Putting values into practice, putting practice into values: exploring new doctors’ decision-making

Miriam Zukas, Sue Kilminster, Naomi Quinton and Trudie Roberts
University of Leeds

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Summary

This paper is concerned with the ways in which doctors new to particular positions of responsibility learn to make decisions. The paper is drawn from a larger study on doctors’ learning responsibility. We focus on values in decision-making and action, particularly in relation to conflicting and congruent knowledge between and within higher education and the clinical workplace. Drawing on a range of empirical examples, we propose that, despite notions of ‘evidence-based medicine’ and clinical protocols structuring practice, doctors’ learning and activity is mediated through the culture and values of the immediate workplace; values cannot therefore pre-empt and inform practice because values and practice are relational. We attempt to theorise this using the notions of learning cultures and cultures of learning (Hodkinson, Biesta and James, 2008).

Introduction

Undergraduate programmes in medical education work hard to develop a value base for new doctors, both in the university and in clinical settings. They may do so by focusing specifically on the development of professionalism and related attributes of practice and/or by incorporating discussions and development of values in general and specific programmes. Value-based foundations for decision-making include the notion of ‘evidence-based medicine’ and the use of practice protocols. It is assumed that there will be a direct link between this extensive educational process and doctors’ future decision-making and action in the workplace, although it is recognised that contexts and particular situations vary. The basis for the assumption is the idea that knowledge, values and practice may be transferred.

Researchers have long been concerned to identify ways in which that which is learned in one place (values, knowledge, practices) can be transferred to a new location - ‘learning transfer’ (Haskell, 2001; Colliver, 2004; Norman et al, 2005). A key problem is that such research has consistently failed to find
empirical evidence of learning transfer (Bransford & Schwartz, 1999). More recently, attention has turned to ways to prepare for the transfer (Bransford & Schwartz, 1999) and to the nature of learning after the transfer has taken place (Eraut, 2004). Such work recognises the importance of context and practice but remains focused on the individual mind and disembodied learning. As such, transfer, is a concept that is generally associated with and prioritised by those who see learning as a process of acquisition (Sfard, 1998).

In contrast, researchers within a growing tradition see learning as situated, and entailing participation in a community and/or activities (Lave and Wenger, 1991; Engeström, 2001). From this perspective, researchers exploring doctors' learning place emphasis on the ways in which medical staff learn to fit in with the culture and working practices of their new location or role, thus moving the focus towards socially derived understandings of learning within the work environment (eg Bleakley, 2002, Dornan, 2005) and away from transfer.

Work and learning practices involve specific activities determined in part by patients, divisions of labour, clinical protocols, ward culture, the culture of each speciality, institutional and organisational cultures and so on. This recognition of learning in practice is critical. Hodkinson, Biesta and James (2008) call this the “learning culture” of the workplace - the social practices through which people learn (see also Lave and Wenger, 1991). The learning culture is not the context in which learning takes place; nor do ‘learning cultures’ suggest sites for the application of pre-existing or separate knowledge. Instead, together with their histories, artefacts and institutions, ‘cultures are constituted by actions, dispositions and interpretations and exist in and through interaction and communication’ (Hodkinson et al, 2008, p 34). This entails a two-way process of individuals being (re)produced by culture and cultures being (re)produced by individuals. However, those individuals are not all equal participants in relation to cultures – they have differential power and position. Values are therefore carried within the setting through the social practices of the participants.

This is not to deny the relevance of individuals’ pre-existing knowledge, values and skills. But we argue that what they already know is only a part of what is needed for effective performance as a new professional and/or in a new location. In the terms of Dreyfus and Dreyfus (1986, 2005), how do such professionals learn expertise in a new situation? We know that such learning is difficult: for example, Jane Stewart (2008) demonstrated the complexities for new doctors making a decision to call for help. In order to better understand such learning we have to examine the transition process itself where individuals and learning cultures meet. We need to know how medical professionals learn as they change roles, so that it becomes possible to identify ways in which the transition process can be influenced to enhance such learning. We also need better understanding of the ways in which values
are embedded within work, and what happens when values as taught and values in practice do not coincide?

Research approach

This paper draws on an ESRC-funded project which explored how doctors learn responsibility by examining their transitions to new levels of performance. The study was funded as part of the ESRC's Public Services Programme and has three main purposes. First, we seek to understand how doctors' transitions are regulated, managed and monitored. Second, we explore how performance is understood by trainees, healthcare professionals, employers and regulatory bodies. Third, we investigate how specific learning cultures support transitions, which is where this paper starts.

The empirical work for this paper is derived from a 'collective' case study of two groups of doctors working in elderly medicine in hospitals: first year foundation doctors (F1s) who had graduated from university, and were now beginning work in general clinical practice; and specialist registrars (SpRs; now known as specialist trainees) who were beginning working in specialist clinical practice. We were concerned to understand how doctors come to practise what we called 'markers of responsibility': for F1s, they have responsibility for prescribing for the first time in their careers; and for SpRs, they have responsibility for patient management, again for the first time in their careers.

In 2008 we recruited doctors at the appropriate levels working in care of the elderly wards. We interviewed 10 F1 and 10 SpR doctors from a range of hospitals on two occasions, with each interview approximately 3 months apart. We also observed doctors during a 'typical' shift if we were able to obtain participants' permission. In the course of our semi-structured interviews in which we explored aspects of doctors' learning, we asked doctors to speak about prescribing and patient management for two common problems - urinary tract infections and upper respiratory infections. Supplementary interviews with other healthcare professionals (including consultants, ward sisters, pharmacists) were also conducted.

All interviews were transcribed fully and individual cases. The analysis has been an iterative process, and is still not complete, but draws on a systematic approach to description, then analysis and finally interpretation as suggested by Wolcott (1994). The team itself is constituted by two researchers with clinical backgrounds, one with an educational background and one with a background in biological sciences; all four have been involved in all stages of the data collection and analysis.

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Those we interviewed gave us many instances where values, both those they had learnt as undergraduates and what might be termed espoused professional values, were quickly brought into question in practice. Infringements of codes surrounding patient safety and patient confidentiality were commonplace. For example, when there were delays in issuing computer passwords, participants ‘borrowed’ passwords in order to be able to access patient information online, thus infringing guidelines on patient confidentiality (Caldicott, 1999). Security passes were shared in order to access wards because there were often delays in issuing passes to newcomers. Such infringements were ignored in practice because of other urgent demands – swift access to records and to wards in order to look after patients. So how then do new doctors come to learn values in practice? We examine three examples in more detail below.

Following the guidelines

Charles (a pseudonym) is a specialist registrar for elderly medicine who described his first day at his new hospital. He met with his educational supervisor, who was also a senior clinical manager in that hospital:

He took us (two new registrars) into a room – didn’t really tell us an awful lot but he did tell us that we shouldn’t do this – it’s a bit political – that we shouldn’t do blood cultures because they have an enquiry into every MRSA [a bacterial infection] which you have on the ward – this goes completely against any medical advice or you know what should be done and purely to save the Trust money. I thought it was really rather disgraceful and my boss of my medical education – my sort of supervisor – should be telling me not to do this so I was somewhat bemused at that.

The prevalence of MRSA, a difficult to treat infection, and other hospital-acquired infections have been the subject of much public, political and clinical concern. Recent guidelines (Department of Health, 2008) require that each trust’s chief executive report all cases of MRSA to the Health Protection Agency. Charles was therefore confronted with the clash between what he understood to be correct procedure and the messy politics of practice. He was being advised about the avoidance of procedures he knew were expected, and yet he was required to take such advice seriously, not least because of the power relations between him and his educational supervisor.
It is unclear whether Charles will follow his understandings about correct procedure or the advice of his educational supervisor; his actions in practice will depend on both the learning culture of his ward (the expectations, ways of working, social practices) and Charles’ dispositions. Whilst initially he brings certain values to the situation which influence and structure possibilities for action, these are not absolute: they will, of necessity, be influenced and structured by those around him. He will learn quickly to integrate practice and values if he is to survive as a specialist registrar. It is possible that Charles will be able to change practice, but it will depend on forming alliances with others (particularly those who are full participants such as consultants) who seek also to change practice.

Charles also explained that his educational adviser told him that, when he was on call, he ‘should avoid being on the younger admissions unit even though everybody else would be and I would be expected to be on that ward so that kind of went against my principles’. The underlying issue here was one of limited resources: his educational supervisor was keen to ensure that members of the elderly team remained dedicated to care of the elderly. When Charles went on the admissions unit and raised the issue, the consultant there ‘said I’d been told a lot of rubbish and that I should be on the admissions unit’, so Charles quickly learnt that there were, as he put it, ‘quite a lot of politics here’. In this case, although Charles’ view (what he termed his ‘principles’) was upheld by another consultant, nevertheless he was challenged to confront the fact that other considerations (limited resources, relative turf wars, and so on) might be just as important as ‘principles’ in determining priorities.

Prescribing in practice
Prescribing is an activity which cannot be separated from values in practice, despite its lay reputation as a set of absolute skills. Previously both research and anecdotal reports suggested that new doctors are not adequately prepared to prescribe. Our study found that the introduction of closer working with pharmacists and microbiologists and the establishment of clear prescribing protocols seem to be making a difference. But prescribing decisions involve judgement, where there may be no agreement about how best to proceed. Caroline, a foundation-year doctor, described a case where she had to make a difficult prescribing decision. Although her patient’s inflammatory markers were rising, she decided not to use antibiotics because the patient was well, and she understood the clinical advice to be ‘don’t treat numbers, treat the patient so if the patient has no signs of infection then why treat?’ Caroline found it hard to take this decision because her training also advised her to respond to signs of infection but she felt supported by the nursing staff who knew the patient’s consultant well and knew what he would do; the next day, the consultant concerned further endorsed her decision by saying ‘no, you’re absolutely right’.
Caroline presented the situation, as an independent decision taken on the basis of evidence from the literature or from the guidance offered to her from the protocols but it became clear that – in practice - her decision was almost entirely dependent on the particular consultant under which she worked:

Yeah, whereas if it had been the other consultant I would probably have started antibiotics.... Because he is for antibiotics so it just depends on who the consultant is, you have to know who you are working for.

Thus doctors learn to make prescribing decisions which are contingent on individual consultants’ values and (mis) interpretations of evidence, nurses’ interpretations of consultants’ prescribing practices, protocols issued by the pharmacy, interactions with other professionals and their own knowledge. The value and rhetoric of evidence-based medicine is subsumed by practice. From this point of view, it appears that new doctors cannot be adequately prepared to prescribe because prescribing is an activity which is embedded in social practice. It embodies and reifies specific values of the specific learning culture and, as such, cannot be ‘taught’ outside practice.

**Learning from others**

In our study, although we had restricted ourselves to investigating care of the elderly, learning cultures varied from elderly ward to elderly ward, let alone hospital to hospital. Those learning cultures were constituted historically by social practices involving clinical staff, patients, technologies, protocols, organisational and institutional practices and so on. But this is not to suggest that the doctors we were looking at had no part to play in their own learning – in other words, the doctors were agents too. Hodkinson et al’s (2008) cultural theory of learning suggests the idea of horizons for learning as a way of taking both individuals and learning cultures into account. Such horizons for learning are relational in that they are a complex inter-relationship between an individual’s dispositions and the learning culture. Thus, doctors developed values in practice through the inter-play between participating in the learning culture of the workplace and their (changing) dispositions and values. In analysing learning, other important aspects also come into play – the position and capitals of the individuals for example; but because of space, we put these to one side in order to focus on the interplay between learning culture and cultural learning.

As part of the study, we spoke to other professionals about doctors’ transitions to new levels of performance. Often, nurses, pharmacists, physiotherapists and other professionals spoke about doctors’ ‘organisation’ – the ways in which they managed the flow of work. One senior nurse described how some doctors would turn up at a certain time, undertake all necessary jobs and then respond to ‘bleeps’ (or calls) throughout the night, ‘firefighting’ as patients deteriorated; others would turn up
regularly throughout the night to check for jobs and to check on patients – such doctors were
‘organised’, said the nurse.

The ‘bleeps’ for doctors were not, however, evenly distributed. Nurses would decide whether or not to
‘bleep’ a specific doctor depending on their confidence in the doctor’s judgement and skill, the severity
of the patient’s illness or even the availability of another doctor. Furthermore, doctors who were willing
to respond to prompting from nurses – perhaps through nurses raising ‘subtle’ questions about doctors’
next course of action – were more likely to be called, even if they were inexperienced. In other words, in
the same (relatively expansive) workplace (Fuller and Unwin, 2003), different doctors had different
horizons for learning, depending on their dispositions and relationships. These different horizons for
learning were linked to different affordances for practice, which in turn depended on nurses’ and others’
perceptions of and judgements about doctors’ performance.

Although both doctors and nurses failed initially to mention that nurses – especially experienced senior
nurses - featured strongly in junior doctors learning, and there was some ‘coyness’ on the part of both
professions in this respect, some junior doctors understood very well the significance of good
relationships with nurses. When asked how she would prepare for her next transition, one doctor said
she would start by ‘introducing myself and being nice to the nurses’. This doctor understood just how
important it was to establish good working relationships, even as a relatively junior doctor, apparently
with little relative power. Despite the constant rhetoric about interprofessional learning and valuing each
other’s contributions to patient care, some doctors seemed unaware of nurses’ contribution to their
horizons for learning.

Discussion

The study illuminated the ways in which values in the clinical context are not absolute, despite notions
of professionalism, ‘evidence-based medicine’ and clinical protocols. Instead, learning in practice is
mediated through the culture of the workplace, and may depend on particular consultant practice, on
team culture, on individual dispositions in relation to cultures of learning, and so on. New doctors may
struggle to make ‘correct’ decisions on the basis of what they have been taught if the culture of the team
and particularly the consultant militates against that learning. They may also fail to recognise learning
opportunities and to gain access to workplace expertise if they do not fully understand how the
workplace actually works. This raises important questions about the ways in which new doctors are
educated to engage with values in practice. We have argued that we need to understand professional
values and judgement in practice as relational, rather than fixed. Rather than seeing values as
somehow out there, pre-empting and informing practice, we have to understand them as embodied and inseparable from practice.

References
A separate list of references is available.