A SUITABLE CASE FOR TREATMENT: DOCTORS AND THEIR EXPERIENTIAL LEARNING

USTREZEN PRIMER ZA OBDELAVO: ZDRAVNIKI IN NJIHOVO IZKUSTVENO UČENJE

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Abstract

In this paper I consider the nature and meaning of experiential learning among a group of doctors, working in inner-city contexts, and using autobiographical methods. Medicine remains a very ' male' profession, in which emphasis is given to the application of 'objective', scientific knowledge to patient's problems. The paper explores particular doctors' struggles to be effective and reflective practitioners in a medical world. Especially, where experiential learning in relation to knowledge about self, the emotions and the cultural dimensions of health, can be professionally derided. Still,' success' may depend on the integration of medical and experiential insight.

Key words: family practice, continuing medical education, learning

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Izvleček

V tem članku preučujem naravo in pomen izkustvenega učenja v skupini mestnih zdravnikov ob uporabi autobiografskih metod. Medicina ostaja zelo »moški« poklic v katerem se poudarek daje uporabi objektivnega, znanstveno osnovanega znanja pri obdelavi pacientovih problemov. Članek raziskuje posebne težave zdravnikov pri njihovi težnji, da bi bili učinkoviti in reflektivni v svetu medicine, kjer je izkustveno učenje, še posebej v odnosu do znanja o samemu sebi, emocijah in kulturnih dimenzijah zdravja, profesionalno zasmehovano. In to kljub temu, da je »uspeh« lahko odvisen od povezovanja medicinskega znanja z izkustvenim.

Ključne besede: družinska medicina, permanento medicinsko izobraževanje, učenje

Introduction

This article derives, uniquely, from in-depth, longitudinal, collaborative and what is termed autobiographical research among 25 General Practitioners (GPs), or family physicians, working in demanding inner-city contexts (1). The research focused on their experiential learning, role and well-being during a time of changing roles and expectations, including within the management of health care in Britain, and a period of growing criticism over performance and levels of accountability. Dr Kildare has been replaced by Dr Harold Shipman and stories of doctors' mistakes far outweigh the triumphs (2). The inner-city presents distinct challenges to doctors in a mounting crisis of social exclusion, escalating problems of mental health, growing alienation as well as increasing inequalities in health and health care (3).

The research sought to chronicle and theorise the impact and meaning of social and cultural change, as well as the role of experiential and lifelong learning, among a diverse group of doctors. For this purpose, case study material and an interdisciplinary 'cultural psychology' related sources were used. It documented some of their doubts and anxieties about their training as well as the biomedical model, in the face of problems, which often seemed more social and psychological than physical. It explored the psychological distress and feelings of helplessness that can haunt a doctor, and the difficulties of dealing with this

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in a medical culture in which doctors are taught they should know and cope. The stories at the heart of the article are, however, of two doctors who, because of multiple identities and experiences of oppression, have felt on the margins of the profession. Such GPs - 'outsider-insiders' - raise radical questions about the health of medicine, its training, epistemological assumptions, and the forms of learning required for effective practice. The argument developed, derived from the stories, is of the centrality of experiential and emotional learning, rather than its marginality, in becoming a more effective doctor.

Self-directed learning

The starting point for the research was an evaluation of self-directed learning groups (SDL) for GPs in inner-London. The groups were established following concern over standards of care and the morale of doctors. They were designed to give space for GPs to consider 'critical incidents' with selected patients, cases that might be causing particular anxiety. These might include the unexpected death of a patient, or a doctor feeling muddled, inadequate and disturbed by a patient with psychological problems. The aim was to address the doctor's fears and anxieties in the role as well as to consider different management options and what they might need to learn to feel more competent in the role. Each group consisted of about 8 doctors, was confidential, and led by a skilled facilitator. The idea was to create a learning rather than a blame culture in which the doctors could be more open about their work, and žfailures', without fear of criticism. The evaluation provided the basis for a far more extended study, lasting for four years, of how GPs manage their work and learn, in the context of a changing health care system, and whole life histories. The research involved 6 interviews, for most doctors, lasting upwards of 2 hours each. Transcripts and tapes were used to establish themes and consider their meaning and significance, collaboratively and dynamically, over time.

Many of the GPs considered their initial training, especially its overly textbook approach and construction of illness as primarily physical and biological, was often inadequate in the face of actual patients with multiple problems, rooted, as these frequently were, in the psychosocial pathologies of the inner-city. While patients clearly want the most effective treatment available, based on the latest scientific evidence, it does not follow that most consultations require this. What is more often needed is a relationship in which patients can consider their 'dis-ease' within the totality of their lives, and explore the different options that might be available to them. What some of these doctors understood - because of their own multiple identities and experiences of oppression - was the need for patients, and their stories, to be listened to. They knew, experientially - because of their own gender, ethnicity or sexuality - what it was like to be silenced and misunderstood.

Medical culture

GPs operate in a medical culture where specialist, hard, 'scientific' knowledge has traditionally been deified, while the softer skills of human communication and psychosocial medicine are often considered 'other', 'subjective' even 'woolly'. This is a culture in which learning from experience about the emotional aspects of medicine continues to have an uncertain status, despite increased emphasis on communication and whole person medicine (4). In fact, there is some evidence the situation may be getting worse. In writing about the effects of greater accountability and weeding out the unacceptable in medical practice, Salinsky and Sackin (5) conclude that the study of interpersonal issues and such matters as the doctor-patient relationship are in danger of going to the bottom of the pile. In addition, they both agree that 'the archaic system of junior doctor training in medical schools means that many students become less person-centred and lose their humanitarian ideals'. For GP trainees (or 'registrars') 'the bottom line of training is passing the very basic test of summative assessment' while anything not directly connected with that is easily considered irrelevant. The increasing pressure of the GP registrar year can make it more difficult to develop the humanitarian side of their work. These accusations, if true, are deeply worrying.

Historically, of course, GPs have been situated on the edge of the medical profession, at the interface between the 'scientific' claims of mainstream medicine, and the messy swamp of actual lives and uncertain symptoms (6). By the time a patient sees the specialist, a degree of clarification, a narrowing of possibilities will have occurred. GPs are, by definition, Jacks-of-all-trades; and general practice, as McWhinney (7) notes, in its attempts to discover a distinct epistemological basis, fits uncomfortably in the highly scientistic milieu of the medical school. In this and other respects, it is under constant pressure to become more 'scientific' as well as more theoretical and quantitative. The neglect of the experiential, especially the emotional, can be a consequence.

A key point is the epistemological basis of the profession, and what doctors need to learn, is contested space. There is a long established belief among many GPs that the skills and understanding required for much of their work has been neglected and there is developing interest in more experiential, case study based forms of learning, which include focusing on the doctor's feelings. These ideas build on older traditions, such as Balint groups, which employed psychoanalytic insights to enable doctors to consider the emotional dimensions of their work, including the transference and counter-transference aspects of the consultation. Disturbance, as Michael Balint, the distinguished psychoanalyst, once noted, often disturbs and doctors have to learn to understand their own feelings and use these reflexively, not the least to understand more of what may be happening inside the patient. Furthermore, doctors should remain open to their patient and their struggles, rather than feeling overwhelmed and thus retreating into defensive practice. However, such groups, including SDL, remain 'minority sport' among GPs as a whole (8).

All of which can have serious consequences for the health of doctors, especially when combined with the growing 'blame' and litigious culture of health care, and the pressure of rising expectations. But the resistance on the part of many doctors to engaging with the emotional aspects of their work also raises a series of questions about the values of medical culture itself and processes of professional socialisation. Namely, many doctors find it hard to talk about their anxieties and perceived inadequacies, most of all mental health problems, mainly for fear of what colleagues might think. Some male doctors in the study were enmeshed in the discourse of doctor as all-knowing hero, partly, as defence against fears of inadequacy and their own emotional troubles. Particular doctors admitted to dispending drugs far too promiscuously to ward off the demands of their patients (1). Whatever the causes, the evidence of increasing unhappiness, stress, alcoholism and even suicide among many doctors is mounting (1, 2). This is a profession on the edge.

What is being suggested is that some of these problems are a consequence of the profession's own value base, which includes the dominant status of the intellectual model of medicine, grounded in the notion of bringing the natural sciences, that is 'objective' knowledge and a technical rationality, to bear on people's health problems (2), to the neglect of other more experiential ways of knowing. Autobiographical research, of the kind used in the present study, can clarify more of what doctors, in reality, may need to know, including the place of learning about the self, and emotional understanding, as a basis for better understanding others, alongside the science.

Autobiographical methods

There is a turn to biographical, life history and/or narrative research methods across the social sciences. This is partly an attempt to clarify the complex interplay of social structure and individual agency, or, in processes of professional socialisation, formal and informal learning. The biographical imperative has switched attention to the personal, affecting the orientations of many disciplines but also their interrelations with each other (9). The personal, in these perspectives, is perceived to be deeply socio-cultural as well as political, in which individuals are both shaped by but also actively shape, however unconsciously, the cultural worlds they inhabit. There is also an interdisciplinary momentum at the core of the turn: people and their stories are not easily categorised according to particular disciplinary frames. Stories about learning, for instance, frequently defy definition as 'sociology', 'psychology' or 'education'. Biographical research is, in these terms, challenging the gaps between disciplines: sociology, for instance, has traditionally lacked any convincing account of how the social, including learning, is translated into changes in inner-life, and how this can be theorised. Mainstream psychology, on the other hand, tends towards an essentialism in which learning, for example, is conceived in individualistic and asocial ways, as in some theories of motivation (10). Biographical methods render new interdisciplinary conversations essential.

The term 'autobiographical' requires explanation. This challenges the idea of the detached, objective biographer of others' lives, and the notion that a researcher's history, identity, (including gendered, raced, classed and sexual dimensions), power and membership of a discursive community, play little or no part in shaping the other's story in research; or ought not to, in the name of rigorous and objective science. Liz Stanley (11) writes, instead, of intertextuality at the core of biography, which has been suppressed in supposedly 'objective' accounts of others' lives. It is as if telling the story of someone else is a purely cerebral affair, disconnected from the self, psyche, academic and personal identity as well as discursive frames of the enquirer, and his/her relationship with the researched. This is, of course, part of preserving a kind of *de facto* claim for biography and life history research as science: a process producing 'the truth,' and nothing but the truth about its subject (11).

Michelle Fine (12) insists that social scientists have persistently refused to interrogate how they create their stories. There has, at times, been a presumption, as in the natural sciences, that theories and methods neutralise personal and political influences: "That we are human inventors of some questions and repressors of others, shapers of the very contexts we study, co-participants in our interviews, interpreters of others' stories and narrators of our own, becomes, in some strange way, irrelevant to the texts we publish" as 'research'. Fine argues, instead, for the reflexive and self-reflexive potential of experience, in which the knower is part of the matrix of what is known, and where the researcher needs to ask herself or himself in what way has she or he grown in, and shaped the processes and outcomes of research.

Such questions have been central to my own work on adult learners managing change and dislocations in their lives, and using higher education as a way of reconstructing their identities. I grew close to particular learners, and drew on my own experience, in particular interviews, in ways which were seen to empower the 'other'. Dialogue and reciprocity were considered a positive resource, rather than a negative influence, in the struggle to interpret experience (10). In the present research, in asking questions of doctors about learning and managing change, I realised how much I was asking similar questions of myself. In hearing their stories of the psychosocial complexity of personal and professional development, and of what facilitates or inhibits growth, including the role of gender, and a deeply gendered culture, in shaping the way we think and feel, I was searching to articulate more of my own.

I was training as a psychotherapist, as well as being an academic educator, during the time of the study. I was struggling with questions about being a male therapist in a profession discursively infused, over many decades, with the symbolically 'feminine' notions of breast, feeding, good enough mothering and empathy (13). I was asking, for instance, questions about being a man socialised into a competitive individualistic masculinity, in a profession that places empathic attunement at the core of its work. I was also wondering, symbolically, about the relative place of the 'masculine' and 'feminine' in living as a man, at a time of profound questioning of 'macho' stereotypes and essentialist accounts of gender.

I came to share more of my own experience, in the research process, as relationships with particular doctors developed and as they bared their souls to me. There were many parallels, I discovered, between the stories of some of these doctors - both male and female - around issues of gender and learning, for instance, and the place of the symbolically feminine in health care, and my own experience and struggles as a man, a therapist and an educator. The dialogue, in these cases, focused increasingly, in growing depth and reflexivity, on the relationship between personal and professional identities, the self and the other, in the struggle to learn, and to become more effective practitioners.

Two case studies: insiders and outsiders

I want to use two case studies to illustrate these points, especially the interplay of formal and experiential learning, as well as the žpersonal' and the 'professional'. Dr Aidene Croft, for instance, is an outsider and lesbian, who works in a difficult and impoverished part of London's East End. She is white but talks with a 'different' accent. She told me she had experienced a major 'mental breakdown' in her career and, in the course of a year, phoned the BMA Stressline and Samaritans, and sought psychological help. She had felt over the edge as a doctor, unable to cope with patients and their disturbance. Some of the pain of her troubled life history was no doubt stirred up by interactions with particular patients: her own story included a mother who died when Aidene was four, difficult relationships with a succession of stepmothers, and a distant, emotionally withdrawn father. Becoming a doctor, she surmised, was part of an attempt to heal a fragile world.

She mentioned her sexual identity, from the outset, and that this fitted uneasily into the 'male' and predominantly heterosexual culture of medics. She was working as a single-hander when we first met, having left a group practice and suffered an emotional crisis. She had needed, most of all, she said, to find her own authenticity as a doctor. She felt torn between her feelings and living in the head as a doctor. Her life and work did not feel 'real': 'I was very much trying to connect the two… I couldn't actually tolerate that level of incompatibility'. Aidene was sceptical of conventional 'male' medicine. She worked in a women's hospital where doctors had dismissed the notion of Pre-Menstrual Tension. But 'there wasn't an ovary in the room', she said. She was also critical of her profession's neglect of mental health problems.

She talked, early on in the research, about the relationship between aspects of her identity and interactions with particular patients:

You know I think because if your sexuality is outside the normal experience of people's expectations of their

doctor, it leads to identification with everybody from Greeks to Turks, black people, Irish people, you know what it's like to be an outsider, you know, to fudge around issues, to not quite explain, for people to instantly lose their curiosity or suddenly go quiet or whatever. All my experience is about being out of orb…you just know there is that hesitation that people then rethink… And I think it makes me more accepting of people. Many doctors find it terribly difficult to just accept people as they are without trying to change them into the wrong perception...

Aidene knew what it was like to feel lost in an alien culture, and to struggle to explain this to others. She was sensitive to the mental distress of many minority patients, and wanted to research mental health issues among different ethnic populations. She talked of how black and Irish people were over-represented in mental health services and quoted research indicating that rates of depression in various minority communities exceed those of the 'English'. Levels of schizophrenia were high too, as were a range of anxiety states and personality disorders (14, 15).

A significant other

Aidene almost left medicine completely. She hated hospital medicine and its customs, including the very male, 'clubbish' culture that often predominated. She disliked many aspects of her formal training; becoming a more effective doctor, on more of her own terms, was rooted in experiences outside medical schools and hospitals. She found, for instance, more humanity in general practice as she forged a strong relationship with a GP trainer. This enabled her to learn, experientially, in profounder ways:

I had a wonderful trainer, very…astute, insightful, a really very very nice man. And thought yes this is it. This is where it is at… Feed me, feed me, this is a fascinating subject…You could be very honest about your deficiencies in learning. I had done paediatrics and gynaey and house jobs. I knew sod all about dermatology… this was a really clever bloke. I mean clever, clever in a very wide sense. Within two or three weeks I was in there saying - Jesus I haven't a clue about dermatology, give me some pictures, skins, I had no experience of this kind of skin… I had left home when I was 16 and was one of 11 children and suddenly here I was being given this - I had gone to boarding school… And suddenly it was all - now what would you like? Where can we go?… it just seemed incredibly generous and useful… he was somebody who respected people. I could learn from him that much more...

For the first time, she felt seen, valued and 'fed' in the medical world, as she did in her personal life with a new partner. It enabled her, alongside therapy, to understand more fully her own needs as well as those of her patients, and that she could be a doctor on more of her own terms. She also learned to be realistic over what she could offer: she could not solve a housing crises or the abusiveness of officialdom, although she might help. But she could nonetheless listen, as she put it, 'to, for and with' the patient's story. Empathic relationship and narrative-based practice were at the heart of effective health care, and of her most significant experiential learning.

New relationships - with colleagues and others - were at the core of learning and professional growth in the narratives of many of the medics. Sean Courtney, in reviewing processes of adult learning and change management, noted how frequently a significant other was essential to what he termed 'life spacing': taking risks, experimenting, and managing personal transitions and crises (16). There were similar findings in my earlier research into men and women managing change, and using education, in communities undergoing major economic and social dislocations (10). What often seems critical to successful transitions is being able to share - with a colleague, a teacher, a friend or therapist - uncertainties and doubts, and feelings of failure in a non-judgemental and empathic relationship. There was transitional space and encouragement to think, and be open, without fear of blame. Aidene's trainer offered time, support and space to think, and learn, during a period when she felt badly about herself as a doctor.

Psychoanalytic, especially feminist object relations theory, can help explain some of these psychosocial processes. Individual development, in this view, is always located in an intersubjective context, and 'inner' experience is shaped by a person's interaction with others, from earliest times but also over the course of a life (17). Psychological development is conceived as constantly contingent and profoundly social as subjective life is forged in the relationships in which we are embedded and the wider scripts that inform these (18, 19). Object relations theorists, for example, in considering how intersubjective experience translates into intrasubjective life, often use the metaphor of psyche as consisting of a cast of characters, of people and dynamics in the social world, which become internalised. Some people injure or constrain us; others may inspire and accept us, and provide us with a sense of basic legitimacy and hope. People and relationships 'out there' become part of an internal drama, which forms the basis of personality. But the drama

can change, even for highly disturbed people, as new, more empathic others enter the social, and, over time, the psychic stage. These 'good objects' may be people we know directly, whom we respect and can identify with. They may be friends, teachers, or other learners and may mirror, in their actions and responses, new biographical possibilities (10, 13). Human beings, in this view, exist in a shared space of affective intercourse, and there is fundamental overlapping between one and another. This implies rather different philosophical assumptions about personhood to the Cartesian separation of each person's inner-space from the other, as if we were mere physical bodies positioned according to distance arrangements. Such an intersubjective perspective is now taking hold in developmental psychology, phenomenology as well as psychoanalysis (17).

And our need for others may be strongest at times of frightening change, or of disturbance, when primitive anxiety feelings are evoked, that, for instance, we might disintegrate under the pressure. For a doctor, the disturbance of a patient may dig deep into his or her own pathology as one life connects with another, as emotional distress and pain touches her own pain and emotions. At another level, a doctor can feel bereft at the loss of idealism, in the face of the harsh reality of, and a sense of impotence in relation to, the problems of the inner-city. Such experience can, on the one hand, evoke paranoid defensiveness and acting out in omnipotent ways; or, on the other, it can lead to new understanding and psychological growth. One psychiatrist has described how the need to defend states of omnipotence can induce states of denial, turning to drink, having an affair and or playing pointless power politics in the medical profession (20).

Despising the mainstream

The case of Dr Daniel Cohen illustrates how disturbance can be a means to experiential learning of the profoundest kind, to personal and professional growth. Like Aidene Croft, Daniel felt himself to be an outsider in medicine:

….I don't believe in what I think the mainstream believes in… I am actually often appalled by the discourse, just appalled by… the whole set of assumptions about the nature of reality, about the assumption of the doctor's power and the assumption of sexist and racist… ideas and… the collusion around that… I feel profoundly alienated by it, which is why I have so little to do with it… Like mining a seam of gold called the medical fact… from a pile of shit, which is the patient's sort of life… a way of talking about… patients as if the patient isn't there…

Daniel's crisis came 8 years ago, over the amount of work and its endlessness. There were very few professions, he said, having such a workload in terms of volume or intensity. And there was no career development path for the GP; at the age of 37/38 you might 'look forward' to 20 years struggling with the same sorts of issues, with few other options.

The personal and the professional

Being a doctor had forced him to ask questions of himself, at many levels. There was no neat distinction between questions patients asked: "who am I?" or "where do I come from?" or "why do I have the kind of problems that I think I have?" and those of the doctor. There was a seamless web connecting their story to his. Daniel used psychotherapy and experiential groups to reconsider aspects of his own family history and identity, in what he termed a process of narrative recovery and reappraisal. He was the child of refugees from Nazism, which led many like him into the caring professions. The desire to heal, he thought, was primarily directed at self. He was brought up, he said, with the experience of Nazism and fleeing persecution not being talked about at all. There was, in this context, a powerful imperative to succeed and never to rebel as well to care for a fragile world. He described himself as having been outwardly successful but inwardly distressed.

We shared and compared experiences, as young men, of needing to perform for parents, and of being raised as males to succeed in highly competitive ways. We talked about the place of the feminine and masculine in the work of a doctor as well as in therapy, and the need for a kind of Jungian balance:

I suppose a great deal of my job is masculine… as we tried to start this interview it was interrupted by a phone call from hospital with information as to whether a patient did or did not carry a particular germ… I have to deal with that... the feminine side is that I am constantly striving to contain and manage those sorts of moments in order to create space for feminine types of experience (rather than) all-knowing theatre… The feminine? Yes. Acceptance, tolerance, understandings of process rather than events and outcomes…things that are fluid rather than chopped up and categorised. A sense of connection being more important than anything…

There was, he said, great suspicion of subjectivity and emotional learning within a 'masculine' medical culture that often deified the objective and measurable. Yet such learning and cultural literacy were often at the very core of being a better doctor. A Somali woman refugee came to mind as we talked:

...A mother and five children, father not in this country… may have been killed in the war there… Children with a huge range of problems from asthma to epilepsy… Often just turning up out of the blue without an appointment… And the anxiety and the sort of tension that arrives with that sort of situation are absolutely massive for a GP… And I struggle to create situations where I can meet more of their needs really by putting an hour aside for them at a special time with an interpreter… the mother of that family brought me a present for Christmas. Somebody had come over from Somalia with this and she brought it to me as a gift and I was immensely moved because it was a really strong symbol that we were providing… a secure base… and that she identified me as one white British person in authority who she can trust… And we ended up having the most extraordinary conversation with the mother about Darwinian evolution in relation to why were her children getting asthma and eczema here when children didn't get it in Somalia and we talked about the way the immune system might be adapted for one environment but actually then is mal-adapted to another environment because the sort of ancestral immune system as it evolved is not to meet what it meets here.

He found himself having a grown up conversation with this mother and she was transformed from being an exotic stereotype into an intelligent equal. This was part of a process of her becoming a person again, through being understood, by a significant other. 'That she could have what I would guess is her first conversation with somebody British which wasn't just about immediate needs, about housing or benefits, or prescriptions and that sort of stuff but recreate her as an equal adult'. In telling this story, he realised, for the first time, that he was making a connection between his own history and that of the Somali patient. A GP, in his own family's narrative, acted as a bridge, for his parents and other relatives dislocated by war and persecution. There were differences, of course, in that his parents were central European Jews who chose to have a central European Jewish refugee for their GP. And yet '…I think it is in a way always coming back to the business of a personal search, actually trying to find out what life is about and what you should be making of it'.

Daniel, like Aidene, placed key relationships at the heart of his learning as a doctor: with two colleagues, with a therapist, a new partner and their young children. He understood himself, and his cultural roots, more deeply, which helped him develop professionally. GPs like him, he concluded, were situated between the truth discourse of the mainstream and the uncertainties and messiness of whole people and whole problems, including themselves. A subversive synthesis was required, taking what was essential from the medical model but locating this within a person and narrative-focused practice in which doctors had to learn from within. The personal and professional were, for effective practice, all of a piece.

The role of story

Telling one's whole story, we concluded, was at the heart of effective experiential learning and of psychological health: for the doctor as well as the patient. Being able to tell a story in all its potential complexity, and to rework it in new ways, in the light of experience, is a fundamental human necessity. Jeremy Holmes (21) notes that the word 'narrative' derives from *gnathos* or knowing. Making the unconscious conscious can be reformulated in terms of knowing and owning one's story. Narrative, he suggests, 'turns experience into a story which can be temporal, coherent and has meaning'. It creates, potentially at least, links between past, present and future. Even the most painful material can be translated into symbolic form, which allows some detachment from what may be horrific experience. Freud argued for the therapeutic power of story and the importance of a narrative truth in 'the talking cure'.

But storytelling, in health care and learning, among doctors as well as their patients, is no easy process, bedeviled as it so often is by psychological defences, such as omnipotence, and by the fear of what powerful others might think. We are 'storied' as well as storytellers, denying and repressing important aspects of our lives and identities. Doctors, like the rest of us, often simply reiterate the dominant narratives of a culture, but in ways, which do injustice to their own experience. The narrative, for instance, of doctor as scientist, objectively observing others and their problems and bringing the perspectives of natural science to bear on people and dis-ease, is woefully inadequate and disturbingly reductionist in relation to what doctors actually do, and what they need to learn. What particular doctors - like Aidene Croft and Daniel Cohen - are doing is to challenge this limited and limiting story: in a new, subtler and more holistic narrative of what it means to learn as a doctor, and person. Autobiographical research, of the kind developed in this study, can facilitate such a process.

Conclusion

A powerful case for a new paradigm of learning in and about medicine was made in these stories: one that connects experience and learning, mind and body, head

and heart, the science and the subjective, formal training with actual doctor-patient encounters. The dominant paradigm within medicine has been of professional knowledge and technique derived from systematic, scientific enquiry. Such a story, however, has badly neglected the psychosocial, subjective, messy and indeterminate aspects of a doctor's work, and how profounder forms of learning depend on exploiting profounder forms of experience. Despite claims that medicine is encompassing multiple ways of knowing a world, the objective and arguably 'male' way - taking us into the real world and out of ourselves - remains dominant. The two stories at the heart of this paper suggest that a capacity to learn from experience lies at the heart of being both a more reflective, critically aware but also effective practitioner. And that such learning requires significant others, secure yet challenging transitional spaces, and encouragement to experiment with the story of who and what we are, and might be, both personally and professionally.

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