Introduction: The relationship between clinician teachers and their students is of major importance in medical education. However, there is very little known about the effects on clinicians when conflict occurs between these parties. What do clinicians perceive to be major causes of these conflicts? How do they react when and after conflict occurs? What are their motives for staying involved in teaching even after these conflicts occur? This phenomenological inquiry was undertaken in order to explore these questions.

Methods: A phenomenological inquiry exploring the lived experience of 12 clinician teachers in medical schools was performed. The clinicians were selected using purposeful sampling and snowballing techniques. Semi-structured interviews were performed and an analysis based on the methods described by Hyenar was undertaken. The interviews revolved around discussions based on episodes of conflict with medical students that the clinicians considered significant. The analysis and emergent themes were partially constructed around and informed by theories of conflict, conflict management and role conflict.

Results: A number of themes emerged which describe the phenomenon from the clinicians’ experience. These themes included the following; clinicians perceived that many of the major student/clinician conflicts involved students with significant psychological and behavioural problems; the conflicts had a significant emotional impact on clinicians; though the responses to conflict varied, “avoidance” was a mechanism commonly used by clinicians and; the assessment of attitudinal and behavioural professional issues in the workplace was problematic for many clinicians. However, despite these issues clinicians remain deeply committed to the education of medical students.

Discussion and Conclusion: This phenomenological inquiry brings a clear clinician perspective to challenging student/clinician encounters which may help medical schools and medical educators better understand the lives of clinician teachers. It offers some insights as to how clinicians might be assisted in their teaching role.
optimize learning opportunities. The ways in which clerks describe the incentive structures of clerkship may be foreign to researchers and experienced clinicians, but attention to these perceptions can improve our understanding of how clerks choose to spend their time and energy. For instance, the efforts clerks make to project an air of competence and knowledge may obscure important opportunities for learning, support, and professional growth. By examining preceptors’ exercise of power and learners’ perceptions of empowerment, the health profession education community is afforded a clearer understanding of the formation of resilient health professionals.

#3F3 (120)
Prevention of harmful stress amongst doctors

Rachel Locke, University of Winchester, Winchester, UK
Amanda Lees, University of Winchester, Winchester, UK
Samantha Scallan, University of Winchester, Winchester, UK

Introduction: Contributory factors to high stress levels amongst doctors and the need for resilience are well documented. Less is known about educational interventions that may help doctors to recognise and manage the harmful effects of stress in their own practice. This paper presents findings from a thematic synthesis of international literature concerning pedagogy for educational interventions to combat stress for doctors, which can be offered as continuing professional development or as part of medical curricula. The synthesis was conducted as part of a mixed methods study which included focus groups with medical educators and an online Delphi exercise.

Methods: The systematic literature review involved searches of key databases: Medline, PsycINFO, ERIC, PubMed, Web of Science, and Proquest. Keywords searched included intern, resident physician, doctor, surgeon registrar, psychiatrist or general practitioner and stress, burnout resilience or fatigue. A protocol defined the search and the quality of the results to be evaluated. The thematic synthesis was guided by the following research questions:
- What are the pedagogic features of successful educational interventions to manage the harmful effects of workplace stress for doctors?
- What are the contextual factors affecting learning and outcomes?

The first stage of study selection and exclusion included screening of title/abstract. At stage two, articles were rejected that were not relevant to the review i.e. wrong intervention or professional group. The third stage appraised the quality of the literature. Data was extracted from the final selection of studies using a standardized template for the purposes of thematic interpretation.

Results: From 1555 papers initially retrieved, 38 studies were included in the synthesis. Interventions reported on in these studies used numerous pedagogic approaches to managing stress:
1. Learning to relax/personal stress reduction, with mindfulness based approaches often featuring.
2. Support groups (including Balint groups).
3. Curricula, training or tutorials for medical trainees/staff
4. Cognitive Behavioural Coaching including individually and group delivery.
5. Personal therapeutic interventions.
6. Reduction of external stressors through identification and seeking to reduce them through problem solving. Interventions spanned several specialisms and were provided for trainees, qualified doctors and multi-professional team members. Interventions were offered at three levels: primary (to prevent harmful stress from occurring), secondary (targeted at ‘at risk’ doctors) and tertiary (support services for those experiencing difficulties) (Dyrbe and Shanafelt 2016).

Discussion and Conclusion: Following on from the description of the types of intervention discovered, the paper considers in more detail what can be learnt about which types of intervention appear to work well for whom (e.g. more experienced staff versus medical trainees) and in what ways (e.g. reduction in measured stress levels versus improved work satisfaction), reflecting on the differing foci and associated outcomes of various pedagogic approaches. Only a small number of UK based interventions were included in the review, interventions offered within the US, Australia and Scandinavia were more frequent. The paper reflects on whether the geographic spread of included interventions may be linked with wider societal narratives about the nature of stress, wellbeing, the caring professions and about who should care for doctors themselves.


#3F4 (143)
Unravelling Intersubjectivity in residency training: It does take two to tango

Francisco Olmos-Vega, Pontificia Universidad Javeriana, Bogotá, Colombia
Diana Dolmans, Maastricht University, Maastricht, Netherlands
Carlos Guzman-Quintero, Pontificia Universidad Javeriana, Bogotá, Colombia
Renée Stalmeijer, Maastricht University, Maastricht, Netherlands
Pim Teunissen, Maastricht University, Maastricht, Netherlands

Introduction: Workplace learning results from a balance between what is afforded to residents and how they decide to engage with such affordances, a balance difficult to strike. Crucial to finding this balance is intersubjectivity: the shared understanding between residents and supervisors towards accomplishing common goals. It is like dancing the tango; synchronized dancers must understand each other and share a dancing repertoire to respond to each other moves. However, little is known from the medical education literature about how residents
and supervisors develop intersubjectivity when dealing with patients. Unravelling intersubjectivity could help us understand how social interactions ignite workplace learning.

**Methods:** To this purpose, we conducted a constructivist grounded theory study taking place at the Universidad Javeriana Anaesthesiology Department, at Bogotá, Colombia. We conducted focus groups with residents (n=11) and supervisors (n=18) to determine how they experienced their supervisory interactions at the workplace, and how they achieved a mutual understanding regarding how to provide patient care. Preliminary categories from focus group analysis allowed us to guide observations in the workplace. We performed observation sessions over a five-month period in varied workplace settings and with residents from different levels of training. Observations lasted at least 6 hours at a time, two to three times per week. Constant comparison between focus groups and observation analyses allowed us to elevate key codes into major categories. Five follow-up semi-structured interviews with residents and supervisors helped us refine the emerging categories. Through theoretical sampling and iterative data collections and analysis, we reached theoretical sufficiency.

**Results:** Residents and supervisors achieved intersubjectivity by adapting to each other while providing patient care. As resident and supervisor teams changed continuously, actors were exposed to a lot of variation in dealing with patients because each of them had their unique way to work. Consequently, residents and supervisors developed various adaptation processes to reach agreement on how to provide patient care. Those processes included following protocols, complying with supervisors’ principles, negotiating supervisor’s preferences and sharing decision-making. Experiencing repeated adaptation processes resulted in intersubjectivity reifications that we called working repertoires: a set of action-reaction combinations that each team of supervisors and residents uses to work together, and that helped them overcome challenging patient care situations.

**Discussion and Conclusion:** Residents and supervisors tried to understand each other’s preferences and needs while providing patient care to work efficiently together. Because of asymmetrical levels of competence and continuously changing supervisory arrangements, residents and supervisors developed various adaptation processes to come to agreements. In such processes, we observed how the resident gained an increasingly central role in the team, progressing from following supervisors’ directions up to sharing decision-making with them. Thus, achieving intersubjectivity in supervisory interactions resulted not only in improving team work but also in easing the conflict between providing supervision and allowing resident autonomy. Future research should explore how teams maintain intersubjectivity on the long term and how residents’ peers influence its development.

**References:**

---

**#3F5 (241)**

**Navigating contexts: How medical students construct a professional identity while dipping into different social cultures**

Marieke Adema, University Medical Centre, Groningen, Netherlands

Esther Helmich, University Medical Center Groningen, Netherlands

Janet Raat, Hanzehogeschool Groningen, Netherlands

Gerard Bos, Maastricht University, Maastricht, Netherlands

Fedde Scheele, VU University Medical Centre, Amsterdam, Netherlands

Diana Dolmans, Maastricht University, Netherlands

Debbie Jaarsma, CEDAR (Center for Educational Development and Research in Health Professions), University Medical Center Groningen, Groningen, Netherlands

**Introduction:** Students (co-)construct a professional identity through interaction with their social contexts. Considering the current rotational model of a clerkship, medical students dip into different cultures in a brief kind of way while navigating through different social contexts. This interplay between the individual and the social context supposed to have an influence on the construction of a professional identity. Therefore, the aim of this study is to illuminate if and how students’ use the social resources by dipping into different social cultures to shape their identity as a future physician.

**Methods:** This longitudinal qualitative study took place in a series of mandatory 4-week clinical rotations during year 5 of the 6-year medical undergraduate programme at a Dutch University. Students could choose to participate in 10 to 12 clinical rotations. We asked students to record experiences in their 3rd week of each rotation which made them think about whom they were and what kind of doctor they wanted to become. We received 160 audio recordings from 12 students of six affiliated hospitals. The coding of transcripts of the audio diaries was performed by three researchers (MA, ANR and EH), using template analysis.

**Results:** Students have agency in selecting pieces of a possible identity. Instead of adopting a full doctor’s identity, they practice parts of possible identities that resonate with their personal identity and their imagined doctor’s identity. In each social context they reflect their own values and beliefs with role models to build and practice parts of their imagined doctor’s identity. Getting responsibilities, being taken seriously and receiving constructive support encourage students to play-act possible doctor’s identities. Nonetheless, an environment where students get limited opportunity revealing the type of doctor they want to become discourages the construction of students imagined doctor’s identity. Finally, social context acts as glue for their possible doctor’s identity, when dipping into a context where all pieces of a possible identity fall into place.

**Discussion and Conclusion:** When talking about identity construction in literature, we talk about students socialization into a doctor’s identity, as if identity is
Monolithic. As shown, students borrow and reject bits and pieces of different identities they encounter in different social contexts. Clerkship is one of the most important places for them to do this and the place where they can act-play borrowed parts of identity to see whether it suits their imagined identity as a future physician. Furthermore, an environment where clerks are allowed to practice their imagined doctor's identity seems to support the construction of a professional identity which is coherent with students' sense of self. In contrast, feeling unsafe to express ones imagined doctor's identity results in socially accepted behavior inconsistent with ones self.