoning, communication skills and knowledge of the health care system</td>
</tr>
<tr>
<td>Myers Briggs Type Indicator (MBTI)™</td>
<td>A self-inventory which is based on Jung’s theory and has been designed to identify a person's personality type, strengths and preferences.</td>
</tr>
<tr>
<td>NACE scale</td>
<td>Measures narcissism, Aloofness, Confidence and Empathy</td>
</tr>
<tr>
<td>Narcissistic personality disorder</td>
<td>A disorder in which one feels powerless and dependent yet appears to be authoritative and self-aggrandizing</td>
</tr>
<tr>
<td>NEO™-PI-3 (NEO-5)</td>
<td>A concise measure of the five major domains of personality (Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness) and the six facets that define each domain.</td>
</tr>
<tr>
<td>NEO test</td>
<td>An industry standard personality test: Neuroticism-Extroversion-Openness</td>
</tr>
<tr>
<td>Neuroticism (Big Five)</td>
<td>The personality dimension that includes nervousness, tension and anxiety</td>
</tr>
<tr>
<td>Neuroticism (Eysenck)</td>
<td>One of Hans Eysenck's three biologically orientated personality dimensions (includes emotional instability and apprehensiveness)</td>
</tr>
<tr>
<td>Neuroticism-Extraversion-Openness Personality Inventory Revised (NEO-PI-R)</td>
<td>A 240 item self-report of descriptions of behaviour</td>
</tr>
<tr>
<td>Nomothetic (common) traits (Allport)</td>
<td>The study of personality that involves large groups of individuals in order to infer general principles or variables (traits which are shared by several people within a given culture)</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Ontology</td>
<td>Theory of the view on reality. What is the nature of physical and social reality?</td>
</tr>
<tr>
<td>Openness (Big Five)</td>
<td>The personality dimension that includes imagination, wit, originality and creativity</td>
</tr>
<tr>
<td>Overall Position (OP)</td>
<td>A tertiary entrance rank used in the Australian state of Queensland for selection into universities. Like similar systems used throughout the rest of Australia, the OP shows how well a student has performed in their senior secondary studies compared to all other OP-eligible students in Queensland</td>
</tr>
<tr>
<td>Paradigm</td>
<td>An interpretive framework, which is guided by a set of beliefs and feelings about the world and how it should be understood and studied (Guba 1990)</td>
</tr>
<tr>
<td>Patient–Practitioner Orientation Scale (PPOS)</td>
<td>A validated instrument designed to measure individual preferences towards various aspects of the doctor–patient relationship</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>A philosophy which explores the meaning of individuals' lived experiences through their own description. The research approach adopted is based on this philosophy (Holloway and Wheeler 2010)</td>
</tr>
<tr>
<td>Phenomenological reduction</td>
<td>The field of the researcher’s attention is 'reduced' to the phenomenon under study (also referred to as 'bracketing')</td>
</tr>
<tr>
<td>Positionality (Hopkins, 2016)</td>
<td>The particular philosophical stance a researcher takes in relation to the various perspectives that underpin a research approach</td>
</tr>
<tr>
<td>Purposive sampling</td>
<td>Sampling individuals and sites for study which are thought to purposefully inform an understanding of the research problem and central phenomenon of the study (Creswell 2013)</td>
</tr>
<tr>
<td>Predictive validity</td>
<td>A measurement of how well a test predicts future performance. It is a form of criterion validity, in which the validity of a test is established by measuring it against known criteria. In order for a test to have predictive validity, there must be a statistically significant correlation between test scores and the criterion being used to measure validity</td>
</tr>
<tr>
<td>Privileged stakeholders</td>
<td>Those given exclusive authority in medical student selection and education decision-making by virtue of their higher socio-political, financial and/or academic status</td>
</tr>
<tr>
<td>Professional competence</td>
<td>The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served</td>
</tr>
<tr>
<td>Proprium</td>
<td>Gordon Allport's term for the core of personality that defines who one is: selfhood (The overall construct that unifies personality traits and provides direction for a person's life)</td>
</tr>
<tr>
<td>Psychology</td>
<td>Comes from ancient Greek 'psyche', first introduced by the poet Homer to express the essence of 'the self'</td>
</tr>
<tr>
<td>Term</td>
<td>Definition and Example</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psychoticism (Eysenck)</td>
<td>Personality dimension which includes a tendency toward psychopathology, involving impulsivity and cruelty, tough-mindedness and shrewdness</td>
</tr>
<tr>
<td>Purposive (judgemental) sampling technique</td>
<td>A type of nonprobability sampling technique which selects participants with a specific purpose in mind</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>Awareness of the researcher’s contribution to the construction of meanings throughout the research process and an acknowledgment of the impossibility of remaining ‘outside of’ one’s subject matter while conducting research</td>
</tr>
<tr>
<td>Reliability (applied to qualitative research)</td>
<td>Dependability or consistency: Other researchers can repeat the study and will get similar results</td>
</tr>
<tr>
<td>Resident physician</td>
<td>More commonly referred to as a resident, senior house officer (in Commonwealth countries), or alternatively as a senior resident medical officer or house officer. Residents have graduated from an accredited medical school and hold a medical degree (MD, DO, DPM, MBBS, MBChB). A first-year resident is often termed an intern.</td>
</tr>
<tr>
<td>Resilience</td>
<td>The ability to remain strong and to grow stronger when facing adversity. Also referred to in the context of manifest competence despite exposure to significant stressors. Adversity is recognised in the literature as a prerequisite for developing resilience in any domain</td>
</tr>
<tr>
<td>Role-model</td>
<td>A person looked to by others as an example to be imitated</td>
</tr>
<tr>
<td>Saturation</td>
<td>Also known as ‘informational redundancy’ (Lincoln &amp; Guba 1985), indicating that everything of importance to the research agenda of the project has been obtained. Can refer to ‘data saturation’ (sampling to redundancy) or theoretical saturation (no new concepts or dimensions are emerging during the data analysis)</td>
</tr>
<tr>
<td>Sense of coherence (SOC)</td>
<td>The sense of comprehensibility, manageability and meaningfulness</td>
</tr>
<tr>
<td>Service (experiential) learning</td>
<td>A medical education model that combines academic topics with community service that is mutually beneficial to the student learner and the community involved</td>
</tr>
<tr>
<td>Signature stakeholders</td>
<td>Participants whose doctor experiences were found to most strongly represent the phenomenological themes, units and/or sub-units of meaning in my data analysis structure (see Table 3 in section 3.3.5.2)</td>
</tr>
<tr>
<td>Situational Judgement Tests (SJT$s$)</td>
<td>Measurement methodology used to assess individuals’ reactions to a number of hypothetical role-relevant scenarios, which reflect situations candidates are likely to encounter in the target role</td>
</tr>
<tr>
<td>Snowball sampling method</td>
<td>A sampling technique used to recruit additional participants from those already selected to participate in a qualitative study</td>
</tr>
<tr>
<td>Social accountability</td>
<td>The obligation for medical schools to orientate their teaching, research and service to the health and social needs of the communities that they serve</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Social media</td>
<td>A group of internet-based applications that allow the creation and exchange of user-generated content within a virtual community or network</td>
</tr>
<tr>
<td>Source personality trait (Cattell)</td>
<td>Building blocks of personality which exist at a deep level and are causes of behaviour in diverse situations over extended periods of time</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Those involved in and/or affected by, medical selection and education decision-making from a privileged or less privileged position</td>
</tr>
<tr>
<td>Stress</td>
<td>A person’s response to the various factors influencing their life</td>
</tr>
<tr>
<td>Supporting stakeholders</td>
<td>Participants whose experiences with doctors were included in the analysis for supporting similar, yet stronger experiences of the 'signature stakeholder’ participants</td>
</tr>
<tr>
<td>Surface personality trait (Cattell)</td>
<td>Evidenced by a cluster of overt elements that seem to go together</td>
</tr>
<tr>
<td>State-Trait Anxiety Inventory (STAI)</td>
<td>A questionnaire developed by psychologists Spielberger, Gorsuch &amp; Lushene to measure two types of anxiety: 'State Anxiety' (about an event) and 'Trait Anxiety' (anxiety as a personal characteristic)</td>
</tr>
<tr>
<td>Symbolic interactionism</td>
<td>Use of a limited set of adjectives or adjective dimensions to describe and scale individuals</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>The science which deals with the study of identifying, grouping, and naming organisms according to their established natural relationship</td>
</tr>
<tr>
<td>TE score</td>
<td>Tertiary Education Score, based on a pupil’s performance in secondary school</td>
</tr>
<tr>
<td>Training for Health Equity Network (THEnet)</td>
<td>Formed in 2008, a collaboration of 11 health professional schools that aspire towards social accountability</td>
</tr>
<tr>
<td>Typical Entry Score</td>
<td>In relation to the 3 sections of the GAMSAT it is a candidate’s overall score of at least 60 with scores of at least 50 on each of the three sections</td>
</tr>
<tr>
<td>Tolerance of ambiguity</td>
<td>The way an individual (or group) perceives and processes information about ambiguous situations or stimuli when confronted by an array of unfamiliar, complex or incongruent clues</td>
</tr>
<tr>
<td>Trait (Allport)</td>
<td>A generalised neuropsychic structure or core tendency that underlies behaviour across time and situations</td>
</tr>
<tr>
<td>Trait approach</td>
<td>Use of a limited set of adjectives or adjective dimensions to describe and scale individuals</td>
</tr>
<tr>
<td>Transferability</td>
<td>How well the study’s findings inform medical education contexts that differ from that in which the original study was undertaken</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Triangulation</td>
<td>Facilitates validation of data through cross verification from more than two sources. In particular, it refers to the application and combination of several research methodologies in the study of the same phenomenon</td>
</tr>
<tr>
<td>Tribunal</td>
<td>A disciplinary body with the power to remove a doctor from practice other than on an interim basis</td>
</tr>
<tr>
<td>Typology</td>
<td>A categorical scheme in which a person is a member of only one of a small set of groups</td>
</tr>
<tr>
<td>UCLA GA Scale</td>
<td>A validated 14-item survey assessing geriatrics attitudes on a 5-point Likert scale that was developed for primary care residents (University of California, Los Angeles)</td>
</tr>
<tr>
<td>Validity (applied to qualitative research)</td>
<td>Authenticity which means offering a fair, honest and balanced account of social life from the viewpoint of people who live in it every day: Validity grows with the creation of a dynamic and coherent ensemble of data</td>
</tr>
<tr>
<td>Variable</td>
<td>A research concept that varies in amount or kind and that should be measurable</td>
</tr>
<tr>
<td>Vicarious empathy</td>
<td>To have a visceral empathic response ('gut reaction')</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>The optimisation of physical, mental and social health</td>
</tr>
<tr>
<td>Widening participation (WP)</td>
<td>A policy introduced in the UK in 2004 to encourage universities to adopt admissions systems that increase application and acceptance rates for applicants from non-traditional backgrounds</td>
</tr>
<tr>
<td>Wong and Law Emotional Intelligence Scale (WLEIS)</td>
<td>A trait measure of emotional intelligence (EI)</td>
</tr>
</tbody>
</table>
### B - ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAMC (USA)</td>
<td>Association of American Medical Colleges</td>
</tr>
<tr>
<td>ABIM (USA)</td>
<td>American Board of Internal Medicine</td>
</tr>
<tr>
<td>ACGME (USA)</td>
<td>Accreditation Council for Graduate Medical Education</td>
</tr>
<tr>
<td>ACER (Australia)</td>
<td>Australian Council for Educational Research</td>
</tr>
<tr>
<td>AERA (USA)</td>
<td>American Educational Research Association</td>
</tr>
<tr>
<td>AHPRA (Australia)</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AMA (Australia)</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>AMC (Australia)</td>
<td>Australian Medical Council</td>
</tr>
<tr>
<td>AMEE</td>
<td>Association for Medical Education in Europe</td>
</tr>
<tr>
<td>AMSA (Australia)</td>
<td>Australian Medical Students Association</td>
</tr>
<tr>
<td>ANZAHPE (Australia and New Zealand)</td>
<td>Australian and New Zealand Association for Health Education Professionals (formerly ANZAME)</td>
</tr>
<tr>
<td>APA (USA)</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>ARIA (Australia)</td>
<td>Accessibility/Remoteness Index of Australia</td>
</tr>
<tr>
<td>ATAR (Australia)</td>
<td>Australian Tertiary Admissions Rank</td>
</tr>
<tr>
<td>BA/MBBS</td>
<td>Bachelor of Arts, Bachelor of Medicine, Bachelor of Surgery</td>
</tr>
<tr>
<td>BHS/MBBS</td>
<td>Bachelor of Health Sciences, Bachelor of Medicine, Bachelor of Surgery</td>
</tr>
<tr>
<td>BMA (UK)</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BMAT (UK)</td>
<td>BioMedical Admissions Test</td>
</tr>
<tr>
<td>CAQDAS</td>
<td>Computer Assisted Qualitative Data Analysis Software</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CASPer</td>
<td>Computer-based Assessment for Sampling Personal Characteristics</td>
</tr>
<tr>
<td>CBME</td>
<td>Community-Based Medical Education</td>
</tr>
<tr>
<td>CBME</td>
<td>Competency Based Medical Education</td>
</tr>
<tr>
<td>CLEIMS (Griffith University, Australia)</td>
<td>Clinical Learning through Extended Immersion in Medical Simulation</td>
</tr>
<tr>
<td>CMC (Australia)</td>
<td>Crime and Misconduct Commission</td>
</tr>
<tr>
<td>COC (Australia)</td>
<td>Compound of Criteria</td>
</tr>
<tr>
<td>COME</td>
<td>Community-Oriented Medical Education</td>
</tr>
<tr>
<td>CPI</td>
<td>California Psychological Inventory</td>
</tr>
<tr>
<td>CRPs</td>
<td>Clinical Reasoning Problems</td>
</tr>
<tr>
<td>DTI</td>
<td>Diagnostic Thinking Inventory</td>
</tr>
<tr>
<td>EBM</td>
<td>Evidence-based medicine</td>
</tr>
<tr>
<td>ENTER</td>
<td>Equivalent National Tertiary Entrance Rank</td>
</tr>
<tr>
<td>EPAs</td>
<td>Entrustable professional activities</td>
</tr>
<tr>
<td>GAMSAT (Australia)</td>
<td>Graduate Australian Medical Schools Admission Test</td>
</tr>
<tr>
<td>GCA (Australia)</td>
<td>General Cognitive Ability</td>
</tr>
<tr>
<td>GEM (UK)</td>
<td>Graduate entry medicine</td>
</tr>
<tr>
<td>GEMP</td>
<td>Graduate entry medical programme</td>
</tr>
<tr>
<td>GEMSAS</td>
<td>Graduate Entry Medical School Admissions System</td>
</tr>
<tr>
<td>GEMSAS</td>
<td>Graduate Entry Medical School Admissions System</td>
</tr>
<tr>
<td>GCSE (UK)</td>
<td>General Certificate of Secondary Education Examination (taken at age 16)</td>
</tr>
<tr>
<td>GMC (UK)</td>
<td>General Medical Council</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GMP</td>
<td>Graduate Medical Program</td>
</tr>
<tr>
<td>GPA (Australia and USA)</td>
<td>Grade Point Average</td>
</tr>
<tr>
<td>GU (Queensland, Australia)</td>
<td>Griffith University</td>
</tr>
<tr>
<td>GUMSAA (Queensland Australia)</td>
<td>Griffith University Multi Station Admissions Assessment</td>
</tr>
<tr>
<td>HPAT-Ireland</td>
<td>Health Professions Admission Test-Ireland</td>
</tr>
<tr>
<td>HPE</td>
<td>Health Professions Education</td>
</tr>
<tr>
<td>IEF (USA)</td>
<td>Iowa Evaluation Form</td>
</tr>
<tr>
<td>IRSAD (Australia)</td>
<td>Index of Relative Socioeconomic Advantage and Disadvantage</td>
</tr>
<tr>
<td>IPA</td>
<td>Interpretive Phenomenological Analysis</td>
</tr>
<tr>
<td>IRI</td>
<td>Interpersonal Reactivity Index</td>
</tr>
<tr>
<td>IRSD</td>
<td>Index of Relative Socioeconomic Disadvantage</td>
</tr>
<tr>
<td>ISAT</td>
<td>International Student Admissions Test</td>
</tr>
<tr>
<td>ITP</td>
<td>Implicit Trait Policy</td>
</tr>
<tr>
<td>JSE</td>
<td>Jefferson Scale of Empathy</td>
</tr>
<tr>
<td>JSPE</td>
<td>Jefferson Scale of Physician Empathy</td>
</tr>
<tr>
<td>JSPE-S</td>
<td>The Jefferson Scale of Physician Empathy–Student Version</td>
</tr>
<tr>
<td>LIC</td>
<td>Longitudinal Integrated Clerkship</td>
</tr>
<tr>
<td>LOT-R</td>
<td>The Life Orientation Test-Revised</td>
</tr>
<tr>
<td>MAT</td>
<td>Mental Agility Test</td>
</tr>
<tr>
<td>MAA (Australia)</td>
<td>Mature aged application (aged 21 years and over)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine, Bachelor of Surgery</td>
</tr>
<tr>
<td>MBI</td>
<td>Maslach Burnout Inventory</td>
</tr>
<tr>
<td>MCAT-GPA (USA &amp; Canada)</td>
<td>Medical College Admission Test - Grade Point Average</td>
</tr>
<tr>
<td>MCCE (Canada)</td>
<td>Medical Council of Canada Examinations</td>
</tr>
<tr>
<td>MCCQE (Canada)</td>
<td>Medical Council of Canada Qualifying Examination</td>
</tr>
<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
</tr>
<tr>
<td>MDANZ (Australia &amp; New Zealand)</td>
<td>Medical Deans Australia New Zealand</td>
</tr>
<tr>
<td>MHPT</td>
<td>Mental Health Problems in need of Psychiatric Treatment</td>
</tr>
<tr>
<td>MCI</td>
<td>Melbourne Curiosity Inventory</td>
</tr>
<tr>
<td>MMI (McMaster University, Canada)</td>
<td>Multiple Mini Interview</td>
</tr>
<tr>
<td>MMPI (Minnesota University, USA)</td>
<td>Minnesota Multiphasic Personality Inventory</td>
</tr>
<tr>
<td>Mojac Scale (Australia)</td>
<td>Measures moral orientation</td>
</tr>
<tr>
<td>MOR (Israel)</td>
<td>Measuring tool for non-cognitive attributes</td>
</tr>
<tr>
<td>MSATU</td>
<td>Medical Student Attitudes Toward the Underserved</td>
</tr>
<tr>
<td>MSC (UK)</td>
<td>Medical Schools Council</td>
</tr>
<tr>
<td>MSCEITTM</td>
<td>Mayer-Salovey-Caruso Emotional Intelligence Test</td>
</tr>
<tr>
<td>MSPI</td>
<td>Medical School Preadmission Interview</td>
</tr>
<tr>
<td>MSQ</td>
<td>Medical Situations Questionnaire</td>
</tr>
<tr>
<td>NACE Scale (Australia)</td>
<td>Narcissism, Aloofness, Confidence, Empathy</td>
</tr>
<tr>
<td>NBME (UK)</td>
<td>National Board of Medical Examiners</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NCA's</td>
<td>Non-cognitive attributes</td>
</tr>
<tr>
<td>NCME (USA)</td>
<td>National Council on Measurement in Education</td>
</tr>
<tr>
<td>NCT</td>
<td>Non-cognitive testing for medical student selection</td>
</tr>
<tr>
<td>NEO™-PI-3</td>
<td>NEO™-Personality Inventory-3 Interpretive Report</td>
</tr>
<tr>
<td>OP (Queensland, Australia)</td>
<td>Overall Position</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective Structured Clinical Examination</td>
</tr>
<tr>
<td>PBQs</td>
<td>Past-Behavioural Questions (as part of the MMI admissions test)</td>
</tr>
<tr>
<td>PCC</td>
<td>Patient-Centred Care</td>
</tr>
<tr>
<td>PCRS (USA)</td>
<td>Physician Competency Reference Set</td>
</tr>
<tr>
<td>PDR</td>
<td>Patient-doctor relationship</td>
</tr>
<tr>
<td>PeArLs</td>
<td>Personally arranged learning sessions at conferences</td>
</tr>
<tr>
<td>PMSS</td>
<td>Perceived Medical School Stress</td>
</tr>
<tr>
<td>PPOS</td>
<td>Patient–Practitioner Orientation Scale</td>
</tr>
<tr>
<td>PPPIMS (Griffith University, Australia)</td>
<td>Personality, performance and professionalism in medical students</td>
</tr>
<tr>
<td>PQA (University of Newcastle, Australia)</td>
<td>Personal Qualities Assessment</td>
</tr>
<tr>
<td>PSS</td>
<td>Perceived Stress Scale</td>
</tr>
<tr>
<td>QTAC (Queensland, Australia)</td>
<td>Queensland Tertiary Admissions Centre</td>
</tr>
<tr>
<td>RCGP (United Kingdom)</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Areas</td>
</tr>
<tr>
<td>RS-14</td>
<td>Wagnild and Young Resilience Scale</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>RCS (Australia)</td>
<td>Rural Clinical School</td>
</tr>
<tr>
<td>SAHPE</td>
<td>Socially-Accountable Health Professional Education</td>
</tr>
<tr>
<td>SC's</td>
<td>Selection Centres</td>
</tr>
<tr>
<td>SCT</td>
<td>Script Concordance Testing (Clinical reasoning Test)</td>
</tr>
<tr>
<td>SEEG (United Kingdom)</td>
<td>Selection for Excellence Group</td>
</tr>
<tr>
<td>SJT</td>
<td>Situational Judgement Test (as part of admissions testing)</td>
</tr>
<tr>
<td>SME</td>
<td>Subject Matter Expert</td>
</tr>
<tr>
<td>SPA</td>
<td>Supporting professionalism in admissions</td>
</tr>
<tr>
<td>SQs</td>
<td>Situational Questions (as part of the MMI admissions test, for example: What would you do in this situation?)</td>
</tr>
<tr>
<td>SSPIs</td>
<td>Single-Station Personal interviews</td>
</tr>
<tr>
<td>STAT</td>
<td>Special Tertiary Admissions Test</td>
</tr>
<tr>
<td>SWLS</td>
<td>Satisfaction with Life Scale</td>
</tr>
<tr>
<td>TAMSAD</td>
<td>Tolerance of Ambiguity in Medical Students and Doctors</td>
</tr>
<tr>
<td>TE score (Australia)</td>
<td>Tertiary Education score</td>
</tr>
<tr>
<td>TER (Australia)</td>
<td>Tertiary Entrance Ranking</td>
</tr>
<tr>
<td>TES (Australia)</td>
<td>Typical Entry Score (in relation to the GAMSAT)</td>
</tr>
<tr>
<td>THEnet</td>
<td>Training for Health Equity Network</td>
</tr>
<tr>
<td>UAI (Australia)</td>
<td>Universities Admissions Index</td>
</tr>
<tr>
<td>UCAS (UK)</td>
<td>Universities and Colleges Admission Service</td>
</tr>
<tr>
<td>UCCA (UK)</td>
<td>The Universities Central Council on Admissions</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>UG</td>
<td>Undergraduate (medical programme)</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
</tr>
<tr>
<td>UKCAT (UK)</td>
<td>United Kingdom Clinical Aptitude Test</td>
</tr>
<tr>
<td>UKMED</td>
<td>United Kingdom Medical Education Database</td>
</tr>
<tr>
<td>UMAT (Australia and New Zealand)</td>
<td>Undergraduate Medicine and Health Sciences Admissions Test</td>
</tr>
<tr>
<td>UQ (Queensland, Australia)</td>
<td>The University of Queensland</td>
</tr>
<tr>
<td>URM (USA)</td>
<td>Underrepresented Minorities</td>
</tr>
<tr>
<td>USMLE (USA)</td>
<td>United States Medical Licensing Examination</td>
</tr>
<tr>
<td>WA</td>
<td>Widening Access</td>
</tr>
<tr>
<td>WFME</td>
<td>World Federation for Medical Education</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WOC</td>
<td>Ways of coping (questionnaire)</td>
</tr>
<tr>
<td>WP</td>
<td>Widening Participation</td>
</tr>
</tbody>
</table>
C - SEMI-STRUCTURED INTERVIEW SCHEDULE (FINAL VERSION)

[Please note that this final version of the interview schedule evolved within an IPA paradigm. Prompt questions that initially focused on ‘the good doctor’ were expanded to accommodate opposing participant responses as the interviews progressed]

August 2013

“Informing medical student selection: What do Gold Coast stakeholders consider to be the characteristics of a good doctor?”

Schedule for Individual Interview

1. Welcome, thanks, introduction - hand out information sheet and invite participant to select a pseudonym from a selected letter of the alphabet - refer to power point slide no’s 1 & 2 (10 minutes)

   - Ensure participant comfort
   - Confirm participant’s verbal permission for audio recording and note taking
   - Confirm confidentiality of data gathered during the session, including participant choice to offer any personal information to receive correspondence regarding the study
   - Offer reassurance that participant consent may be withdrawn at any stage of the data collection process without prejudice
   - Ensure safeguarding of participant’s personal identity and that of others, by requesting the participant to assume a pseudonym beginning with a letter of the alphabet that has been handed to him/her; and by requesting that no persons and/or places are named during the interview
   - As the interview may raise issues of a personal and sensitive nature, offer reassurance that the participant remains under no obligation to share any information, particularly if he/she feels that it may cause distress. The researcher will avail herself in the event that a participant wishes to seek further support and/or referral, immediately post-session, as well as at any time during the project
   - Make the Griffith University’s Ethical Clearance Certificate available for inspection
   - Sound check audio recording equipment
2. **Questions for discussion – refer to power point slide no's 2, 3 & 4**  
(up to 45 minutes)

- What does the 'good doctor' mean to you?
- Are you able to give some examples of good characteristics in doctors?  
  (try to avoid naming people and places)
- Tell me how you came to this view
- Are you able to give some examples of bad characteristics in doctors?  
  (try to avoid naming people and places)
- Tell me how you came to this view
- How do you think these views might inform the selection of our future doctors?  
  Particularly in relation to positive characteristics (such as being a good communicator and being  
  empathic): From your experience, do you consider these to be inherent or do you think that they can be  
  learned/acquired?
- Is there anything else that you would like to add?

3. **Closure – refer to power point slides no’s 5, 6 & 7**  
(5 minutes)

- Sum up discussion and invite any final questions
- Reiterate confidentiality and privacy needs
- Provide further information and resources at participant's request, for example, references
- Invite future contact from the participant regarding results of the session and the study
- Be prepared to offer any informal debriefing as appropriate
- Invite participant feedback (informal/formal) on the interview experience

4. **Post-session**

- Safeguard all interview material, including notes and audio recording
- Make back-up copies of interview material, label clearly and keep separate from the originals
- Transcribe data as soon after the session as possible
### D - EXTRACT FROM CODING BOOK FIELD NOTES

<table>
<thead>
<tr>
<th>PHENOMENOLOGICAL THEME</th>
<th>UNIT OF MEANING</th>
<th>SUB-UNIT OF MEANING</th>
<th>INITIAL CODING</th>
<th>EXAMPLES OF PARTICIPANT DESCRIPTIONS OF DOCTORS</th>
<th>SOURCES from the LITERATURE</th>
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<tbody>
<tr>
<td>Positively Evaluated Doctor Experiences</td>
<td>Being Patient-Centred</td>
<td>Ensuring Patient Safety</td>
<td>Accountable; transparent</td>
<td>Adheres to sound hygiene principles, for self as well as for others</td>
<td>Yes: Transparency; honesty; integrity; being ethical and always thinking of the patient first rather than your own personal gain and ego and money and thinking; “How important I am in the world … to the whole world!” Forget all that, because once you’re a doctor, you know, all of that fades into insignificance. [Participant 39]</td>
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<td></td>
<td></td>
<td>Acknowledges mistakes honestly and confronts consequences; does not deflect blame</td>
<td>Lifelong learner; willing to learn from patients; a drive for self-development</td>
<td>So they [doctors] really approach their own commitment to lifelong learning with their responsibility to educate others. [Participant 34]</td>
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<td>Courageous; moral courage; strength of character; not afraid to take risks or to admit to mistakes</td>
<td>Maintains high ethical standards; respects professional boundaries and patient confidentiality</td>
<td>You need to be able to identify your limitations … but then going that step further and having the guts to seek the assistance and not being afraid to admit that you don’t know … it’s pointless having insight if you do nothing with it. [Participant 3.5]</td>
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<td></td>
<td></td>
<td>Honest; sincere; trustworthy</td>
<td>Professional, upholds professional and ethical creeds and codes of practice</td>
<td>Absolutely competent! I felt completely safe in his hands. [Participant 18]</td>
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<td></td>
<td></td>
<td>Maintains confidentiality</td>
<td>Quick thinker and can make decisions under pressure</td>
<td>I was so impressed with his ability to connect with the family, he managed to de-escalate the situation, bring all the emotion down to a level where he could communicate what he had to do and really provide a lot of information very quickly, with the least amount of drama. [Participant 3.4]</td>
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<td>Safe, including keeping patients physically and emotionally safe</td>
<td>Physically and emotionally safe</td>
<td>From my viewpoint, the paramount importance is being safe: if you can be a safe doctor, then you have done what you need to do for your patient. [Participant 1]</td>
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<td>Vigilant and aware of situations</td>
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<td>On our ward rounds we need to be able to recognise difficult situations and to make our concerns known if we are worried about a patient. [Participant 26]</td>
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<td>A passion for healing and helping</td>
<td>Effective educator, including mentoring others</td>
<td>I would look for good communication skills. I would look for someone that would have passion: A passion for ‘normality’; and who really wanted to look at their patient as an individual … wanted to work with people rather than, you know, with ‘diseases’. [Participant 37]</td>
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<td>Affable and agreeable</td>
<td>Reliable, available and accessible when needed</td>
<td>A doctor who is prepared to ‘give and take’ to make that women feel that they involved in their care is important. And I think that there are definitely some doctors out there that have got that. [Participant 37]</td>
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<td>Assertive; good advocacy skills</td>
<td>Uses initiative, is resourceful and thorough; proactive; can apply knowledge in novel circumstances</td>
<td>I get to work with compassionate doctors who have these [good] characteristics of insight, of integrity, of proactively seeking out a complex answer to a complex question, so I’m dealing with the ‘thinkers’. [Participant 30]</td>
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<td>Collaborative and Collegial</td>
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<td>A respectful collaborative partnership [between the woman and her doctor] is really important. The evidence shows that where you’ve got good collaboration, you get good clinical outcomes. [Participant 37]</td>
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<td>Committed; strong personal resolve; loyalty to self and others</td>
<td>It’s about your attitude and approach to medicine, rather than knowledge itself … there needs to be that interest and commitment that drives you. [Participant 13]</td>
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<td>Common sense about the world; good general knowledge; worldly; sensible; streetwise; savvy; willing to share life experiences</td>
<td>It’s not rocket-science! It’s just being aware … switched on to what patients need. [Participant 23]</td>
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Sources:
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<tr>
<th>Cooperative; persevering; willing to go the extra mile</th>
<th>Often you have a group of doctors working under one umbrella, but there will always be one or two who really stand out, they’ve just got that ability to go that extra step. [Participant 21]</th>
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<tr>
<td>Dedicated</td>
<td>Once you sign up to do medicine, that carries a certain amount of baggage, and you have to be prepared to accept that. And that means working nights, working weekends, working holidays. [Participant 11]</td>
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<td>Down-to-earth; straight down the line; realistic; practical</td>
<td>He was a down-to-earth country doctor. [Participant 4.7]. He [his doctor] did not beat around the bush or sweep things under the carpet; he was just straight-down-the-line. [Participant 22]</td>
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<td>Generous in spirit; spiritual</td>
<td>She’s developed a passion about helping disadvantaged communities, which shows a generosity of spirit as she could be earning lots of money in private practice. ... [Participant 18]</td>
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<td>Humble; can express that they are human like everyone else</td>
<td>We should never take advantage of the fact that our patients are vulnerable, which requires patience, active listening, humility and respect. [Participant 31]</td>
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<td>Inspirational; inspires others; has wide popularity; described as being ‘unique’</td>
<td>The thing that was admirable about him [the consultant] was he had really incredible dedication and he did manage through a combination cajoling and inspiration to motivate his team. [Participant 27]</td>
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<td>Kind; considerate; sympathetic; humane</td>
<td>I know a couple of doctors who are just wonderful human beings: Very compassionate, some who weren’t outstanding students but actually did become very good clinicians, very thorough, very kind, good listeners and very inclusive of teams. [Participant 3.1]</td>
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<td>Motivated; enthusiastic; interested; engaged</td>
<td>Those junior doctors were courageous and they were interested and engaged … I think it was their enthusiasm and their dedication to wanting to make a contribution that impressed me. [Participant 34]</td>
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<td>Natural or innate curiosity, including about others; inquisitiveness; an enquiring mind</td>
<td>One of the key things you need for medicine is an inquisitiveness, because those students who can’t apply what they learn do not develop or go anywhere. [Participant 2.2]</td>
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<td>Old-fashioned; older and wiser</td>
<td>I would like to see doctors treat people like they used to in the old days, which was actually treating each of you as an individual and treating you for your own causes of your own problems. [Participant 5.6]</td>
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<td>Patient-centred; patient-friendly; genuine concern for the patient as an individual</td>
<td>It’s about the patient rather than the doctor … She treats her patients as equals … they appreciate that they are being treated like human beings as opposed to just numbers or diseases or symptoms. [Participant 9.7]</td>
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<td>Reassuring manner</td>
<td>He [his GP] has a calming effect on me … I need to have some sort of reassurance that I’m moving forward, because dealing with my pain can be very daunting. [Participant 20]</td>
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<td>Relaxed manner; puts patients at ease; nice bedside manner</td>
<td>So I thought that relieving our anxiety and telling us what the outcome was quickly, given how busy he [the surgeon] was, was really impressive. [Participant 8.5]</td>
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<td>Warm; welcoming; approachable; friendly; sociable; positive reputation; endearing</td>
<td>My expectations of my doctor are simple things like just being friendly, warm and kind. [Participant 30]</td>
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Combining the 'art' with the science of medicine

**Altruistic; a desire to help others and to alleviate suffering.**
Academically sound, astute and knowledgeable
First, they have to have a certain level of knowledge and then they’ve got to be flexible with their knowledge so that they can’t handle the nuances and complexities of medicine. [Participant 11]

**Articulate.**
Doctors need to be articulate; they need to be willing to do their job even if they weren’t paid for it. It needs to be a calling. [Participant 29]

**Benevolent/ Caring**
They’ve got to know how to handle people and they’ve got to be articulate. [Participant 22]

**Change Agent; embraces change; innovative; proactive; works well in any healthcare system**
His specialist is a very caring person. I have complete trust in him. ... to be a good doctor you not only have to be good at what you do, but you have to be a good ‘people person’ and a caring person. [Participant 19]

**Community focused; deep commitment to social justice**
Health care is not what it used to be. We need doctors who can embrace change and be able to move with the times. [Participant 35]

**Conscientious; eagerness to learn; a thirst for knowledge**
Health care is not what it used to be. We need doctors who can embrace change and be able to move with the times. [Participant 35]

**Confident; self-assured; healthy self-esteem; quietly confident; inspires confidence in others**
I have one doctor in mind that really instills this confidence that she knows what she’s saying and she’s sure of herself, but can also accept that she can be wrong and she doesn’t know sometimes ... seeing that confidence is important for [medical] students. [Participant 9.5]

**Compassionate**
Extraordinary doctors I’ve known are the ones that don’t just care for their patients and their families, but have a real care for the whole community and their place within the community. [Participant 3.8]

**Confident; self-assured; healthy self-esteem; quietly confident; inspires confidence in others**
I have one doctor in mind that really instills this confidence that she knows what she’s saying and she’s sure of herself, but can also accept that she can be wrong and she doesn’t know sometimes ... seeing that confidence is important for [medical] students. [Participant 9.5]

**Conscientious; eagerness to learn; a thirst for knowledge**
In all my years of working with [medical] students motivation and that dogged determination surpass anything else … they may not be the highest achievers but are doggedly determined to make a success of their careers. [Participant 38]

**Diligent; hard-working; strong work ethic**
If it’s someone’s whose academically dedicated, who studies hard and who can put in the ‘hard yards’ because I know that doctors need to be able to work hard. [Participant 17]

**Effective coping skills; manages stress in personal and working life**
I’m all for a doctor who is well-balanced and well-rounded … they need to cope with crises and can’t allow their professional worlds to fall apart. [Participant 35]

**Effective manager including of human as well as material resources**
Someone who knows how to work within and manage a system to actually bring the greatest good for the greatest number and actually have systems of care that focus on the patient. [Participant 27]

**Empathetic; places themselves in the other person’s shoes**
I think empathy is the key to being able to relate to people and to understand people, particularly for a doctor. [Participant 18]

**Good corporate citizen; good commercial and business acumen**
The private medical practice market is extremely busy … we are fast approaching a level of saturation so doctors need to be able to market themselves and to be ‘commercial savvy’ to attract patients. [Participant 33]

**Healthy work-life balance; practises self-care; cultivates interests and hobbies outside of work**
There’s no question about doctors needing to have a healthy work-life balance otherwise you end up with doctors who have academic discipline that I admire, but their lives are pretty barren and that’s tragic. [Participant 9]

**Independent; autonomous**
We see doctors as having autonomous roles and being the overall managers of their patients … we expect them to work independently but collaboratively, which demands more depth to their skills and knowledge. [Participant 38]

**Intuitive; aware of peoples’ expectations, intuitive wisdom**
He [the doctor] had a lot of intuition about how we were feeling and what we were needing at the time. You either have it or you don’t. [Participant 5.4]

**Mature and responsible; professional maturity**
Medicine is a ‘mature grown-up profession’ because you have to have that broader understanding of human nature to be a good doctor and you can only get that through experience. [Participant 28]
| Organised; practises self-discipline and self-control; composed; good locus of control (internal & external) | We stress the importance of composure for our junior doctors ... instead of stressing and forgetting everything they’ve learnt they need to remain cool, calm and collected and assess their patient in a systematic and organised way. [Participant 39] |
| Positive attitude and outlook; an optimism about what’s possible; bright personality | This senior doctor showed us that with the right attitude we could do most things. She had such a positive influence on us like tasks we thought were drudgery she approached with enthusiasm and made them interesting. [Participant 3.1] |
| Positive role-model, including for the medical profession as a whole | We had mostly good role-models who were interested in teaching [medical] students and who looked after their junior medical staff ... it was then up to us to pass that on to the next generation of doctors. [Participant 1] |
| Practises holistically; ensures continuity of care; focuses on prevention as well as cure | I shopped around until I found a doctor who has that holistic approach and who understands my whole situation: Past, present and future. [Participant 20] |
| Problem-solving ability | I think what has made her a good doctor is that she’s always had this drive to solve problems and to find the best solution. [Participant 18] |
| Resilient and socially robust; tenacity; perseverance | I say to my registrars ‘you know I want you to care and when bad things happen you will get upset but you’ve gotta be able to pick yourself up, dust yourself off and keep going’. [Participant 11] |
| Skilled negotiator, delegator and coordinator | There needs to be a respectful collaborative partnership [between the woman and her doctor] with shared goals ... doctors therefore, need to be able to negotiate with women in a supportive way. [Participant 37] |
| Strives for excellence; embraces the art and science of medicine | Doctors need to have a deeply held conviction for the vocation of medicine that includes strong communication and interpersonal skills, combined with personal values of integrity and courage. [Participant 34] |
| Strong intellect; intelligent | I get to work with compassionate doctors who have these [good] characteristics of insight, of integrity, of proactively seeking out a complex answer to a complex question so I’m dealing with the thinkers. [Participant 30] |
| Tactile; uses therapeutic touch | He [her surgeon] was a ‘hand-holder ... when your heart’s pumping and you’re trying not to cry! I relied on his therapeutic touch as I had no-one else to lean on ... so that was a good experience. [Participant 17] |
E – ETHICS APPROVAL FOR PILOT STUDY

GRIFFITH UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE

16-Jun-2011

Dear Ms Lombard

I write further to the additional information provided in relation to the conditional approval granted to your application for ethical clearance for your project "NR:Stakeholder consultations on medical student selection." (GU Ref No: MED/21/11/HREC).

This is to confirm receipt of the remaining required information, assurances or amendments to this protocol.

Consequently, I reconfirm my earlier advice that you are authorised to immediately commence this research on this basis.

The standard conditions of approval attached to our previous correspondence about this protocol continue to apply.

Regards

Ms Karen Moorehead

Office for Research
N54 2.39 Nathan Campus
Griffith University
ph: 07 3735 4277
fax: 07 3735 4277
email: k.moorehead@griffith.edu.au
web: 

At this time all researchers are reminded that the Griffith University Code for the Responsible Conduct of Research provides guidance to researchers in areas such as conflict of interest, authorship, storage of data, & the training of research students. You can find further information, resources and a link to the University's Code by visiting http://www62.gu.edu.au/policylibrary.nsf/xupdatemonth/e7852d226231d2b44a25750c0062f457?opendocument

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F – ETHICS APPROVAL FOR MAIN STUDY

GRIFFITH UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE

08-May-2012

Dear Ms Lombard

I write further to the additional information provided in relation to the provisional approval granted to your application for ethical clearance for your project "NR: Informing Medical Student Selection: What do Gold Coast stakeholders consider to be the personal characteristics of a good doctor?" (GU Ref No: MED/04/10/HREC).

The additional information was considered by Office for Research.

This is to confirm that this response has addressed the comments and concerns of the HREC.

Consequently, you are authorised to immediately commence this research on this basis.

The standard conditions of approval attached to our previous correspondence about this protocol continue to apply.

Regards

Chris Rose'Meyer
Policy Officer, Research Ethics and Governance

Office for Research

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At this time all researchers are reminded that the Griffith University Code for the Responsible Conduct of Research provides guidance to researchers in areas such as conflict of interest, authorship, storage of data, & the training of research students.

You can find further information, resources and a link to the University’s Code by visiting


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“Informing medical student selection: What do Gold Coast stakeholders consider to be the characteristics of a good doctor?”

Information for interview participants

You are invited to participate in a study to identify Gold Coast stakeholders’ beliefs, experiences and opinions in relation to the characteristics of the ‘good doctor’.

This study is being conducted as part of Marise Lombard’s doctoral studies.

You are asked to participate in an interview where these questions will be explored.

The interview is planned to last up to an hour and is being conducted at a location that is most convenient for you.

If you decide to take part, your responses to questions will be audio recorded and the recordings will later be transcribed so that the information you have provided can be analysed by the researchers.

In order to safeguard your privacy, we ask that you give yourself a pseudonym beginning with the letter of the alphabet that has been handed to you. We also ask that you do not name persons or organisations during our discussion but rather refer to the role of the person you are describing or the type of organisation you are referring to.

When the information you have provided is analysed and reported, the researchers will be very careful not to include information that might tend to identify you.

As our discussion may raise issues of a personal and sensitive nature, please be reassured you that you are under no obligation to share any information, particularly if you feel that it may distress you. As an experienced educator, primary health care nurse and midwife, the primary researcher is available to provide further support or referral to appropriate services, after the session, as well as at any time during the project.

Any information you supply for our note taking and recording is entirely voluntary and confidential. The audio recording of the interview will be coded in a ‘transcription process’ to remove any identifying data. Once the transcripts are completed, the contents of the audio recording will be erased and the transcription data stored in a locked filing cabinet for 5 years after which they will be destroyed (as per Griffith University policy).

It is anticipated that results of the project will be written up for publication in academic journals and presented at professional or academic conferences. Such presentations will not contain any information that could identify you as a participant of the project. A summary of the results can be made available to you on request.

Please rest assured that any decisions you make in relation to the interview will in no way impact on your relationship with Griffith University or any of its academics.
The conduct of this research involves the collection, access and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at: http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or Telephone (07) 3735 5585.

This part of our project has been approved by the Griffith University Ethics Committee. Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the ethical conduct of this research project, please contact the Manager, Research Ethics and Integrity, Griffith University. Telephone (07) 3735 5585 or email research-ethics@griffith.edu.au.

Sincerely

Senior Investigator:
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