

Teaching Medical Anthropology in UK Medical Schools: Cultivating Autoethnographic Practice among Medical Students

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Abstract

Behavioural and social sciences (BSS) are a core component of undergraduate medical education in the United Kingdom. Despite the formal recognition of BSS by the UK's General Medical Council (GMC), anthropology remains largely at the periphery in the medical curriculum. Medical students often describe it as 'fluffy' or as 'common sense', in comparison to biomedical learning content. To make anthropology more relevant and applicable to future clinical practice, we draw on ethnographic data (interviews, focus groups, field notes and reflective texts written by medical students) collected by an anthropologist during fieldwork in two UK medical schools. We suggest moving this content out of the preclinical phase and instead incorporating it into the clinical phase. Specifically, we propose that having students conduct a micro-autoethnography during the clinical phase brings together two crucial aspects of medical student training: BSS principles and formation of a professional identity. Embedding these concepts in this specific context will allow students to process tensions they may feel between interactions they observe in a clinical context and team versus what they have been formally taught. This process allows them to negotiate their own professional identity between practice and ideal while more robustly situating BSS content in a relevant and immediately applicable manner within the current constraints of the medical curriculum.

Keywords

Medical education; social and behavioural sciences; curriculum development; professional identity formation; professionalism

Introduction

Anthropology and medical education have long been intertwined. As early as the 1890s, anthropologists have been employed in medical schools teaching and researching. The English clinician Havelock Ellis (1892) advocated in *The Lancet* for the importance of integrating anthropology in the medical curriculum. Medical practitioners have long acknowledged the central role social factors play in disease risk and outcomes. For instance, Virchow coined the famous phrase "medicine is a social science" (Virchow, 1849 in Carrese, 2000).

The importance of anthropology to medicine continues. Leading anthropologists-physicians, like Arthur Kleinman (1989) and Paul Farmer (2001), brought medicine and anthropology together in their work. The combination of these disciplines produced key concepts, including theories around the social determinants of health, health inequalities, structural violence, cultural competency, cultural humility, structural competency, and structural humility. Although the definitions and names of such concepts abound, at their core these concepts highlight how structural, social, and cultural factors influence health and illness. Such concepts provide medical students with a theoretical framework through which they can learn how the social world directly impacts and interacts with illness and health outcomes. In other words, these facilitate a more anthropological understanding of health.

Anthropology in the UK Medical Curriculum

In 1993, the General Medical Council (GMC) solidified their commitment to the behavioural and social sciences (BSS) by declaring it should be a core component in UK medical curricula. This document, *Tomorrow's Doctors: Outcomes and standards for undergraduate medical education*, informs the teaching and learning of every UK medical school. In *Tomorrow's Doctors'* subsequent versions (GMC, 2015), the GMC reiterated the importance of BSS in the medical curriculum (GMC, 2018). This BSS content draws heavily from the disciplines of psychology, sociology, and anthropology. It is to the latter discipline that we turn our attention in this paper.

Anthropology is our collective home discipline: all three co-authors have been trained as anthropologists. That is, for many years we have been conducting ethnographic fieldwork, reading, discussing, and writing about theories and research related to anthropology in general, and medical anthropology in particular. Harvey is an anthropology undergraduate student, whilst Dikomitis and Wenning are currently working as researchers and medical educators in UK medical schools. We recognise, however, that how anthropologists 'do' medical anthropology, and how medical educators and medical students 'do' anthropology, are radically different. Space and time allocated in the curriculum (on an anthropology versus a medical course) to discuss theoretical concepts, and the perceived relevance and importance of such concepts, create completely different experiences of what anthropology is and how it can be applied to health, illness, and clinical practice.

Thus, despite the emphasis on BSS learning content - including anthropology - by the GMC, it remains that the work of embedding anthropological theory and concepts into the medical curriculum is far from complete. As Martinez and Wiedman (2021, p. 2) note, it is "not to say that anthropology has nothing to offer medical education, or that medicine could not benefit even greatly from engagement with anthropology, it's to say that we need to find ways to do it better." This is especially important as Litva and Peters (2008, p. 309) write that UK medical educators largely view it as "nice to know" rather than "need to know" content, which contributes to the perceived irrelevance of BSS content by medical students themselves (Benbassat, 2015; Miyachi et al., 2021). While examples of ways to engage with anthropological learning content effectively and efficiently do exist in some medical schools, we propose here a student-led ethnographic assignment that can be applied and replicated throughout medical schools in the UK – to indeed, offer "a way to do it better".

Our paper is underpinned by ethnographic fieldwork conducted in UK medical schools by Dikomitis (Dikomitis et al., 2018; Dikomitis, 2021; Dikomitis et al., 2022). We then offer a way to integrate this content into the wider medical school in a practical, efficient, and effective way. Current evidence suggests that students do not perceive BSS content as relevant, particularly when it is presented through conventional teaching methods such as classical readings (Tabatabaei et al., 2016) or when the lectures, readings and handouts are perceived as "preaching the obvious" (Benbassat, 2015, p. 20) – the "fluffy stuff" that does not require protracted study (Dikomitis, 2021; Dikomitis et al., 2022). Therefore, we propose an alternative way of engaging students to ensure that BSS content relates more strongly to their current and future clinical practice.

Medical Students' Perceptions of Social Sciences

The recommendations contained in this article are based upon fieldwork conducted at the North England Medical School (NEMS), a pseudonym. Dikomitis conducted ethnographic fieldwork among medical students and educators, including participant-observation, semi-structured interviews, focus groups and analysed students' reflections. In this article, we use the following data sets: interviews with medical students ($n=11$), focus group with medical students ($n=1$), and reflective essays written by medical students who selected the medical anthropology course Dikomitis taught at NEMS as their optional module ($n=19$). We analysed the data with QSR NVivo (Version 12, 2020).

It is important to note the curriculum structure of NEMS, as it impacts on how students engage with BSS learning content. NEMS had a Problem-Based Learning (PBL) curriculum. The emphasis of PBL is on structured learning based around a problem (Maudsley, 1999; Boud and Feletti, 1997). In this approach, students are presented with a case study around which that week's lectures, placements, skills sessions, discussions, and self-directed learning revolves. BSS content is always embedded in each PBL case. The PBL groups at NEMS, at the time of fieldwork, consisted of a facilitator and approximately 8-12 students.

The reflective essays were written as part of a Student-Selected Component (SSC). Such optional modules provide students with the opportunity to engage with extra learning content, in addition to the core medical

curriculum (Dikomitis, 2021). In the case of NEMS, SSCs were intensive, two-week long courses. Dikomitis taught the SSC 'Introduction to Medical Anthropology'. At the end of the course, students wrote a reflective essay on their perceptions of anthropology.

Ethical Approval

The Research Ethics Committees at the university's Department of Education and the School of Social Sciences at NEMS provided ethical approval for this study. All students received a detailed description of the study and written informed consent was obtained before they participated in the study. For the SSC reflective texts, grades were not assigned and thus this study posed no undue risk or stress for students to participate or to convey only positive sentiments. For the interviews, medical students chose their own pseudonyms, which are the ones we use in this paper. This study received no external funding, but Dikomitis received a small budget from internal university funding which was used for transcription costs.

In the next section, we provide a summary of the study findings and current literature, before proposing an alternative engagement with social science learning content. We suggest a mini-autoethnographic component that students can complete during a clinical placement.

Situating Social Science in the Medical Curriculum

Medical students in Dikomitis's (2021) study commonly de-prioritised BSS content in all aspects of their education: attending lectures, revising regularly, and studying for exams. The hidden curriculum – the informal interactions that students have with other students, faculty and studying itself – contributes to this because each student cohort reinforces, by such deprioritisation, the hierarchy of knowledge in medicine, which places biomedical knowledge at the top (Hafferty, 1998). For instance, Claudia, a 20-year-old medical student, explained: "I find the ethics and the social stuff really interesting, and I love talking about it, but when you know that like the sciency stuff is there you kind of just shove it aside."

Evidence of similar attitudes toward BSS content was rife in the data. A common reference to BSS was as the 'fluffy stuff', as BSS was known at that medical school:

I think it's called fluffy because it's not something that you can outline as fact and it's not something that you can sit down and learn as a fact. (Stephanie)

[It's] quite interesting to learn that but I think it's just because it's hard to, [...] because it's not measurable if that makes sense and the answers are not specific. (Ashak)

[Fluffy stuff] is part of medicine, but it's like kind of a side thing. (Focus group)

The perceived lack of what medical students called 'fact-based learning' in social sciences contributes to its compartmentalisation, both formally in the curriculum as well as in the way students approach studying the content. Medical students generally assigned less time and effort into revising as they coined the learning content as 'common sense'. Yet despite the inference to its simplicity, it is simultaneously, perceived as too 'big' to fully comprehend in trainee physicians' limited time within what is commonly viewed as an overloaded medical curriculum, creating an inherent contradiction (Chiavaroli et al., 2019, p. 228).

Anthropologists who are teaching medical students need to be aware of this as one of the main challenges they will face in teaching medical students. An important balance between theory and clinical application of anthropological thought must be reached, however, because medical students are training to become doctors, not necessarily anthropologists. As such, all teaching should be framed in terms of clinical relevance.

Therefore, for BSS learning to be taken seriously as a *core* component of the medical curriculum, and perceived as relevant to clinical practice, it is just as important for students to observe its use in their placements as in their classrooms (Beagan, 2003, p. 612). Changes to the formal curriculum may not necessarily lead to a corresponding improvement in practice, when the hidden curriculum – including physicians' socialisation – remains unaddressed (Bandini et al., 2017).

One way of doing this was suggested by Jaye and Egan (2006). They introduced communities of clinical practice (CoCPs), which build upon the ‘communities of practice’ model of social learning first introduced by Wenger (2000). Each CoCP consists of interdisciplinary teams organised around an individual patient and is dedicated to their care. Every CoCP has its own system of values and implicit expectations negotiated between its members through sustained mutual relationships. In these CoCPs, social participation acts as the basis of learning, where medical students do the rounds, participating peripherally in various CoCPs. Jaye et al. (2010) detail how medical students closely observe surgical consultants to gain an understanding of what is expected of them, altering their self-development in such a way as to concord with the norms of the CoCP. Thus, the development of a professional identity occurs within the clinic as such values and norms are internalised through students’ experiences of CoCPs to become ‘one of the team’, with such processes of self-disciplining functioning externally to formal education.

We suggest that an effective way for medical students to engage with anthropological theories and methods can be through an applied clinical placement project. Students will conduct a mini-ethnography on the clinical environments in which they are training. This exercise will aid in their development of critical thinking and increase awareness around their own socialisation processes in becoming a doctor, including how such processes may enhance or detract from the core values a graduate should embody, as stipulated by the GMC (2018).

Ethnography and the Construction of a Professional Identity

Increased awareness of the impact of the hidden curriculum on students’ learning led to growing concerns about how they constructed and perceived their professional identity (Hafferty, 1998; Bandini et al., 2017). Graduating from medical school is not an endpoint; rather, it is a starting point with the training and tools one learned at medical school. Such training aids the development of behaviours and attitudes that are concordant with the medical profession’s core values (Cruess and Cruess, 2019). Several theories from developmental and social psychology centre around the idea that professional identity is superimposed upon an individual’s pre-existing personal identity. As such, each person has an individual identity “style” that is expressed through the negotiation of personal identity and the normative pressures associated with their social identity as a medical student-cum-future doctor (Goldie, 2012, p. e643). Some of the tensions associated with this process are explored in an anonymised statement from one of the medical students in the study (Dikomitis, 2021):

Medicine is a world of rules and regulations, from the application process onwards we jump hoops and *present our selves as the individual we are required to be*. In fact, *Tomorrow's Doctors*, a 100-page booklet, dictates who we are expected to be and how to behave, leaving very little personal expression. (Reflexive text, emphasis added)

Here, we follow other social scientists and medical educators (Kleinman and Benson, 2006; Reeves et al., 2013; Gonzalo et al., 2017) in advocating for the training of medical students in ethnography, specifically in support of narrative-based professionalism, which Quaintance et al. (2010, p. 120) demonstrated can enhance student reflexivity. Whilst Quaintance et al. (2010) focused solely on positive examples of professionalism, we suggest a holistic ethnographic approach is more appropriate. This approach stresses engagement and written reflection on the good and the bad, especially as experiences of the latter can work to reinforce perceptions of what the former *ought* to be (Punch, 2010, p. 90). This is how one medical student reflected on a clinical experience:

On an obstetrics rotation, I asked a pregnant lady about her plans on returning to work; later the consultant questioned the relevance of this question. I felt it was [an] integral part to how you were going to manage and understand this patient. It made me think the consultant thought I was not ‘medical’ enough and was too ‘fluffy’, because honestly, I was interested in what her plans for work were. Looking back, I still would have asked the same question. (Reflexive text)

The importance of such reflections is shown by Cruess and Cruess (2019, p. 246), who argue that role models act as a powerful force impacting the formation of students’ professional identities. Such role models act as both a guide for the identity to which they aspire, as well as a gatekeeper concerning full membership of the medical community of practice (Wenger, 2000). When interactions with role models lead to contradictions between what medical students have been taught in the classroom (i.e., to consider the social factors that may affect the patient’s recovery) versus the norms and values of specific CoCPs (i.e., the ‘social’ is not the doctor’s concern), it can lead to anxiety and self-doubt concerning what being a doctor means. This draws parallels with the “unsettled time” that ethnographers experience when attempting to comprehend their interlocutors’ understandings and how it differs from their own (Reyes, 2020, p. 276). Therefore, medical students’ own

experiences of unsettled time may make them more open to ethnographic methods and the application of the anthropological approach in learning *how to be* in a different cultural environment (King et al., 2022).

It is precisely such struggles and contradictory messages that medical students face. It is imperative that these effects of the socialisation process are made clear to medical educators, but more importantly to students themselves: they should understand the impact power relationships within CoCPs can have on their developing professional identity (Cruess and Cruess 2019, p. 249). Specifically, in the interpersonal stage of identity development as laid out by Kegan (1982), medical students, often young adults, construct their world using a “socialised lens” (Lewin et al., 2019, p. 1301). It is through such a lens that they seek out examples of what they perceive as successful individuals (such as consultants) as models of ways of being. They try to emulate the behaviour of these individuals in their own practice, as signifying their willingness to uphold the norms of the medical community to their peers acts as an important aspect of their identity at this stage (Cruess and Cruess, 2019, p. 243). In this way, how social structures organise communities encourage the (re)production and internalisation of certain value-laden norms of practice that can contradict formal learning (Goldie, 2012, p. e642). This is exemplified in the ambivalence one medical student displayed toward taking a social history:

We kind of get told in lectures and stuff that you should be asking questions about smoking and you should be hinting at things like that, but actually the reality is that people don't really have time for it when you're consulting, like you do because you get marks for it, so you have to ask but it's unlikely when you're consulting with a patient that you're actually going to get in-depth about their, you know, their way of life and start advising them on their diet and everything like that, because in a ten minute consultation you just don't have the time and you're, you don't necessarily think it's relevant to diagnosing their illness, erm, so I guess in summary I'm just saying that... *people look at things in a biomedical perspective.* (Stephanie, emphasis added)

An autoethnographic project may facilitate medical students to frame their everyday, embodied experiences during their training in a way that “derive[s] broader sociocultural meaning and understanding through their connection with the wider social context” (Perrella et al., 2021, p. 464). From this, they can explore the impact of social influences on their development as a medical professional, an important prerequisite for developing sociologically-informed practitioners (Collett et al., 2016, p. 17). Of further significance here, cognitive conflicts between classroom and learning during a clinical placement, such as the one discussed above, have catalytic potential in terms of changes in self-conceptualisation. Informed with the reflective capacities of autoethnography, however, students may be able to better support themselves as they develop an internal set of standards which allows them to address conflicting expectations and values they come across during their work (Kegan, 1982, p. 225).

An example of the potential for reflective practice offered by autoethnography comes from Perrella et al. (2021). In this study, two of the authors are third-year medical students who conducted an autoethnography based on their experiences whilst on clinical rotation. The researchers produced a reflective account of the students' evolving identities facilitated by continuous data collection and iterative analysis of written reflective exercises (Perrella et al., 2021, p. 465). These raw reflections were then supplemented by full reflective entries a few days after. Both forms of writing were then discussed, critiqued, and built upon in bi-weekly meetings between the medical-student authors, as well as less frequent meetings with two senior scholar-collaborators with experience in autoethnography. Overall, this led to the collaborative coding of eighty-five narrative reflections, from which they generated an overarching theme of self-preservation (Perrella et al., 2021, p. 466). One particularly striking narrative recounted one student freezing and staying silent ‘just to survive’ being grilled with questions by a surgical resident, reinforcing the hierarchy of the operating room (Perrella et al., 2021, pp. 467-468). Ultimately, the medical students – autoethnographers – reflect that such acts of self-preservation are necessary for maintaining any sense of valid professional identity. If left unchecked, however, it could eventually lead to habits of avoidance, cynicism and detachment from patients and colleagues, contributing to a professional self that is discordant with the core values of the profession (Perrella et al., 2021, p. 469).

We can conclude that conducting autoethnographic work provides an intellectually stimulating space for learners to reflect on how certain situations can lead to reactive behaviour that contributes to identity dissonance (Goldie, 2012). Turning the cognitive synthesis of these experiences into narratives may then grant them the “practical wisdom” and self-assurance to consciously address and possibly move away from these attitudes (Epstein, 2008, p. 1048). Finally, on an educational level, this can act as an exploration of the institutionalised norms affecting students' development in their own words (Goldie, 2012, p. e646). All of this serves to familiarise students with

how the sociocultural affects the individual and encourages engagement with wider anthropological theory while providing the tools and space to apply these in practice.

Proposal: Autoethnographic Assignment for Medical Students

The purpose of this autoethnographic assignment is to bring together these two disciplines – anthropology and medicine – and find a way for medical students to engage with the key concepts and theories produced from this union, including the social determinants of health, health inequalities, structural violence/competency/humility, cultural competency/humility, etc. Autoethnography refers to systematically analysing personal experience through writing to understand sociocultural experiences (Ellis et al., 2011). This assignment will aid in both the understanding and application of key anthropological concepts and theories. This deeper engagement will allow students to link theory with observation and can reflectively inform their own professional identity and practice.

The Ethnographic Assignment

Considering the stringent time demands during medical training, it is appropriate to ask medical students to present their findings in a short report format (4000 words) instead of a longer form of ethnographic writing (Reeves et al., 2013, p. e1373). This could be better for medical students, who often have a background in natural or biomedical sciences and may be unfamiliar with long-style essay writing. Concerning the duration of the project, longer-term student projects have been shown to be feasible, but it is important that they fit within the curriculum structure and the length of clinical placements. We suggest a micro-autoethnographic approach (McArthur, 2019) to be centred around the overarching research question: *How do your experiences in your clinical communities of practice relate to anthropological concepts and shape the doctor you are developing into?* In response to this question, they will be required to explore their experiences during placement, drawing on key concepts in medical anthropology, and reflect on how this will inform their future practice. Table 1 presents an overview of medical student-led autoethnographic projects with differing research designs, of which parts may be adopted and mixed according to the varying curriculum structures and assessment requirements of medical schools.

Table 1: Previous student autoethnographic projects with varying research designs that could be adapted.

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| <p>Perrella et al. (2021)</p> <ul style="list-style-type: none"> • Timeframe: one year of core clinical clerkship, bi-weekly meetings between collaborators • Participants: two medical students and two mentor-type collaborators (shared critical reflections) • Writing style: analytical-interpretive – accurate account of events as they relate to overarching theme of professional identity formation (PIF) | <p>Gallé and Lingard (2010)</p> <ul style="list-style-type: none"> • Timeframe: participant-observation and reflective journaling during 5-week interprofessional placement • Participants: single student author • Writing style: narrative vignettes – whole stories followed by analysis informed by existing theory |
| <p>Kim et al. (2019)</p> <ul style="list-style-type: none"> • Timeframe: 158 weekly reflective narratives over first 3 years of medical school • Participants: one medical student and two other researchers collaborate to code and analyse reflections by medical student • Writing style: critical ethnography – personal experiences as primary data source for analysis/critique of social practices | <p>Levine et al. (2019)</p> <ul style="list-style-type: none"> • Timeframe: autoethnographic narratives based on one year of interprofessional experience placements • Participants: 10 student narrative authors collaborate in group meetings involving other researchers • Writing style: analytical-interpretive – specific events related to wider discourse on healthcare education |

The ‘micro’ in a micro-autoethnography refers to the fact that the research would be centred around the socio-cultural organisation of interactions within a particular situational setting: the clinic (Garcez, 1997). Taking the “outdoor psychology” approach explored by Geertz (1983, p. 21), the social nature of cognition is stressed: a “working consensus” (Streeck and Mehus, 2004, p. 386) is constructed through interactions among members of

a CoCP, culminating in a (non-static) shared vision of the world that is internalised and reproduced through the socialisation process (Jaye and Egan, 2006). The interactional processes by which medical teams construct a “professional vision” of their world has been studied using a micro-ethnographic research design (Streeck and Mehus, 2004, p. 390). Notably, Schrewe et al. (2017) conducted a critical discourse analysis of twenty medical student case presentations. They identified an objectified conceptualisation of patients - often identifying patients *as* the disease processes occurring in their body. In this, it is communicated that a doctor’s concerns should be only biomedical in nature (Schrewe et al., 2017, p. 665). This then has consequences for the professional identity medical students will form as they learn to talk, act and think *like a physician* through the internalisation of these norms and values that are communicated through their experiences in the clinic (Jaye et al., 2010, p. 61). When medical students use the conceptual apparatus of micro-ethnography, they may be able to observe interactional processes of working consensus formation/maintenance within CoCPs, and ultimately examine the implication this has for individual professional identification (Schrewe et al., 2017, p. 666).

One theoretical avenue to explore with medical students in the classroom before they embark on their own research might be that of moral economy, the “moral architecture” of sociocultural values underlying economic activities (Jaye et al., 2018, p. 524). The macro-level culture of UK medicine, shaped as it has been by individualised healthcare discourses and overarching audit culture of the neoliberal political milieu, finds its embodiment in micro-level moral economies of care within individual CoCPs (Qureshi, 2013, pp. 6-9). These can include moral judgements of ‘worthy’ and ‘less worthy’ patients, with the former in possession of a greater stock of moral capital with which they can legitimately compel better care from members of the CoCP (Jaye et al., 2018, p. 524). These greater stocks are generated due to that fact that a) the patient is perceived to have a good chance of recovery (and is therefore worthy of investment) and/or b) the cause of the patient’s ailment is perceived as unrelated to an individual lifestyle choice (Higashi et al., 2013, pp. 19-20). Training in micro-ethnography to be able to observe how patient-doctor relationships transpire in interactions according to the logic of these moral economies is likely to be significant to medical students. We posit this because medical faculty reported these relationships as the most important BSS subject in a national UK survey conducted by Satterfield et al. (2010).

We believe that this consciousness, shaped and informed by anthropological theory, will facilitate a more in-depth reflection on how these social processes have shaped students’ experiences within the clinic. Placing the self as the subject of study is the overarching goal of the micro-autoethnography. Framing the personal thoughts and experiences of the student as integral to the work provides an avenue toward reflexivity concerning how experiences in medical teams contribute to a professional identity actualised in a certain habitus (Collett et al., 2016, p. 17). This may encourage students to question the “culture of tolerance” (Neve and Collett, 2018, p. 498) concerning unprofessional behaviour in medicine by examining how it is reproduced in learning contexts whilst reaffirming the idea of what the professional physician *should be* (Perrella et al., 2021, p. 470; Wald, 2015, p. 702). Muncey (2010, p. 51) reflects that constructively processing the complex and sometimes unwanted emotions involved in this is not a simple task one can do without material aids. These aids consist of both field notes and a reflective diary containing personal feelings concerning these experiences (Fusch et al., 2017, pp. 926-930). An “intellectual diary” of immediate analytical ideas written in the margins beside the entries from which they were generated, can also be used to act as a supplementary addition to the journal and diary (O’Reilly, 2012, p. 104). Through this, they can engage with key concepts in medical anthropology and apply it directly to what they observe, including doctor-patient relationships, gendered dimensions of healthcare, structural racism, health inequalities and cultural health beliefs. We want to stress to students that entries into these mediums need to be timely and frequent, and noting down specific details of the scene (physical objects, people, dialogue) often aids in emotional recall to recapture the state of mind/self at the time (Gallé and Lingard, 2010, p. 725). This approach a) motivates continuous, iterative analysis that mitigates recall bias (Perrella et al., 2021, p. 465), b) incites frequent ‘stepping back’ from their direct experiences to see what common themes can be generated, and c) provides the intellectual space to link these themes back to the existing theory, enabling a more contextualised understanding of the findings (Reeves et al. 2013, p. e1373).

Preparing for Ethnography

O’Reilly (2012, p. 101) writes that anyone conducting ethnography must learn how to prioritise what observations are relevant to record versus those that serve only as insignificant detail, and this is doubly important for medical students who will have to balance this amongst a heavy coursework load. Therefore, it may be fruitful to introduce the assignment with a workshop that focuses on identifying and recording transformative moments that lead to new insights about one’s own “personal sense of physicianship” (Perrella et

al., 2021, p. 465). These should include smaller (1-day) observation and recording tasks that recreate the time pressures of placements but in an unmarked environment, encouraging students to experiment and develop their own methods of brief notetaking to prompt a later account of more detail, for which rapid feedback can be given (Gallé and Lingard, 2010, p. 725). Related reflection tasks should also be included to allow students to become more comfortable with the vulnerability inherent to centring research around themselves, especially as traditional research training almost uniformly involves efforts to eliminate the self from research in the name of objectivity (Muncey, 2010, p. 21). These tasks should utilise the literature on ethnographic writing, such as Narayan (2012, pp. 99-110) who offers some possible prompts to engage the self in the autoethnographic text (adapted for this assignment):

- 1) *Situate yourself in a specific scene by detailing the thoughts it generated at the time.*
- 2) *Describe a moment of interaction to which you responded strongly and reflect on how your previous experiences of the social context shaped that reaction.*
- 3) *Describe some ways you have been transformed (physically, mentally) over the course of the project as it relates to the social practices of your group.*
- 4) *Recount a painful instance of maladaptation to the expectations of a CoCP; how might the ways you had to 'shape up' have shifted your clinical affect?*
- 5) *Recall turning points you may have experienced during your development in clinical placements and discuss the social forces that could have shaped them.*

To assist in completing this task, students can draw upon previous essay writings and feedback. Most medical schools in the UK require students to write an essay, drawing on and implementing BSS themes in narrative format, in the first year. This previous writing assignment would provide a foundation for students to conduct this autoethnographic assignment.

Assessment

The marking rubric from King et al. (2022, p. 12), who evaluated short ethnographic student accounts of 'taskscape' throughout Australia, can be adapted to assess the assignment proposed. It includes *Observation* as a criterion, with good marks in this area being dependent upon "a compelling description of observation process," demonstration of attention to detail and an explication of how these activities were captured in research notes (King et al., 2022, p. 12). These attributes are good indicators that the student has embraced the ethnographic approach by following proper note-taking procedure, indicating that they have both studied and put into practice these social science methods within the clinic. This may enhance the perceived clinical relevance and validity of BSS, particularly as it is traditionally "squeezed into the 'pre-clinical' phase" and therefore necessarily presented in abstract (Forrest, 2017, p. 286). Additionally, evidence of observation procedures in their report further indicates students have taken a step back to engage in an etic perspective. The importance this has concerning students' ability to reflect is well summarised in a quote from a medical student during their SSC project with Dikomitis. The student compared perspectives on hospital childbirth in the UK and the Netherlands:

Researching the project [for the module task] allowed me to feel like an anthropology student, rather than a medical student, and it became easier to objectively critique some of the birth practices in the NHS.

Thus, the distancing inherent to taking an outsider's perspective provides the intellectual space to read the "unconscious grammar" of the social environment they experience every day (O'Reilly, 2012, p. 98). This then ideally contributes to an epistemological subject-object move, in which a new mental lens is constructed that allows one to see how their socialised lens shaped their previous thinking (Lewin et al., 2019). As such, the CoCP's norms and values around which their subjectivity was based now become an object to hold in reflection, facilitating a critical examination of them anthropologically (Carrese and Marshall, 2000).

In this frame of mind, "insightful critical reflection on experiences and observations" can fruitfully be generated (King et al., 2022, p. 12). Wald (2015, p.702) defines critical reflection as the "self-assessment of values, attitudes, beliefs, reaction to experiences, and learning needs" and writes that without these metacognitive exercises, professional identity (trans)formation cannot occur. Conceptual language from the social sciences is an important aspect of making direct experiences less ambiguous in terms of the social processes that shape them, thus its usage should be prevalent (Neve and Collett, 2018, p. 498). Marks should therefore be given for use of theoretical terms and engagement with trends in the literature, making use of explicit key medical anthropology and social science concepts of what they observed and experienced, with the best reports being oriented toward

making a substantive contribution to current discourse on professional identity formation in the clinic (Reeves et al., 2013, p. e1373).

However, the majority of marks should be awarded for demonstrations of “practical wisdom” (Epstein, 2008, p. 1048): this raised consciousness should inform a qualitative reconstruction of their professional selves (Kegan, 1982, p. 213). This would be evidenced in the identification of “transformative moments” (Perrella et al., 2021, p. 654), commonly reported to be negative experiences that challenge one’s current self-conceptualisation and throws it into a state of disequilibrium (Kay et al., 2019). Perrella et al. (2021) show that reactions to such negative experiences can induce shame upon reflection, but this may act as evidence of an emerging evolution in their self-conceptualisation, a “re-seeing of the past through one’s new eyes” (Kegan, 1982, p. 216). Therefore, reports highlighting experiences of shame could be given marks for indicating a trajectory toward a self-authoring lens in which an internally defined value system informs the notion of the doctors they *want to become*. Importantly, this is a character that emerges either with support from role models and peers, or despite these external influences (Kegan, 1982). This should be clearly shown in the depth of the explorations of the implications of the socialisation processes on their own “physician story” with reflection on how it may be better (self-)authored in the future (Wald 2015, p. 703).

Ultimately the proposed ethnographic assignment fits into the aspirational elements of medical students’ education, outside of the conventional competencies often assessed in exams (Wald, 2015). Whilst this may be perceived as troublesome to more conservative medical curriculum designers, permitting an alternative assessment method as has been proposed here can help positively shape professional identity of the next generation of doctors, who ideally avoid the ‘cheat-sheeting’ of BSS content, or what Forrest (2017) terms the “tactical approach” (p. 291) to learning. In our data set, medical student Beckie disclosed her experience of this:

I could probably make a list of the things that I would need to know about the anatomy but I, I don't learn the anatomy from a list, whereas with the sort of Theme C [BSS] things I would normally do it that way.[...]Because in that respect it feels a bit more like A Level where you're basically learning a list to be able to pass the exam question.

Our proposal is intended to be an experiential route to learning social science theory and methods, in contrast to the kind encapsulated by Beckie. This may challenge the “perceived inconsistencies between the BSS and the biomedical sciences” by promoting an equally engaging mode of learning (Benbassat, 2015, p. 20). We hope overall to promote the validity of tackling issues from multiple perspectives in the workplace simultaneously, both biomedically and anthropologically, in our bid to “find ways to do it better”, as suggested by Martinez and Wiedman (2021, p. 2).

Conclusion

In summary, we propose a micro-autoethnographic assignment that anthropologists and other social scientists teaching medical students could implement into an existing medical curriculum. The ideal outcome of its implementation is threefold:

- 1) to enhance the understanding and application of key concepts and theories from medical anthropology
- 2) to familiarise students with methods of anthropology by conducting an autoethnographic assignment *in situ* to promote the validity and relevance of anthropological concepts to medical practice
- 3) to promote a heightened awareness of the processes of socialisation which can support a better-informed transition to becoming a doctor. A new epistemological lens of self-authorship permits medical students to better reconcile their personal and professional values, allowing them to develop a professional identity no longer constructed solely around the norms of their communities of practice.

This assignment, taking place during clinical placements, ensures that students begin integrating key theories with observed clinical practice. This avoids the current pattern of ‘list making’ of seemingly abstract concepts, and instead promotes a deeper engagement by applying them to real-life scenarios. By integrating an autoethnography with a clinical placement, it reifies anthropology as a core component of medical education.

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