Experience(s) of the medical profession: A qualitative study using narrative facilitators

Short title: Experience(s) of the medical profession

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Abstract

Background: Physicians' narratives are means to approach and comprehend the practice of medicine, and physicians' embedment in their work and the healthcare context.

Objective: This study aimed to explore physicians' professional experiences and to examine how they are affected by factors related to their inner (psychological) and outer (institutional and social) world.

Methods: The study was designed as an exploratory qualitative study based on "narrative facilitators" (NF). Their goal is to encourage storytelling and to support the narrative process. The analytic approach was specific for each NF.

Results: Thirty-three physicians participated in the study. The findings showed a focus on the transformations of a profession, the need for physicians to adapt in terms of role and status, and their withstanding of conflicting projections from the public and patients (NF: press articles). The institutional context was described as not welcoming and impersonal (NF: photo-based story). When reacting to the quotes from their peers, participants showed a variety of un-patterned stances with respect to different aspects of medicine and the medical profession, illustrating heterogeneity with regard to professional attitudes and identities (NF: quotes from biographies/narrative accounts). Finally, findings also indicated that physicians often limited their narratives to a description of the materiality of the elements putted into play (NF: blurred video sequences).

Conclusions: Disenchanted physicians are not beneficial, neither for the patient nor for the health care system, and their feeling of being worn out may do harm and negatively affect themselves and their families.

Keywords: physicians, qualitative research, narratives

1. Introduction

Over 10 years ago, in a Lancet article entitled 'The suffering of physicians', Cole and Carlin reminded that the patient is not the only "whole person" in the consulting room, and that physicians also suffer from the "dehumanization" of modern medicine [1]. The issues they addressed, notably in relation to the clinical encounter, have meanwhile become of utmost importance [2,3]. To allow vulnerable physicians to recover meaning and to avoid burnout, Cole and Carlin recommended "to respect" physicians' stories. This evidently requires both that physicians tell their stories and that somebody listens [1].

Whether physicians suffer or not, their narratives are means to approach and comprehend their lived experiences [4,5]. Such narratives reveal the practice of medicine, but also inform about the physicians' embedment in their work and the healthcare context. They are a precious resource offering insights into how physicians perceive professional and personal challenges [5,6]. Moniz et al. pointed out in a recent article on systems flaws identified by physicians in written reflective material that "narrative is a valuable mode of self-expression in medicine and that, by engaging with narratives, we can come to grasp the meanings and interpretations that individual storytellers ascribe to their experiences" [7].

The overwhelming majority of studies exploring physicians' experiences focuses on how they cope and struggle with issues such as budget constraints and workload or anxiety, depression, and burnout [8–12]. Alongside these studies, the issues of identity as physician (physicianhood) [13–15], professional socialization [16] as well as professional identity formation during medical training have received attention [17–19]. More rarely, the psychological functioning of physicians has been examined, for instance by investigating their defense mechanisms [20]. Actually, we do not know much about the way the health care institution, patients' and public's expectations towards medicine and physicians, or society's dominant discourses impact physicians' experiences.

This study was triggered by an observation made during a qualitative investigation aiming to approach the perspective of physicians on communication with and care of dying patients. This observation of "what was silenced" in focus group discussions can be summarized as follows: physicians did neither spontaneously talk about them as playing a part in the medical encounter and about what they experience nor about contextual elements of their daily work. We therefore decided to proactively invite physicians to tell their stories about their professional experiences and to examine how they perceive their outer world, approached through the institutional/health care and social context, how they are marked by the socialization process with peers (identity dimension), and how they are affected by factors related to their inner world (psychological state). As part of the present exploratory study, it seemed important to us to investigate these factors altogether to gain a comprehensive insight of physicians' experiences.

2. Methods

The study was designed as an exploratory qualitative study to examine physicians' lived experiences by means of interviews based on "narrative facilitators".

2.1 Data collection

We have developed facilitators of narratives as a method to empirically address the factors, which might impact physicians' experiences. The facilitators of narratives rely on techniques inspired by visual sociology (use of photographs as narrative support [photo-based story]) [21], clinical psychology (Thematic Apperception Test [blurred video sequences]) [22] and on custom techniques (use of press articles and quotes from peers [press-book and quotes from biographies/narrative accounts of the experience of being a physician]). This method aims to encourage storytelling and to support the narrative process on experience. Put differently,

narratives were produced as an artefact of research, but with prompts (our facilitators) aiming at facilitating and supporting the narratives without being overly constraining.

As shown in Table 1, the interview guide consisted of four distinct types of facilitators of narratives. Lasting about 90 min, the interviews were conducted in 2016-2017 by the first and the second author and audiotaped. They were analyzed directly afterwards, but the drafting of the manuscript was delayed due to unexpected institutional commitments and overlap with other projects.

Insert Table 1 here

2.2 Participants

In continuation of our study on the perspective of physicians on end-of-life communication and care, we conducted interviews with chief residents and senior staff members working in geriatrics, palliative care, oncology and internal medicine at Lausanne University Hospital, Switzerland.

2.3 Data analysis

The analytic approach was specific for each facilitator. It may seem to be a non-obvious choice, but it was a way to stay close to the raw narrative data and to the four different aspects that we examined (dominant discourses, the institutional context in which physicians are working, their socialization with peers, and their psychological state). The data also reflected dimensions that were external or internal to the physicians. In other words, we used different techniques of analysis to differentiate between introspective data (related to the inner world of the physicians) and more extrospective data.

Specifically, the dominant stories outlined by physicians based on the press-book, were analyzed with thematic analysis [23]. Patterns of stories were identified and characterized through an iterative, open-coding process.

Narratives of physicians related to the photo-based story of a hospital physician were examined with a photo-elicitation analysis [24]. The analysis focused on (i) what we aimed to show with each photograph (photo composition) and what physicians told about it, (ii) and what else the physicians saw in the pictures.

With respect to the quotes, which were evaluated on a 10-point analogue scale, we used a statistical-based approach. Latent class analysis on polytomous variables served to detect any potential latent classes among our sample, which may have a similar stance with respect to the quotes [25]. To do so we employ the poLCA package in R, which maximizes the log-likelihood of each latent class model using EM and Newton-Raphson algorithms [26].

The focus of the analysis for the first three facilitators was on the told and telling. In contrast, the narrative material produced in relation to the video sequences was analyzed by means of the cues provided by the individual storytellers (physicians), which provided insight into their concerns and interests, and allowed us to explore their self-representations.

Physicians' narratives related to the facilitators were distinct but deeply interrelated. In the results, we report on the core stories, elaborated on the key aspects that emerged from the analyses.

2.4 Reflexivity

Two investigators analyzed the data (CB and SO). They met regularly with the third investigator (FS) to review the analyses. The different perspectives and backgrounds of the investigators enabled sound discussions of findings and interpretations. CB is a social science

researcher (anthropologist) embedded in a medical service for years, SO is a psychologist, and FS a senior consultation-liaison psychiatrist.

3. Results

33 physicians of Lausanne University Hospital participated in the study (13 were female). Five physicians worked in geriatrics, six in palliative care, 10 in oncology, and 12 in internal medicine.

As part of the reported core stories, we provide room for physicians' voices by means of interview excerpts. Individual physicians are identified by an alphabetical letter and their disciplinary affiliations are indicated.

3.1 The changing profession of medicine

The main story told by physicians, elicited by *press discourses*, was that of a profession in transformation, and of a changing social status. To practice medicine nowadays requires new qualities and competences: clinical expertise is not enough; it has to be completed by management skills, particularly to contain cost. New dimensions have to be taken into account to respect a holistic approach of the patient, as promoted, for instance, by the bio-psycho-socio-spiritual model of care. Physicians are no longer the Gods in white; they make errors for which they are taken accountable. This has an impact on the clinical relationship and may undermine trust.

In some versions of this story, the transformation of the profession of medicine, especially related to scientific progresses and the introduction of new technologies, is associated nonetheless with a dehumanization of care: performance and skills dominate over relational and humane competence. More or less directly linked to these changes, some physicians

perceived an ambivalent stance of the public towards medicine, oscillating between fear and fascination, and blind trust and contempt.

> […] we are in a time when we [medicine in general] are losing a little bit of our identity, and we are also losing ground […] we attempt by different means either to regain prestige or to demonstrate in every possible way that we are critical of ourselves or that we are incredible with regard to technological advances […] This is a moment of identity crisis, whereas medicine was always rather esteemed, and occupied an important place. I consider that as a shift […] (N, palliative care)

> […] the physician of the beginning of the last century, as we imagine him, was never challenged, people trusted him. I do not say it was the good old time (laughs) […] But the [current] system, according to me, generates a lot of fear among the public, and also hope, fascination (H, palliative care)

Certain physicians colored this narrative of a changing medicine positively. They saw a rather triumphant medicine, capable of inspiring trust due to advances in science and technology, quality training objectives, and skills demonstrated by physicians. This medicine offers endless possibilities for the medically ill, who responds to this offer and engages with medicine.

> […] I think people are increasingly interested in their health, and sometimes in an obsessional manner, but generally I consider this is a rather positive evolution. People ask themselves questions like "how can I live healthier?" […] "how should I choose a hospital"? "Where will I get the best care?" […] I consider this rather positive (X, oncology)

3.2 A pragmatic view of the hospital setting

Passing the doors of the hospital, the stories, elicited by the *photos*, revealed a more pragmatic thinking. Physicians were described as very busy, overworked, tired, and even exhausted, lacking energy, due for instance to administrative work, and feeling isolated.

> […] I imagine that he is not doing what he wants to do, well he is not in patient care, he is not related to another person, he is just doing paper work […] and that's not the most interesting part of the job (H, internal medicine)

> […] did we choose medicine for that [being in front of a computer]? No, but if you don't do it, you don't get paid. We are fewer and fewer [physician shortage], it's a vicious circle (L, internal medicine)

> […] a day at the hospital […] we arrive, we see patients […] and we can observe how late we are already (laughs), and we try to do paper work. Once everybody is back home, we still make phone calls, look at the x-rays, prepare the next day, then we also have meetings lasting for hours with liaison nurses, who have requests and who make you fill in 15 different forms. And then, finally, night comes, you are tired, you take off the white coat and you go home. That's how it feels (X, oncology)

The global (the hospital) and local (the office) working space was viewed as not welcoming, impersonal and even depersonalizing. Daylight does not penetrate. An environment on which physicians have not much to say or to decide upon.

[…] You can see that on strategic places, they put on some stuffs to give a modern look, with an attempt to bring in some life and decoration in the hospital […] (L, internal medicine)

[…] the offices of the nurses and of the technicians are refreshed first, and only then those of the physicians. With regard to ergonomics, etc., physicians always come last […] I even saw physicians working just beside the hood for chemotherapy […] there has been this protest for those who work in a place without windows, they can take more holidays. Well, the problem is you have to participate in these meetings [to organize claims] you need time, but we don't have time, and thus people [administrators] consider that it's not important to us. We don't have that lobby […] we have a lot of things which disturb us, and we go along with them (L, internal medicine)

3.3 Being a physician is an individual experience

When one addresses the shared (or unshared) perspectives of physicians on different issues specifically related to the practice and vision of the profession of medicine, the previous relative homogeneity in participants' narratives disappear. Indeed, we could not find evidence for the presence of latent classes (see supplementary material). In other words, the physicians did not cluster into groups, which provide same answers and perspectives on some of the questions related to the *quotes*.

Some quotes evoked *polarized reactions* illustrating split opinions with regard to specific experiences of medicine. Physicians were divided on issues, such as sharing daily work experiences with loved ones, personal strain related to work or the detachment from emotions. The two following excerpts show the split views on this latter issue:

> […] I got used to these things, so now I have even sometimes the impression to lack compassion, sometimes I do not feel sad enough with regard to things I heard […] I have the impression that this compassion, it has left me, since I have already heard these stories before (Q, oncology)

> […] I think I go a little bit further than empathy, I try not to reach compassion, I try not to reach sympathy, but probably I go a little bit further than pure empathy, because this pleases me, it allows me to foster relationships […] (C, internal medicine)

Medicine considered as a calling gave rise to the most *various perspectives*.

> […] the majority [of physicians] they have a sense of calling, otherwise it is not possible to do this job (T, oncology)

> […] I think one have to be honest, it [the job of a physician] becomes a job like any other […] if physicians had a sense of calling, there would be no millionaires among them, and they wouldn't leave to the private sector (E, oncology)

Responses and narratives from physicians were more *homogeneous* when quotes from peers addressed issues, such as medicine as a team effort – a profession with no room for self-gratification –, or medicine as administrative-governed and profit-driven.

> […] sometimes one gets the impression that we have become medical secretaries. The secretaries drop things back to us, and the desk clerk yells at us, since we did not fill in this and this sheet correctly, and radiology calls that they did not get the correct form.

You are in front of a pile of documents to fill in for insurance, and for sure then you find yourself as being very dehumanized. Indeed, nobody considers that we are physicians, that we are here to care for patients and not to stack files […] (X, oncology)

[…] I hate the administrators, I feel not afraid to say it because it's true, these people add obstacles to the system, they force us to complete tons of forms and supporting documents […] (M, internal medicine)

3.4 Focusing on the concrete reality of the situations

While the *video sequences* aimed to orient physicians to respond to a scene by filling it with their own interest and concerns, they often limited their narratives to a description of the materiality of the elements putted into play, thus doubling in words what was put on the screen. The production of free associations, emotions or fantasies were rather lacking. A small minority of physicians referred though to their own experiences, such as feelings of anonymity or on the contrary stressed the importance of exchange between peers.

[…] Well, its half past four in the hospital [the participant refers to clock, which appears in the sequence], it seems to be in pediatrics or something like this, well, it seems to me I recognize a colleague. This video, mainly, it shows plenty of physicians who are in front of a meeting room, I don't know if it's just before or after the meeting and they discuss together and then there is another group of physicians, a smaller one, but still seven or eight, and they discuss together and then they leave, probably to join their offices (O, geriatrics).

> […] There is a physician, I think he's a physician, since he seems to have a pager, let's say he looks like a physician. He strolls in the corridors, he seems preoccupied […] Well, he seems to think about something […] hands in the pocket, the upper or lower pockets, this way, as someone who thinks, a little bit of psychomotor agitation, which could indicate that he either waits for the elevator or he is impatient […] and then, he seems lost in his thoughts, since the nurse walks by, and they don't interact (I, geriatrics)

4. Discussion

We conducted this study in a nowadays medical context with negative physical and mental health consequences and a gradual decline of satisfaction among physicians [2,8,27–32]. Besides studies assessing specific aspects of health and job satisfaction of physicians, naturally occurring narratives by physicians are mostly found in dedicated books or in narrative sections of medical journals [5,7,33,34]. In the meantime, the SARS-CoV-2 pandemic has shown that in an extraordinary context and in situations of crisis, physicians are strongly encouraged to tell their experiences about the practice of medicine [35]. Strikingly, the pandemic has also been a reminder of the fragility that characterizes the relationship between physicians, patients, their relatives and significant others, and the public, which oscillates between trust and distrust, admiration and fear, and gratitude and rejection. This study is part of an effort to provide room for their voices and stories even, or especially, in "ordinary times" [7,36–39]. Lessons can indeed be drawn from physicians' experiences in any context, offering elements of understanding to support them, but also to foster a more realistic and empathic relationship between them and patients and their significant others.

The scope of this exploratory study was broad. Given the observation that physicians' experiences with regard to their inner (psychological) and outer (contextual) world were not easy to elicit, we attempted to encourage their narratives by means of facilitators linked to

different dimensions, allowing us to gain insights into how physicians situate themselves but also into their capacity to situate themselves. Among them were – following a centripetal process – dominant discourses about medicine and physicians, the institutional context in which physicians are working, the peers with whom they socialize, and finally their psychological state. The interest physicians showed for the study during recruitment, their motivation when engaging with the facilitators of narratives and the pleasure they took to talk about their "view of the world", somehow confirm us in our approach. Physicians want to tell their stories, and the facilitators contributed to support the narrative process. Compared to the more elaborated and structured published stories, physicians seemed inclined to share experiences without filtering them through a process of rationalization or courtesy.

The findings show that the participants' narratives focus on the transformations of a profession, the need for physicians to adapt in terms of role and status, and their withstanding of conflicting projections from the public and patients. What hurts is the negative impact of these transformations on the clinical work, which remains as their core business more and more difficult to protect, and the relationship with the patient, even more so since physicians consider facing a public who stares at the hospital with mixed and ambivalent feelings. The positivistic narratives of a minority of participants, applauding scientific progress and achievements of modern medicine, cannot evacuate the rather low morale physicians are demonstrating when looking at their professional lives; a result, which is in line with studies conducted in other health care settings [40,41]. In a recent article, Monitz et al. [7] identified sources of tension and distress for physicians and showed the ways physicians are challenged by system flaws, and try to maintain resilience and to "live up to the ideals of the profession."

Echoing the latter observations, the institutional context was described as rather bleak. Tired, worn out, and somehow resigned, physicians seem gotten used to work in what can be seen as an inhospitable hospital.

On the other hand, physicians remained quite singular and demonstrated an independent mind, when reacting to the quotes of their peers, showing a variety of un-patterned stances with regard to different aspects of medicine and the medical profession. This finding underlines the need for an approach, if interventions are considered, which is tailored to the particular situation and needs of physician; this is also well known from mentoring and other efforts to support physicians during their development [15]. Indeed, physicians are shaped not only by their socialization, but also by biographical events and their private context, which influence career choice, but also career constancy [42].

Physicians' opinions related to "medical matters" appear to be individually formed, leaving room for singularity in the way the profession is conceived, and easily expressed. Contrariwise, physicians tended to double what was projected in the scenes during the exercise to elaborate on the video sequences putting into play the physician's office work, the clinical encounter, the relationship with peers and himself/herself. The material provoked limited resonance with their inner world. We cannot know if the narrative facilitator did not allow the participants to access the underlying psychological dimensions associated with their lived experiences, as we expected it to, or if the difficulty was for them to access their psychic world. This latter interpretation may be supported by the fact that the promotion of reflection and psychological insight is rather rare during the under- and postgraduate medical education, and a lot of emphasis is put on gaining knowledge and learning how to applicate knowledge.

The narratives of participants can be understood in different ways. We propose in the following to elaborate on thoughts and interpretations, which are sometimes not directly supported by the

results, but inspired and stimulated by them. Physicians seem to deplore an atomization of their professional identity: multi-tasking leads to switching identities, multiple injunctions drive them away from their core business and the tasks of fulfilling conflicting goals operate as double bind messages and provoke a feeling of alienation. This professional atomization, together with their singularity when it comes to conceive medical matters, seems to hamper an effective unionization of the profession, which could defend physicians' interests. Their interests are perceived as disregarded, according to the narratives, and lead to a feeling of a loss of agency. Atomization, and the difficulty to stick together and defend the issues at stake, feels like a continuation of what physicians experienced during the socialization process in medical school, which is after all characterized by high competitiveness and selection, shaping their identities way after the final exams [36]. This is in sharp contrast with the efforts made to welcome patients in the hospital, to respond comprehensively to their needs, to perceive them in their individuality and to promote patient-centered care, shared decision-making, empowerment, partnership, and expression of complaints, which are regarded as a learning experience for the health care personnel [43]. The question thus arises: should not we care more for physicians?

We consider that our study has the potential to contain elements, which contribute to answer this question. First, the experience of a loss of agency, of an atomization of the physician's identity and of isolation clearly underlines that physicians need help. It is not good enough to recognize and treat physician burnout and to regularly assess job satisfaction. One of the reasons why the lived experience of physicians is not really taken into account might lie in the lack of a conceptual framework of how to "care for physicians". Such as framework cannot be based on the psychological or cognitive aspects of being a physician today, it has to include their affective and lived experience. Psychological approaches to access the inner world of physicians are precious as are emerging reflexivity training [44] but they need to be

complemented by methods which access the experiences revealed in this study, which physicians have a tendency to hide or neglect. Recent developments in psychiatric liaison, one of the two activities of liaison psychiatry, aim to provide better support and care for clinicians. However, empirical foundations of psychiatric liaison have to be built up, and innovative interventions including contextual determinants of physicians' experiences, remain to be conceived. This is especially surprising, given the fact that in some settings physicians' professional experiences were shown to be close to a catastrophic collapse of morale [40].

5. Conclusion

In conclusion, even if disenchantments of physicians might not be a completely new observation, their underlying reasons should be addressed. Disenchanted physicians are not beneficial, neither for the patient nor for the health care system, and their feeling of being worn out may do harm and is certainly negatively affecting themselves and their families. Physicians, as patients, need respect and support, and deserve to be given the same attention. This last statement by Gorlin and Zucker dates back to 1983 [45]. Nearly 40 years later, physicians and more generally clinicians' experiences are still not a fundamental data for hospitals, and the care of the carers is, from the institutional perspective, a pure slogan in most settings.

Ethics approval: The Human Research Ethics Committee of Vaud (CER-VD) exempted the study from approval.

Informed consent: Participants were fully informed about the purpose of the study, written consent was obtained from all participants.

Conflicts of interest: The authors declare that they have no conflict of interest.

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References

[1] Cole TR, Carlin N. The suffering of physicians. The Lancet. 24 oct 2009;374(9699):1414-5.

[2] Friedberg MW, Chen PG, Van Busum KR, Aunon F, Pham C, Caloyeras J, Mattke S, Pitchforth E, Quigley DD, Brook RH, Crosson FJ, Tutty M. Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. Rand Health Q [Internet]. 1 déc 2014 [cité 18 juin 2020];3(4). Disponible sur: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5051918/

[3] Panagioti M, Geraghty K, Johnson J, Zhou A, Panagopoulou E, Chew-Graham C, Peters D, Hodkinson A, Riley R, Esmail A. Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis. JAMA Intern Med. 1 oct 2018;178(10):1317-31.

[4] Bleakley A. Stories as data, data as stories: making sense of narrative inquiry in clinical education*. Med Educ. 2005;39(5):534-40.

[5] Moniz T, Lingard L, Watling C. Stories Doctors Tell. JAMA. 11 juill 2017;318(2):124-5.

[6] Moniz T, Costella J, Golafshani M, Watling C, Lingard L. Bringing narratives from physicians, patients and caregivers together: a scoping review of published research. Med Humanit. 8 févr 2019;medhum-2017-011424.

[7] Moniz T, Pack R, Lingard L, Watling C. Voices from the Front Lines: An Analysis of Physicians' Reflective Narratives about Flaws with the 'System'. J Med Humanit. 6 avr 2021;42:737-52.

[8] Mihailescu M, Neiterman E. A scoping review of the literature on the current mental health status of physicians and physicians-in-training in North America. BMC Public Health. 24 oct 2019;19(1):1363.

[9] Wurm W, Vogel K, Holl A, Ebner C, Bayer D, Mörkl S, Szilagyi IS, Hotter E, Kapfhammer HP, Hofmann P. Depression-Burnout Overlap in Physicians. PLOS ONE. 1 mars 2016;11(3):e0149913.

[10] Hodkinson A, Anli Zhou, Johnson J, Geraghty K, Riley R, Zhou A, Panagopoulou E, Chew-Graham CA, Peters D, Esmail A, Maria Panagioti. Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. BMJ. 14 sept 2022;378:e070442.

[11] Lindfors S, Boman J, Alexanderson K. Strategies used to handle stress by academic physicians at a university hospital. Work. 1 janv 2012;43(2):183-93.

[12] Dominic C, Gopal DP, Sidhu A. ‘It’s like juggling fire daily’: Well-being, workload and burnout in the British NHS - A survey of 721 physicians. Work. 1 janv 2021;70(2):395-403.

[13] Boudreau JD, Cassell E, Fuks A. A healing curriculum. Med Educ. 2007;41(12):1193-201.

[14] Korica M, Molloy E. Making sense of professional identities: Stories of medical professionals and new technologies. Hum Relat. 1 déc 2010;63(12):1879-901.

[15] Boudreau JD, Cassell E, Fuks A. Physicianship and the Rebirth of Medical Education. Oxford, New York: Oxford University Press; 2018. 400 p.

[16] Pitkala KH, Mantyranta T. Professional socialization revised: medical students’ own conceptions related to adoption of the future physician’s role--a qualitative study. Med Teach. janv 2003;25(2):155-60.

[17] Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. Reframing Medical Education to Support Professional Identity Formation. Acad Med. nov 2014;89(11):1446-51.

[18] Monrouxe LV. Identity, identification and medical education: why should we care? Med Educ. 2010;44(1):40-9.

[19] Volpe RL, Hopkins M, Haidet P, Wolpaw DR, Adams NE. Is research on professional identity formation biased? Early insights from a scoping review and metasynthesis. Med Educ. 2019;53(2):119-32.

[20] Bernard M, Roten Y de, Despland JN, Stiefel F. Communication skills training and clinicians’ defenses in oncology: an exploratory, controlled study. Psychooncology. 2010;19(2):209-15.

[21] Harper D. Visual Sociology. Routledge; 2012. 308 p.

[22] Vane JR. The thematic apperception test: A review. Clin Psychol Rev. 1 janv 1981;1(3):319-36.

[23] Joffe H. Thematic Analysis. In: Qualitative Research Methods in Mental Health and Psychotherapy [Internet]. John Wiley & Sons, Ltd; [cité 15 déc 2020]. p. 209-23. Disponible sur: https://onlinelibrary.wiley.com/doi/abs/10.1002/9781119973249.ch15

[24] Harper D. Talking about pictures: A case for photo elicitation. Vis Stud. 1 janv 2002;17(1):13-26.

[25] Agresti A. Categorical Data Analysis. Wiley–Blackwell; 2013.

[26] Linzer DA, Lewis JB. poLCA: An R package for polytomous variable latent class analysis. J Stat Softw. 2011;42(10):1-29.

[27] Arigoni F, Bovier PA, Sappino AP. Trend of burnout among Swiss doctors. Swiss Med Wkly [Internet]. 9 août 2010 [cité 19 juin 2020];140(3132). Disponible sur: https://smw.ch/article/doi/smw.2010.13070

[28] Businger A, Stefenelli U, Guller U. Prevalence of Burnout Among Surgical Residents and Surgeons in Switzerland. Arch Surg. 1 oct 2010;145(10):1013-6.

[29] Goetz K, Jossen M, Szecsenyi J, Rosemann T, Hahn K, Hess S. Job satisfaction of primary care physicians in Switzerland: an observational study. Fam Pract. 1 oct 2016;33(5):498-503.

[30] Hämmig O. Explaining burnout and the intention to leave the profession among health professionals – a cross-sectional study in a hospital setting in Switzerland. BMC Health Serv Res. 19 oct 2018;18(1):785.

[31] Shanafelt TD, West CP, Sinsky C, Trockel M, Tutty M, Satele DV, Carlasare LE, Dyrbye LN. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017. Mayo Clin Proc [Internet]. 22 févr 2019 [cité 28 févr 2019]; Disponible sur: http://www.sciencedirect.com/science/article/pii/S0025619618309388

[32] Waddimba AC, Mohr DC, Beckman HB, Mahoney TL, Young GJ. Job satisfaction and guideline adherence among physicians: Moderating effects of perceived autonomy support and job control. Soc Sci Med. 1 juill 2019;233:208-17.

[33] Campo R. "Anecdotal Evidence": Why Narratives Matter to Medical Practice. PLOS Med. 24 oct 2006;3(10):e423.

[34] Laura SM, Friedrich S, Mehdi G, Céline B. Calling: Never seen before or heard of – A survey among Swiss physicians. Work. 1 janv 2022;72(2):657-65.

[35] Times TNY. In Harm's Way: The Protesters. The New York Times [Internet]. 5 mai 2020 [cité 19 juin 2020]; Disponible sur: https://www.nytimes.com/interactive/2020/world/coronavirus-health-care-workers.html

[36] Nikles M, Stiefel F, Bourquin C. What medical students dream of: A standardized and data-driven approach. Dreaming. 2017;27(3):177-92.

[37] Schaad B, Bourquin C, Panese F, Stiefel F. How physicians make sense of their experience of being involved in hospital users' complaints and the associated mediation. BMC Health Serv Res. 2019;19(1):73.

[38] Stiefel F, Stiefel F, Terui T, Machino T, Ishitani K, Bourquin C. Spotlight on Japanese physicians: An exploration of their professional experiences elicited by means of narrative facilitators. Work. 1 janv 2019;63(2):269-82.

[39] Bourquin C, Monti M, Saraga M, Stiefel F, Kraege V, Gachoud D, Castioni J, Marques-Vidal P, Bastardot F, Méan M, Lamy O, Vollenweider P, Waeber G, Garnier A. Running Against the Clock: A Qualitative Study of Internal Medicine Residents' Work Experience. Swiss Med Wkly. 2022;152:w30216.

[40] Yasunaga H. The catastrophic collapse of morale among hospital physicians in Japan. Risk Manag Healthc Policy. 3 nov 2008;1:1-6.

[41] Zuger A. Dissatisfaction with Medical Practice. N Engl J Med. 1 janv 2004;350(1):69-75.

[42] Bott EM, Duffy RD, Borges NJ, Braun TL, Jordan KP, Marino JF. Called to Medicine: Physicians' Experiences of Career Calling. Career Dev Q. 2017;65(2):113-30.

[43] Schaad B, Bourquin C, Bornet F, Currat T, Saraga M, Panese F, Stiefel F. Dissatisfaction of hospital patients, their relatives, and friends: Analysis of accounts collected in a complaints center. Patient Educ Couns. 1 juin 2015;98(6):771-6.

[44] Stiefel F, Orsini S, Bourquin C. Clinician Reflexivity Training – an alternative for clinical communication training. Schweiz Krebsbulletin. 2018;(1):31-2.

[45] Gorlin R, Zucker HD. Physicians' Reactions to Patients [Internet]. http://dx.doi.org/10.1056/NEJM198305053081804. Massachusetts Medical Society; 2010 [cité 16 mai 2021]. Disponible sur: https://www.nejm.org/doi/pdf/10.1056/NEJM198305053081804

Table 1. Interview guide

Investigated aspects	Narrative facilitators	Instructions
Dominant discourses on medicine and the medical profession	**Press-book:** 8 booklets with articles about nowadays hospitals, physicians' roles, medical malpractice, heroic physicians, evolution and revolution in medicine	What kind of a story do all these booklets tell about medicine and physicians? How do you feel about the story (what is your reaction)?
Contextual factors related to the medical institution and apparatus	**Photo-based story:** 8 *ad hoc* designed photographs featuring a working day of two physicians in Western university hospitals (from their arrival to the moment they leave the hospital at the end of their shift, seeing patients, walking in the hospital, attending meetings, etc.)	What do you know about the man featured in the photos and what is he doing? How do you know that?
Contextual factors related to physicians' experience of their work and relationship with peers	**Quotes from physicians' biographies/narrative accounts of the experience of being a physician**: 10 plasticized sheets addressing topics like medicine as a vocation, physician burnout, empathy, etc.	To what extent (10-point analogue scale) do you agree with this quote? Why do you agree/disagree?
Physicians' inner world	**Short (2 min) video sequences:** 4 blurred video sequences without sound from two documentary films on the profession of medicine, which feature a physician doing administrative duties, a physician talking to a bedridden patient, a group of physicians, and a physician alone in front of an elevator turning in circles	What do you see in this sequence? What determined what you say?

Supplementary material

Statistical criteria to select the final class Model

Number of classes	BIC	AIC	Gsq	Chisq
1	1796.18	1648.025	1219.256	17286707544
2	1990.002	1692.197	1063.427	1326827042
3	2217.01	1769.554	940.7844	133012836
4	2485.315	1888.208	859.439	31363500
5	2771.437	2024.68	795.9101	35628460
6	3060.091	2163.683	734.914	6698652
7	3349.722	2303.663	674.894	5307569
8	3660.606	2464.897	636.1271	5269220

BIC: Bayesian Information Criterion

AIC: Akaike Information Criterion

Gsq: Deviance statistics

Chisq: Pearson Chi_square goodness of fit statistics

The PoLCA models using 1 to 8 different class are fitted. Four statistical criteria of each model are presented in the table above, indicating that the final number of classes that gives the best fit is one class only. That leads to the conclusion in the paper that there is no evidence of existence of latent classes in the dataset. Among all four fit statistics, the BIC is the most reliable one.