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Recently Qualified Doctors Learning About End of Life Care: A Socio-cultural Perspective

Thesis presented by

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for the degree of

Doctor of Medicine

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism and Intellectual Property.

Signature:_____ Date_____

Catherine Sweeney

Dedication

To Sean, Eoin, Hugh, and Dan

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Abstract

Background

Death and dying are problematic areas in healthcare. In the developed world, socioeconomic and healthcare changes have resulted in increased life expectancy and excessive use of interventions and healthcare resources at the end of life (EoL). Associated with these transformations, there is a wider cultural reluctance to accept the inevitability of death. In the world of contemporary medicine, death can be viewed as failure. Providing care for people approaching and at the EoL is the responsibility of all doctors, not just the remit of a select minority in particular specialties. In the face of increasing specialisation in medicine, generalist competencies can be subverted.

Previous research has focused on knowledge, preparedness, and experiences of medical students and recently qualified doctors (RQDs) in palliative and EoL care. Many studies have identified significant deficits and call for inclusion of more content in both formal and informal curricula. Workplace learning about EoL care has not been as well explored from a socio-cultural perspective. The primary aim of this thesis was to explore and offer insights into how workplace socio-cultural factors influence RQD learning and development of capability in EoL care.

My research questions were:

1. What and how do recently qualified doctors learn within their physician teams about EoL care?
2. How do recently qualified doctors navigate the wider landscape of practice when caring for patients at the EoL?

3. How do consultants support recently qualified doctors and medical student workplace learning about EoL care?
4. How do specialist palliative care consult team (SPCCT) members perceive RQDs' capability and involvement in the provision of EoL care?
5. How can specialist palliative care consult team members support recently qualified doctors to develop capability in EoL care?

Methodology

I have used a qualitative approach in my programme of research. I adopted a socio-cultural perspective, using the theoretical lenses of Communities of Practice (CoP) and Landscapes of Practice (LoP) for analysis. My research was underpinned by an interpretivist paradigm.

Methods

I conducted 4 studies, each using semi-structured interviews. Participants in studies 1 and 2 were RQDs within the first 4 years of qualification. In study 3, consultants who supervise medical students and trainees were interviewed. In study 4, participants were SPCCT members. I inductively applied Braun and Clarke's method of reflective thematic analysis. While CoP and LoP theories informed the design of the studies, they were not applied in analysis until phase 3 of Braun and Clarke's method (generation of initial themes). I sought latent themes and adopted a constructionist approach. In study 3, I also used a realist theory of supervised workplace learning in postgraduate training to examine the data.

Results

Fifteen RQDs, 14 consultants and 12 nursing and non-consultant medical members of acute hospital SPCCTs were interviewed. Cultural aspects in the workplace were powerful mediators of learning about EoL care.

EoL care was not considered to be part of the core business of many physician teams and RQDs were often not supported by senior doctors to learn and develop capability in this area. When patients were identified as dying, what was perceived to be active care was withdrawn and RQDs were often left by their seniors to deliver the medical aspects of EoL care. The RQDs interviewed excused the perceived lack of consultants' knowledge and skills in this area and their disengagement from patient care at the EoL.

The consultant participants had set the bar high for entrustment in EoL communication. Opportunities for supported learning in the form of observation and less commonly participation, were predominantly reserved for senior trainees. Frequently the consultants interviewed failed to recognise that RQDs were involved in communication with patients and relatives towards the EoL and didn't support their learning in this area.

There was substantial variation in consultants' approaches to EoL care. Dying was sometimes diagnosed late. This coupled with a lack of documentation of care plans to inform patient care out-of-hours, resulted in RQDs suffering moral distress when they were required to carry out burdensome investigations and treatments on dying patients. Emotion in a variety of forms was common in RQDs' accounts. As RQDs moved teams frequently on their training journey they had to do the emotional work of adjusting to the local practice within each physician team. The on-call landscape was

even more complex and RQDs had to deal with increased uncertainty and responsibility.

SPCCT participants described their own struggles to gain legitimacy and trust with some physician teams. They noted RQDs' lack of capability and their struggles in providing EoL care. They supported RQDs to develop knowledge and skills and provided emotional support.

Discussion

My programme of research has found evidence that socio-cultural factors in medicine and the wider healthcare system are important influences on what and how RQDs learn about EoL care. Improving the current situation would require changes in how doctors approach EoL care, with acknowledgement that death and dying are a part of life, and that EoL care is the responsibility of all doctors. In tandem with this improvements in knowledge and skills of many senior doctors would be needed. Attitudinal changes and further integration of specialist palliative care healthcare professionals into the care of patients with life-limiting illnesses would also be important.

RQDs require supported workplace learning to develop capability. Consultants play a central role in workplace education of trainees and have a key part to play if RQDs are to develop capability in EoL care. In this context, SPCCT members can also have a prominent role in supporting RQD learning.

Conclusion

My findings present a complex picture and highlight the importance of considering the influences of medical culture on RQD learning about EoL care. Addressing cultural aspects is central to improving RQDs capability in EoL care along with the experiences of patients and their families.

Glossary

Bad News	"Any information which adversely and seriously affects an individual's view of his or her future" (Buckman, 1992, p. 15).
BBN	Breaking bad news
CNS	Clinical nurse specialist
CoP	Community of practice
EoL	End of life
End of life care	"Care that is provided during the period when death is imminent, and life expectancy is limited to a short number of hours or days" (Health Service Executive, 2014, p. 4).
Family	In a palliative care context the family is considered to be whoever the patient identifies as the most important people in their life.
Local physician CoP	The consultant led team of doctors of which a recently qualified doctor was a member. This team can have a single consultant member with a varying number of non-consultant hospital doctors at different stages in training, or less commonly can consist of a larger specialist department level CoP with several consultants and a larger number of non-consultant hospital doctors, again at a range of stages in their training.
LoP	Landscape of practice
NCHD	Non-Consultant Hospital Doctor (NCHD) refers to a hospital doctor below the level of consultant in Ireland. The term includes interns, senior house officers, registrars, senior registrars, specialist registrars (Irish Medical Organisation, 2013).
Palliative care	"An approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It

	prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. Addressing suffering involves taking care of issues beyond physical symptoms. Palliative care uses a team approach to support patients and their caregivers. This includes addressing practical needs and providing bereavement counselling. It offers a support system to help patients live as actively as possible until death" (World Health Organisation, 2020).
Physician team	The medical or surgical team of which a recently qualified doctor was a member.
RQD	Recently qualified doctor. For the purpose of this research, RQDs were identified as doctors at intern or senior house officer level, who were within 4 years of qualification
SHO	Senior house officer
SPC	Specialist palliative care
SPC Service	"Services with palliative care as their core speciality and which are provided by an inter-disciplinary team, under the direction of a consultant physician in palliative medicine" (National Advisory Committee on Palliative Care, 2001, p.10).
SPCCT	Specialist palliative care consult team. The SPCCT work in acute hospitals, offering advice and support to other healthcare professionals but not taking over patient care. The specialist palliative care consult team is an integral part of the wider regional specialist palliative care service.
SREC	Social Research Ethics Committee
SpR	Specialist registrar

Chapter 1

Introduction

“I learned about a lot of things in medical school, but mortality wasn't one of them. Although I was given a dry, leathery corpse to dissect in my first term, that was solely a way to learn about human anatomy. Our textbooks had almost nothing on aging or frailty or dying. How the process unfolds, how people experience the end of their lives, and how it affects those around them seemed beside the point. The way we saw it, and the way our professors saw it, the purpose of medical schooling was to teach how to save lives, not how to tend to their demise.”

(Gawande 2014, p.1)

1.1 Introduction

The primary focus of contemporary medical practice as reflected in undergraduate and postgraduate medical training is to prevent, treat and cure disease, thus seeking to maximise the health of individuals and populations (Gawande, 2014; Quintero, 2014; Rao *et al.*, 2020) . Whilst death is an inevitable part of life, acceptance of this stark reality by society and the medical profession can be challenging (Gawande, 2014). This is particularly evident in a world where modern medicine and healthcare have become increasingly advanced, with treatments available to prevent and treat, and even cure many diseases, where previously this was not possible (Harari, 2020). While diagnosis of dying can be challenging (Neuberger, 2013; Kennedy *et al.*, 2014), late diagnosis of dying is not unusual and is problematic as it impacts on the

appropriateness of care that patients receive at the end of their lives and does not allow patients to prioritise how they spend their remaining time (Gibbins *et al.*, 2009; Gawande, 2014). For a variety of reasons doctors can be reluctant to make a diagnosis of dying (Gawande, 2014; Kalsi *et al.*, 2020). In the recently published *Report of the Lancet Commission on the Value of Death: Bringing Death Back into Life*, the authors discuss the challenges associated with how people are cared for when they are dying in the 21st century. The authors point to an excessive use of interventions and healthcare resources at the end of life and a marginalisation of family and friends (Sallnow *et al.*, 2022). This is the context in which we educate medical students and train junior doctors.

For a patient and their family, confronting life-threatening illness, death and dying can provoke strong emotional responses and profound existential suffering (Sajja and Puchalski, 2018; Tarbi *et al.*, 2021; Sallnow *et al.*, 2022). In caring for patients approaching and at the end of life (EoL), doctors can be confronted with their own emotions (Meier, Back and Morrison, 2001; Childers and Arnold, 2019) and complex ethical challenges (Akdeniz, Yardımcı and Kavukcu, 2021) as they seek to negotiate a veritable minefield of conflicting demands and expectations.

In this thesis, I aim to explicate how socio-cultural contexts impact on learning, experiences, and perspectives of recently qualified doctors (RQDs) in caring for patients at the end of life (EoL). I explore this through analysis of interviews with RQDs, consultants with whom RQDs work and who supervise their training, and acute hospital-based specialist palliative care consult team (SPCCT) members.

1.2 Concepts of illness and disease

Illness and disease are fundamentally different concepts. Disease relates to a pathological abnormality that is present in an individual and is an objective reality. Illness refers to the individual's experience of disease in the unique context of his or her life and is a subjective reality (Idler, 1979). A disease can exist without a patient having an apparent illness and an illness can exist without an obvious disease. In patients with a life-threatening illness the disease is usually apparent. An individual patient's experience of illness is influenced by many factors and is unique to that individual. No two patients with the same disease experience the same illness. Social and cultural factors such as societal expectations and cultural norms influence illness, as do personal life experiences, personality traits and age (Fox, 1968).

Adopting a biomedical approach aligns with the concept of disease, and when used in research and innovation has allowed for great advances in medicine and contributed to improved life expectancy over the past century (Lichtenberg, 2015). Such advances have included the development of new pharmacological and therapeutic agents, new procedures, techniques, and medical devices. A recent example of such an approach at its most powerful is illustrated by the rapid development of effective vaccinations for Covid-19. In an era where evidence based medicine is highly valued, it can be tempting to define good medical care in terms of a biomedical model (Farre and Rapley, 2017; Wade and Halligan, 2017). However, this approach overlooks the impact of social and other factors that influence health. A landmark study by Temel et al. (2010) provides evidence of the benefits of adopting a biopsychosocial approach, which addresses illness. Temel and her colleagues randomised patients with newly diagnosed metastatic non-small cell lung cancer to receive either standard oncological care or standard oncological care integrated with early palliative care. Patients in the

latter group had significantly better quality of life, fewer had depressive symptoms and they lived longer.

The impact on the individual of adopting a biomedical focus is captured in the following quote from Kieran Sweeney, honorary professor of general practice at the Peninsula College of Medicine and Dentistry in Plymouth, in relation to his own care following a diagnosis of mesothelioma:

> In the care I have received, the transactions have been timely and technically impeccable. But the relational aspects of care lacked strong leadership and at key moments were characterised by a hesitation to be brave. What I have always feared in illness was anonymity, being packaged, losing control, not being able to say “this is who I am.” In the end, one is left alone, here, in the kingdom of the sick. (Sweeney, Toy and Cornwell, 2009)

1.3 Palliative care and end-of-life care

Dame Cicely Saunders, the founder of the modern hospice movement, coined the phrase “Total Pain” to represent the suffering that a life-threatening illness brings with it. Total Pain impacts on an individual’s wellbeing across physical, social, psychological, and spiritual domains (Clark, n.d. b). Spiritual suffering, which is an inability to find meaning in one’s life circumstances is central to the concept of Total Pain (Saunders, 2006). All these dimensions of an individual’s life are considered to be interrelated in a complex manner and are significantly impacted in the face of a life-threatening illness. It is recognised by many that in the face of the multiple challenges brought by a life-threatening illness, a purely biomedical approach to healthcare is inadequate (Engel, 1977; Farre and Rapley, 2017). This conceptualisation of health-

related problems as illnesses rather than diseases, demands the adoption of a broader biopsychosocial approach to healthcare. The approach requires consideration of the individual and their unique personal circumstances to inform care (Masters, 2020).

Palliative care is a holistic, team-based approach to the care of people who have life-threatening or life-limiting illnesses, which should be provided based on need. It is concerned with patients and their families, views their problems in terms of breadth and depth, is not solely dependent on a specific diagnosis or body system, and can be applicable at any stage of a serious illness. This complexity is reflected in the WHO definition provided in the Glossary of Terms (World Health Organisation, 2012).

The National Clinical Programme for Palliative Care, (2019) has developed a model of palliative care for Ireland. Palliative care should be made available to patients based on need and may be applicable years in advance of an individual's death. Depending on the complexity of a patient's need, current or anticipated, specialist palliative care clinicians may have an ongoing, intermittent, or advisory role in the care of a patient with a chronic life limiting illness. Specialist palliative care should be integrated with the patient's usual care. EoL care is a component of palliative care. However, despite the common interchangeable use of the terms, they are not synonymous and this conflation of the two terms represents a common misunderstanding of palliative care (McIlfatrick *et al.*, 2014; Krau, 2016; Flieger, Chui and Koch-Weser, 2020).

End of life care can mean a variety of things. The definition identified by the National Clinical Programme for Palliative Care and provided in my Glossary of Terms (care in the last hours or days of life), is the meaning I employ in my research (Health Service Executive, 2014). Other organisations and countries use the term to define care provided in the last one or even two years of life (Irish Hospice Foundation, n.d.; Marie

Curie, n.d.). In the UK, the term “care of the dying” is used to signify the care given to patients in the last hours or days of life (Ellershaw and Ward, 2003).

1.3.1 Historical, social, and cultural perspectives of palliative care

As I use a socio-cultural perspective in my research in this thesis, it is particularly relevant that I explore the practice of palliative care in relation to its place in the broader historical, social, and cultural medical context. Earlier I outlined the concepts of illness and disease and how these concepts align with biopsychosocial and biomedical approaches to the practice of medicine. Palliative medicine did not evolve from another medical specialty, rather it has its origins in the hospice movement. The undisputed founder of the modern hospice movement and consequently palliative care as a medical specialty was Dame Cicely Saunders (Richmond, n.d.). The origins of her idea to develop St Christopher’s Hospice in London was from an encounter with David Tasma, a Polish Jew who was dying of rectal cancer in 1948 (Saunders, 2000). At the time Dame Cicely was working as a social worker, and through their conversations she identified an unmet need for good symptom control and holistic care for people with life-limiting illnesses. She was encouraged to study medicine by Norman Barrett, a surgeon who advised her to *“go and read medicine. It’s the doctors who desert the dying”* (Clark, 2018, p72). Hospices up to this time had limited medical input. After qualifying as a doctor in 1957, she received a grant to research opiates for pain relief and worked in St Joseph’s Hospice in Hackney, developing her ideas for clinical practice, and building up a team around her. Simultaneously she was developing an international network of individuals who shared this interest. She devised plans to build and open her own hospice, and in 1967 St Christopher’s Hospice opened its doors, making modern hospice care as we know it possible (Clark, 2018). Dame Cicely had

put together a clinical model for care based on the assessment and treatment of Total Pain. In this model the integration of clinical care, teaching, and research, and interprofessional collaboration, and cooperation with other specialties were emphasised (Saunders, 2006). Local and international interest in this model of care grew, and from this recognition of palliative medicine as a specialty. In 1985 the Association for Palliative Medicine for Great Britain and Ireland was formed, and from 1987 for a period of 7 years palliative medicine was recognized as a subspecialty of general medicine in the UK. Following this it was formally recognized as a specialty in its own right (Clark, n.d. a). In 1995 palliative medicine was recognized as a specialty by the Medical Council in Ireland (National Advisory Committee on Palliative Care, 2001). Ireland was the second country in the world to recognize the specialty of palliative medicine. Palliative medicine continued to gain international recognition and by 2014, it was recognized as a specialty or a subspecialty in eighteen European countries, a specialty in Australia and a subspecialty in the US and Canada (Centeno *et al.*, 2014; Pilkey *et al.*, 2017). Over the past twenty or so years there have been calls for access to palliative care to be recognized as a basic human right (Brennan, 2007; Radbruch et al., 2013; WHO, 2014). However, global access remains patchy and restricted in low and middle income countries (World Health Organisation, 2020).

1.4 Capability and competency in medical education

Capability has been defined as: *"an integration of knowledge, skills, personal qualities and understanding used appropriately and effectively - not just in familiar and highly focused specialist contexts but in response to new and changing circumstances"* (Stephenson, 1998, p. 2). Dornan *et al.* (2018) describes capability as an ever evolving and individual interweaving of intellectual, practical, and affective capabilities; the

development of which requires supported participation in real world practice. It has been argued that designing education to support the development of capable doctors who are prepared to respond and adapt to changing contexts, is a suitable way of addressing the complexity of medical practice (Fraser and Greenhalgh, 2001; Dornan *et al.*, 2018; Teunissen *et al.*, 2021).

Competence has been defined as: *"the array of abilities across multiple domains or aspects of physician performance in a certain context."* (Frank *et al.*, 2010). The contemporary focus on competency based medical education (CBME) as structure for training and assessment, has been criticised as being reductionist (Talbot, 2004; Brooks, 2009) and not preparing graduates for the complexity of real world practice (Huddle and Heudebert, 2007). A recent review of evidence underpinning assumptions about CBME, found that a considerable amount of the research to date has focussed on aspirational assumptions and the authors identified a need to explore how and why it can be successfully used (Brydges *et al.*, 2021).

To manage EoL care holistically is a complex task. No two patients, their families or situations are ever the same (Idler, 1979). Diagnosis of dying can be uncertain (Kennedy *et al.*, 2014; Kimbell *et al.*, 2016), and strong emotions can be evoked in doctors (Meier, Back and Morrison, 2001; Katz and Genevay, 2002; Jackson *et al.*, 2008; Kuhl, 2011; Whitehead, 2014; Childers and Arnold, 2019) patients and their families (Alexander *et al.*, 2014; Tarbi *et al.*, 2021) when confronted by death and dying. For a doctor to have capability in EoL care, they must be able to practice competently in previously unexperienced situations and in the face of uncertainty. It requires more than following protocols and guidelines. The issues that arose in relation to the use of the Liverpool Care Pathway (Neuberger, 2013) illustrate the difficulties

with the use of guidelines by those who lacked capability. In this case, poor EoL care was due in part to inappropriate application of an approach in an uncaring way by health care professionals who were lacking in knowledge and skills. Hence, I judged that consideration of RQD capability was well aligned with the aims of my research.

1.4.1 The need for RQDs to have capability in EoL care

As my research was conducted in the Irish healthcare system, I initially focus on this context here. In Ireland, the Health Services Executive (HSE) has identified that palliative care provision is the responsibility of all clinicians (Ryan *et al.*, 2014). In 2001, the report of the National Advisory Committee on Palliative Care (NACPC) was published and it was subsequently adopted as government policy (National Advisory Committee on Palliative Care, 2001). Three levels of palliative care specialisation were identified for healthcare staff (across professions) in the report. These levels were based on the roles that healthcare professionals play in the care of patients with palliative care needs:

Palliative care approach – all healthcare professionals should be aware of and apply general palliative principles. This requires all clinicians in hospital and community settings to have basic core knowledge and skills related to palliative care and to be able to comprehensively provide care for those whose needs are not complex.

General palliative care – a proportion of healthcare professionals who have additional training and expertise in palliative care but who are not engaged full-time in the delivery of palliative care. Healthcare professionals in this group would have higher levels of knowledge and skills and be able to provide care where patient and family needs are more complex.

Specialist palliative care – a smaller group of healthcare professionals whose core activity is limited to the provision of palliative care at a specialist level. This group would provide care to those with complex and demanding care needs and require higher levels of certified training.

In the UK, the General Medical Council considers that all doctors have a duty of care to patients at the end of life. They have identified behaviours, values, and skills for medical graduates (General Medical Council, n.d.) and guidance on treatment and care towards the EoL for all doctors (General Medical Council, 2010). The authors of the report of the *Lancet Commission on the Value of Death* argue that :

> All health and social care professionals in all countries and systems must be competent in caring for dying patients and their families. These are core skills, and dying patients should be referred to specialist palliative care services (where available) only when specialist support is necessary. (Sallnow et al., 2022, p. 875).

It has been estimated that approximately 75% of deaths in middle and high income countries are the result of chronic diseases and those dying from these diseases would likely benefit from a holistic palliative approach to their care (Gómez-Batiste *et al.*, 2014). Almost a half of Irish deaths occur in acute hospitals and around 75% of these deaths are expected (McKeown et al., 2010). Junior doctors provide much of the day-to-day care for seriously ill and dying patients. A recent systematic review found that junior doctors care for many patients with palliative and end-of-life care needs from early in their careers (Bharmal *et al.*, 2019). In the UK, it has been estimated that on average in the year after qualification, a doctor cares for 40 people who will die in hospital (including 10 from cancer, 18 from heart disease and stroke, 4 from a

respiratory cause) and another 120 with advanced disease who are not dying at the time (Faull & Woof, 2002). In an Irish survey of interns and senior house officers, 81% of the 110 respondents had pronounced death and 75% had had discussions about end-of-life with a patient's relatives (Linane *et al.*, 2019). People who have life limiting illnesses and who are approaching death often have complex healthcare needs including physical symptoms, psychosocial issues and existential concerns that require their doctors to be able to provide holistic care as part of a team (National Advisory Committee on Palliative Care, 2001; Ryan et al., 2014). Hence, all junior doctors need to have a range of capabilities in this area from the time of qualification and to be supported to develop and enhance these capabilities in an ongoing manner.

The Central Statistics Office in Ireland has predicted that the number of those over 65 in Ireland will rise from 629,800 in 2016 to approximately 1 million by 2031 and 1.5 million by 2051 (Central Statistics Office, n.d.). As our population ages and people live longer with extended periods of ill health caused by of chronic illnesses and multimorbidity, it is anticipated that there will be increasing numbers of patients with palliative care needs related to both malignant and non-malignant diseases. A study looking at figures for England and Wales, predicts that the population with palliative care needs will have increased by over 40% by 2040 (Etkind *et al.*, 2017). These expected changes in population demographics will further increase the need for all doctors to be capable of delivering palliative and EoL care.

1.4.2 Palliative care competencies

The provision of palliative and EoL care requires doctors to have knowledge and skills in a wide range of areas. In 2014, following an extensive process, the Health Service Executive in Ireland published a Palliative Care Competence Framework (Ryan et al.,

2014). In the framework 6 domains of competence for health and social care professionals were identified for each profession and at each of the 3 levels identified in the NACPC report. Table 1 outlines the 6 domains of competence identified for Irish healthcare professionals. Hence competences have been identified across these 6 domains at each level for all doctors involved in providing direct patient care. The framework has been endorsed by the Forum of Irish Postgraduate Training Bodies (Ryan *et al*., 2014). Competencies in palliative care have been identified in Canada for residents (Bromwich *et al.*, 2019) and medical students (Canadian Society of Palliative Care Physicians, n.d.) and for both groups in the US (Schaefer *et al.*, 2014).

Table 1: Domains of competence in the Palliative Care Competence Framework

Domain of Competence
1 - Principles of palliative care
2 - Communication
3 - Optimising comfort and quality of life
4 - Care planning and collaborative practice
5 - Loss, grief, and bereavement
6 - Professional and ethical practice in the context of palliative care

1.5 An overview of postgraduate training in Ireland

In Ireland, the post qualification professional journey of the RQD starts with a year of internship. During this year, the RQD is registered as an intern with the Medical Council and following satisfactory completion of internship, a RQD is eligible to register in the General Division of the medical register. Interns are employed by the Health Services Executive and rotate through four 3-month posts. Most interns work in more than one hospital during their time as an intern, with a minority completing a 3-month

post in a primary care or community setting. All complete a minimum of 3 months in general medicine and 3 months in general surgery, the remaining time is spent on two 3-month rotations across a wide range of possible specialties. Interns are appointed by way of a national intern matching process. Many chose to remain locally to work in the teaching hospitals in which they have trained as undergraduates.

Following internship, many RQDs enter a structured training scheme overseen by a postgraduate training body (e.g., a basic specialist or a general practice training scheme). In the case of medical basic specialist training there are 9 training hubs, one of which is centred around the UCC teaching hospitals. Again, individuals often seek to remain working in the local region on these training programmes.

Some RQDs work for a year or two in short term posts (usually of 6 months to 1 year duration) that are not linked to a basic specialist training (BST) programme. At this point RQDs are called Senior House Officers (SHOs). Those RQDs completing a BST scheme usually spend 3 or 6 months in a post before moving on to another position, often in a different clinical site and in another specialist area. This approach to BST aims to support specific aspects of training and to provide a range of experiences before trainees enter more focussed higher specialist training. A RQD will be part of a physician team led by one consultant, with a varying number of non-consultant hospital doctors (NCHDs), or less commonly can be part of a larger specialist level team comprising of several consultants within a specific specialty and a larger number of NCHDs at a range of levels who cover the service.

A small minority of SHOs in medical BST or general practice training do a three- or six-month placement in palliative medicine. Currently in Ireland, interns do not have placements in palliative medicine.

Following completion of BST those wishing to specialise and become consultants complete higher specialist training. Many of these also spend some time abroad in North America, the UK or Australia gaining additional specialist experience.

1.6 EoL and palliative care in medical education: An overview of the literature

A considerable amount of the research conducted looking at palliative care in medical education, focusses on EoL care, particularly the area of junior doctors' preparedness for, and experiences of practice. This section outlines the main themes that I have identified that are of relevance to this body of research.

1.6.1 Preparedness of RQDs to provide palliative and EoL care

There is evidence that many RQDs feel under prepared to provide palliative and EoL care when they qualify. Bharmal et al. (2019) undertook a systematic review of junior doctors' attitudes to, and experiences and feeling of preparedness for providing EoL and palliative care. Studies conducted in the UK, Ireland, Australia, Canada, and New Zealand were included. US studies were excluded as early postgraduate training there was seen to be substantially different due to early specialist training of graduates. They concluded that junior doctors were often unprepared and felt unsupported by senior doctors when providing end-of-life and palliative care. In a large US study exploring how medical school training had prepared residents for clinical practice, participants reported feeling well prepared for history taking (92%) and presenting a physical examination (86%), but substantially less prepared for EoL care (42%) and dealing with patient deaths (46%) (Chen, Kotliar and Drolet, 2015).

Providing end-of-life and palliative care as a doctor requires a broad range of knowledge and skills, including assessment and management of pain and other

symptoms, communication and interpersonal skills, self-awareness, and self-management (Ryan *et al*., 2014). Studies from Ireland and other countries have found a wide range of areas related to EoL care where recently qualified doctors frequently felt poorly prepared for practice. These included practical aspects such as pronouncing death and legal requirements (Linane et al., 2019), clinical aspects including symptom management, communication, dealing with patient distress, and addressing social, cultural, psychological, and spiritual issues (Bowden et al., 2013; Gajebasia et al., 2019; Linane et al., 2019; Sullivan et al., 2003; Tait & Hodges, 2013).

It has been suggested that it may be more straightforward to prepare students and trainees for some of these areas than others (Schroder *et al.*, 2009; Barclay *et al.*, 2015). Aspects that can be addressed by improved knowledge such as physical pain assessment and management appear to be more easily attended to than areas requiring skills development, or attitudinal and affective changes (Billings *et al.*, 2010; Pieters *et al.*, 2019). However, longitudinal attitudinal improvements in medical students attitudes towards palliative care have been reported from an undergraduate course that deliberately focussed on addressing these issues through exposure to patients approaching end of life, formal teaching, and reflective practice (Borgstrom, Barclay and Cohn, 2013).

The importance of fostering the development of positive attitudes has been emphasised by many involved in palliative care education (Bradley *et al.*, 2002; Gibbins *et al.*, 2010; Barclay *et al.*, 2015). Co-ordinators of palliative care undergraduate medical education in the UK viewed the dispelling of misconceptions, reducing anxiety, and the development of positive attitudes towards palliative care as more important than the learning of factual information (Gibbins *et al.*, 2010).

1.6.2 RQDs learning about palliative and EoL care in their day-to-day work

RQDs learn a lot about being doctors informally while working in their physician teams in clinical learning environments under the supervision of senior doctors (Wiese, Kilty and Bennett, 2018). It has been argued that most professional learning occurs informally (Eraut, 2007; Steven *et al.*, 2014). Several UK studies have reported that newly qualified doctors learned about palliative and EoL care through experience of doing the job (Gibbins, McCoubrie and Forbes, 2011; Price and Schofield, 2015; Gajebasia *et al.*, 2019). Price & Schofield (2015) also identified that written guidance on EoL care, particularly in relation to prescribing, was useful. In addition, their participants identified observation of the practice of other doctors, both good and bad, as a significant educational opportunity, particularly in learning about communication. RQDs report variation in practice in relation to EoL care between specialties (Price and Schofield, 2015; Redman *et al.*, 2017), with some specialties outside of specialist palliative care, such as oncology and gerontology tending to identify approaching death and manage EoL better than others. Variations between specialties in the timeliness of diagnosis of dying have also been reported by others, with surgical specialties often identified as diagnosing dying late (Redman *et al.*, 2017; Chapman *et al.*, 2021).

Gibbins et al. (2011) reported that their participants were uncertain about the knowledge and skills of more senior doctors in relation to EoL care and often went outside their physician team to seek advice from nurses and palliative care staff. Other studies have also highlighted the importance of learning from the specialist palliative care team members (Price and Schofield, 2015; Kawaguchi *et al.*, 2017; Gajebasia *et al.*, 2019). In contrast, research conducted in a large UK hospital by Jack et al., (2002), reported that some senior staff had concerns that more junior doctors might be

deskilled by the involvement of palliative care clinical nurse specialists. However, junior doctors in the same study did not identify this. A systematic review of generalists perceptions of palliative care teams concluded that those who referred frequently to palliative care were better able to provide generalist palliative care and offer holistic management of symptoms than those who referred infrequently or not at all (Firn, Preston and Walshe, 2016).

Research of RQDs learning from working in specialist palliative medicine has found improvement in self-reported recognition of dying, knowledge of symptoms, communication skills and confidence (Lloyd-Williams, 2002; Duong and Zulian, 2006; Morrison and Forbes, 2012; Frearson, 2019). Participants reported being well supported in their roles by nursing staff, more senior doctors, and members of the wider multidisciplinary team (Duong and Zulian, 2006; Morrison and Forbes, 2012; Frearson, 2019). There are conflicting findings on the emotional toll on RQDs of working in this environment. Participants in the interview study conducted by Frearson (2019) raised concerns about the potential negative emotional impact of working in an environment where death, dying and suffering were frequently encountered. However, those interviewed did not feel the experience had an emotional toll. Duong & Zulian (2006) reported that confronting death appeared to have allowed their participants to learn to manage their emotions. However, Lloyd-Williams (2002) found that almost a quarter of their participants scored positively for psychological distress. All these studies were limited by small sample sizes; however, I report them here as there has been limited research published in this area.

Palliative care rotations are not the only setting in which RQDs can have supported exposure to EoL care. A Norwegian focus group study of interns' experiences of

working in nursing homes where they were exposed to EoL care found that participants gained appreciation of the value of individualised care, their role in interdisciplinary teams and learned communication skills (Fosse *et al.*, 2017).

There has been more exploration of medical student learning from clinical exposure to palliative care placements, so I present a brief overview of this here and include medical student studies in the following sections. There is evidence that supported exposure to palliative and EoL care in clinical environments facilitates medical students in preparing to provide patient care. In the US studies, clinical placements in palliative care have been found to enhance learning about symptom management (Anderson et al., 2008; Fraser et al., 2001; Von Gunten et al., 2012). Other studies have found that educational initiatives that included clinical placements changed medical students' attitudes and improved their confidence (Ratanawongsa, Teherani and Hauer, 2005; Anderson *et al.*, 2008; Mason and Ellershaw, 2008; Crawford and Zambrano, 2015).

1.6.2.1 Lack of support for RQDs and medical students providing EoL care

Several studies have identified lack of support for RQDs and medical students, particularly in relation to difficult conversations with patients and their families. The review performed by Bharmal et al. (2019) identified that support from more senior doctors around the provision of EoL care was inconsistent and often specialty dependent; support being less available from specialties that were more focussed on interventions. Redman et al. (2017) identified a need for more clinical, practical, and emotional support by senior doctors for foundation year doctors involved in care of the dying. Tait & Hodges (2013) concluded that some participants believed that senior

doctors used time pressures and medical terminology as barriers to engagement with patients who were dying.

In the US and Canada, medical students in the final years are given higher levels of responsibility in relation to patient care than in other western countries. Studies conducted in North America have also identified lack of support for medical students and RQDs from those more senior in relation to clinical exposure to dying patients (Wear, 2002; Wang, Swinton and You, 2019). The experiences of senior Canadian medical students of having goals of care (GoC) discussions with patients were studied from a socio-cultural perspective by Wang et al. (2019). GoC discussions were frequently conducted by senior medical students without supervision or feedback after they had initially observed one or two such discussions being facilitated by residents. This lack of support for difficult conversations was found to have impacted negatively on learning and identity formation. According to the authors most developed a concept of *"an insidious, inevitable maturation process"* where conflicting elements of identity were reconciled by internalisation of values and norms they had previously considered as undesirable.

Medical students and trainees are not necessarily critical of senior doctors for lack of support. In some studies, participants justified or rationalised the lack of support they received in terms of external factors such as time and system pressures on senior doctors (Wear, 2002; Ratanawongsa, Teherani and Hauer, 2005; Tait and Hodges, 2013; Wang, Swinton and You, 2019). Wear (2002) found that students did not appear to have expectations of support, or to question whether lack of interest or competence on the part of senior doctors might be a contributing factor to deficiencies they experienced in this area.

Participants in Gibbins et al. (2011) turned to nursing and palliative care teams to support and educate them on the job when they had to attend to patients with palliative care needs, as often they were unsure if senior doctors had the necessary knowledge and skills to provide this care and to guide them with feedback.

1.6.2.2 The hidden curriculum and medical culture

In considering learning in the workplace, the hidden and informal curricula are particularly relevant when it comes to learning in the area of palliative and end-of-life care. Hafferty, (1998, p 404) describes the hidden curriculum as *"a set of influences that function at the level of organizational structure and culture"* and the informal curriculum as *"an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students".* Influences of the hidden and informal curricula on learning about palliative and EoL care have been widely identified in palliative care education literature (Wear, 2002; Ratanawongsa, Teherani and Hauer, 2005; Anderson *et al.*, 2008; Billings *et al.*, 2010; Von Gunten *et al.*, 2012; Tait and Hodges, 2013; Bharmal *et al.*, 2019), and distinctions between the two are frequently not made in these publications.

The prevailing medical culture in the western world views death as failure and palliative care is a last resort as it doesn't align with the medical goals of *"cure and save"* (Tait and Hodges, 2013; Sallnow *et al.*, 2022). This culture is reflected in the experiences of RQDs caring for patients at EoL. Studies have found that RQDs witnessed their seniors disengaging with dying patients and encouraged them to do likewise (Brennan et al., 2010; Gibbins et al., 2011) and perceived that talking about death and dying was off-limits (Brennan et al., 2010; Crawford & Zambrano, 2015; Gibbins et al., 2011; Tait & Hodges, 2013). This leads to tacit learning from the hidden and informal

curricula, that patients who are dying are no longer a priority and EoL care is less important than work focussing on prolonging life.

Hence learning about palliative care from the formal curriculum which espouses early referral, holistic care, and non-abandonment at the EoL (National Advisory Committee on Palliative Care, 2001) can be subverted by what is experienced and observed in the world of practice.

1.6.3 The emotional impact of death and dying on medical students and doctors

Emotions are omnipresent in doctors' work and their impact is often overlooked (Shapiro, 2011; McNaughton, 2013; Dornan *et al.*, 2014). Emotion plays a key role in affective learning (McConnell and Eva, 2012; Tyng *et al.*, 2017; Dornan *et al.*, 2018) and the role of emotion in medical education is often under recognised and has not been extensively researched (Shapiro, 2011; McNaughton, 2013). Affective learning is an essential element of developing affective capability and requires learners to be supported by more senior doctors and other healthcare professionals (Dornan *et al.*, 2014, 2018).

There is evidence that doctors at all levels of training and seniority can struggle with the emotional effects of caring for patients who are dying and the deaths of patients (Meier, Back and Morrison, 2001; Childers and Arnold, 2019). The hidden curriculum conveys messages about the display of emotions by doctors (Childers and Arnold, 2019; Wang, Swinton and You, 2019), which is particularly relevant to the emotive issues of death and dying. Medical students and junior doctors have strong emotional responses to the initial deaths they encounter and often perceive from the behaviour of senior doctors that death and emotions are unmentionable subjects

(Ratanawongsa, Teherani and Hauer, 2005; Rhodes-Kropf *et al.*, 2005; Gibbins, McCoubrie and Forbes, 2011; Bharmal *et al.*, 2019). Several authors have identified a medical culture that results in suppression of the emotions that arise when doctors are caring for patients with serious and life threatening illnesses (Wagner *et al.*, 1997; Sullivan, Lakoma and Block, 2003; Rhodes-Kropf *et al.*, 2005; Childers and Arnold, 2019).

Being confronted by death and being involved in EoL care generates strong and often negative emotional responses for medical students (Wear, 2002; Rhodes-Kropf *et al.*, 2005; Anderson *et al.*, 2008; Sagin *et al.*, 2020; Jedlicska *et al.*, 2021). Responses of sadness (Rhodes-Kropf *et al.*, 2005; Anderson *et al.*, 2008; Sagin *et al.*, 2020; Jedlicska *et al.*, 2021), helplessness (Sagin *et al.*, 2020; Jedlicska *et al.*, 2021), guilt, and failure (Rhodes-Kropf *et al.*, 2005; Anderson *et al.*, 2008) have been reported. Sagin et al. (2020) found that a palliative care elective prompted medical students to reflect on their own mortality and that of loved ones. However, some studies have also found positives in addition to negatives resulting from exposure to patients who were dying. These experiences can support the development of empathy, gratitude, and a sense of responsibility (Ratanawongsa, Teherani and Hauer, 2005; Anderson *et al.*, 2008; Sagin *et al.*, 2020). The importance of providing emotional support for medical students experiencing death and dying was highlighted by the authors in all these studies.

Studies of RQDs also provide evidence of the emotional impact of providing palliative and EoL care in acute hospital settings (Schroder *et al.*, 2009; Brennan *et al.*, 2010; Tait and Hodges, 2013; Crawford and Zambrano, 2015; Linane *et al.*, 2019). Early career experiences of death and dying have powerful emotional effects and frequently

remain with doctors long afterwards (MacLeod, 2001; Brennan *et al.*, 2010; Whitehead, 2014; Crawford and Zambrano, 2015). Similar to medical students, RQDs have also reported experiencing sadness (Brennan *et al.*, 2010; Linane *et al.*, 2019), helplessness, guilt, and failure (Jackson *et al.*, 2005; Schroder *et al.*, 2009; Tait and Hodges, 2013; Linane *et al.*, 2019).

Caring for patients with life threatening illnesses and patients who die can also have a strong emotional effect on experienced doctors (Meier, Back and Morrison, 2001; Jackson *et al.*, 2008; Kuhl, 2011; Whitehead, 2014; Childers and Arnold, 2019). Some of the emotional challenges faced by doctors as they come face-to-face with suffering and death, include the tensions they encounter between aiming for cure and avoidance of unnecessary iatrogenic suffering at the end-of-life (Whitehead, 2014; Childers and Arnold, 2019). This is experienced in the context of responsibilities to patients, their families, the wider healthcare system and society, and a medical culture where emotions are suppressed and unacknowledged (Childers and Arnold, 2019). Whitehead (2014) examined the physicians' perspective to explore what might lie behind iatrogenic suffering. Senior doctors are accustomed to patients' deaths and expect to encounter them as a part of the job (Jackson *et al.*, 2005; Whitehead, 2014). However, even experienced doctors experience strong emotional reactions to certain deaths, which can cause them to question their own actions and competence or confront them with their own mortality, that of loved ones, or bring up unresolved emotional experiences (Whitehead, 2014).

Meier et al. (2001) identified the importance of attending to the negative emotions engendered by caring for those with serious illnesses. She argues that not doing so can lead to negative impacts on both the doctor (guilt, distress, burnout) and the quality

of patient care (disengagement and poor judgement by the doctor). Kuhl (2011) reported that poor communication by doctors could lead to iatrogenic suffering for patients approaching death. The findings of Jackson et al. (2008) suggested that oncologists adopting a purely biomedical approach struggled more emotionally when they could not alter patients' disease trajectories and offered less EoL treatment options than those who integrated a biomedical and psychosocial model of care.

1.7 Identifying the problem

If healthcare systems are to effectively care for increasing numbers of people with life-limiting illnesses, it is important for all doctors to have basic capability in palliative and EoL care (Ryan *et al.*, 2014; Sallnow *et al.*, 2022).

In the Department of Health Report, Medical Education in Ireland: A New Direction, (Fottrell, 2006), the vision for medical education was outlined as a *"system which nurtures and develops people of the highest calibre to become caring and effective doctors, who support the wellbeing of the nation and the health of the individual, throughout a lifetime of continuous self-development." p31*. The experiences and preparedness of recently qualified doctors to care for patients at the end-of-life have been explored both in an Irish and an international context. Based on the evidence presented in this literature review it is apparent that many RQDs feel ill prepared to meet the needs of those with life limiting illnesses and those who are at the end-of-life. Furthermore, RQDs are not well supported to learn by more senior doctors in their physician teams. This not only has the potential to impact negatively on patient care and families' experiences, but also the emotional wellbeing of our junior doctors.

The impact of the hidden curriculum has been highlighted in research conducted to date. A number of the studies that I reviewed mention medical culture and the messages it conveys to medical students and RQDs about death, dying and EoL care (Wear, 2002; Billings *et al.*, 2010; Bharmal *et al.*, 2019; Childers and Arnold, 2019). While the impact of medical culture on RQD learning in the workplace about EoL is commonly mentioned, this has not been comprehensively explored. Without a good understanding of the influence of the cultural context in the workplace on medical practice of EoL care, it is likely that formal educational initiatives focussed on developing knowledge and skills in palliative and EoL care will have limited impact on how doctors practise patient care at the EoL.

The objective of this work was to explore the perspectives and experiences of RQDs, consultants and acute hospital specialist palliative care clinicians in relation to RQD workplace learning about EoL care. To my knowledge, apart from a few studies that only included palliative medicine specialists, the perspectives of consultants who supervise RQDs and medical students on their teams had not been investigated in relation to EoL care. In addition, the views, and experiences of members of specialist palliative care teams in acute hospitals about RQD learning had not been well explored. By examining this subject from the perspectives of these groups through a socio-cultural lens, I was hoping to gain new insights and deepen understanding of the facilitators and barriers to RQD learning and development of capability in EoL care. I anticipated using the findings to suggest potential solutions to some of the current challenges in order to improve EoL care experiences for doctors, patients, and their families.

1.8 Theoretical framing

This body of work is underpinned by a socio-cultural orientation and my use of theory and methodology are aligned with this and described in detail in Chapter 2 (Conceptual Orientation and Methodology). My research is primarily analysed from the perspectives of Communities of Practice (Wenger, 1998) and Landscapes of Practice (Wenger-Trayner et al., 2015) theories and both theories were used from the conception of the research and informed data collection. I selected both theories due to their affordances in exploring learning in the workplace from social, cultural, and historical perspectives. CoP theory allows RQD learning to be viewed in relation to participation in the everyday practice of the physician team of which they are a member. LoP theory is a recent evolution of CoP theory that allows exploration of learning to be extended to the wider complex working environment of RQDs. RQDs are simultaneously members of several workplace CoPs and have interactions with many others. They frequently change jobs, usually every three or six months and hence the primary physician team to whom they are accountable changes regularly. Each of these teams has its own area of interest and a unique practice, which has developed historically, and is influenced by institutional and cultural factors. LoP theory has been identified as a useful addition in medical education practice and research and a novel way to explore identity formation (Hodson, 2020). In Chapters 3 and 5 CoP theory is applied in analysis of the data. In Chapter 4 a LoP perspective is taken, and in Chapter 6 both CoP and LoP theories are employed.

In Chapter 5 (Consultants' Perspectives on Supporting Recently Qualified Doctors' Workplace Learning about End of Life Care), in addition to CoP theory, I have used a realist theory of supervised workplace based learning to allow for a more detailed analysis of supervisors' support of informal learning in relation to communication of

bad news to patients and families (Wiese, Kilty and Bennett, 2018). This theory was informed by socio-cultural theories including CoP and hence its use is aligned with my orientation towards socio-cultural perspectives of learning.

1.9 Research questions

1. What and how do recently qualified doctors learn within their physician teams about EoL care?
2. How do recently qualified doctors navigate the wider landscape of practice when caring for patients at the EoL?
3. How do consultants support RQD and medical student informal learning about EoL care?
4. How do SPCCT members perceive RQDs capability and involvement in the provision of EoL care?
5. How can SPCCT members support RQDs to develop capability in EoL care?

1.10 Summary of other chapters

I present my thesis over seven chapters. In this chapter and in Chapter 2 (Conceptual Orientation and Methodology), I have outlined the context and rationale for this work and the methodology I use. These are followed by four data chapters, each describing one qualitative study. All four studies are interview studies and I use a similar methodology in each. For initial analysis I inductively applied Braun and Clarke's method of reflexive thematic analysis (Braun and Clarke, 2006, 2019) and at a later stage applied one of three contemporary educational theories as a lens to address my research questions. There is a focus throughout all these chapters on socio-cultural aspects of learning.

In Chapter 3, I address research question 1 and use CoP theory to explore RQD learning about EoL care within their physician team. This chapter focuses on how and what RQDs learn about EoL care from the practices they engage in on their physician teams. In Chapter 4, I explore RQD learning about EoL in the broader context of the LoP. This chapter takes a wider look at RQD learning as they navigate their way along in their early postgraduate years. In these formative years, they often change jobs every three or six months between physician teams in a variety of specialties, and interact with many other specialties, professions, and systems along the way. I look at how these experiences influence learning about caring for patients at the EoL. In Chapter 5, I consider how consultants support RQDs and medical students to learn communication skills in the context of bad news. I use a theory of workplace learning in postgraduate medical education along with CoP theory to shed light on this area. In Chapter 6, I explore how SPCCTs perceive RQDs capability in EoL care and how they can support learning in the workplace. In Chapter 7, I draw together and synthesise key findings from the four studies. I discuss implications for practice, suggest areas for future research, and identify the strengths and limitations of my research.

Chapter 2

Conceptual Orientation and Methodology

2.1 Introduction

In this chapter I explain my approach to this body of research. I identify the research paradigm that underpins my work and explain how it is coherent with my beliefs about reality, knowledge, and my choice of theories. I outline how these informed the decisions I made in relation to data collection, analysis, and presentation of findings. I also discuss the measures I took to ensure quality and trustworthiness of my research.

2.2 Ontological and epistemological positions

The purpose of research is to produce new knowledge and insights. In order that research outputs can be contextualised, understood, and interpreted, it is important that the research paradigm and hence the assumptions underpinning the research, is made explicit (Bunniss and Kelly, 2010). A research paradigm is a set of beliefs which determine how researchers conduct their research, and is characterised in terms of ontology, epistemology and methodology (Guba & Lincoln, 1994). Various definitions exist for each of these terms and in some cases, there are divergences in these definitions (Carter and Little, 2007), therefore as I proceed, I will explain how I interpret these.

My research is underpinned by an interpretivist paradigm. Researchers using interpretivism consider that as humans we interpret the social context of the world in which we live to make meaning and construct reality (Guba & Lincoln, 1994). Meaning is co-constructed by the participant and the researcher in their interaction and

qualitative methods are generally used to collect data (Bunniss and Kelly, 2010). This paradigm affords exploration of the social world, how it is experienced and conceptualised by individuals (King, Horrocks and Brooks, 2019), and aligns with my aim to gain understanding of social and cultural aspects of learning.

Ontological positions relate to the nature of reality. Researchers' perspectives on reality can be viewed on a spectrum. At one end is a realist ontology, which assumes there is a reality to be known or a truth to be discovered and forms the basis of positivism. On the other end is the relativist perspective; there is no absolute truth to be uncovered and reality is subjectively determined by each individual, based on their experiences and social situations (Denzin & Lincoln, 2005). Between these extremes lies the concept that reality may exist, but humans can never fully comprehend it (Guba & Lincoln, 1994). In relation to the area of interest of this research, I hold a relativist ontological position, believing that each individual has their own reality, influenced by their ongoing experiences. This ontological stance is aligned with interpretative approaches to research (Kivunja and Kuyini, 2017).

Epistemology is concerned with the theory of knowledge and according to Carter & Little, (2007, p.1317) can be seen as the *"justification of knowledge".* Epistemology relates to ontology. A researcher from a realist ontological perspective will aim to set up his or her position independently of the subject of the research and consider their findings valid if replicable and judged to be lacking in bias. Hypotheses are proposed and tested, objectivity is highly valued, and the ultimate aim is to find a truth (Park, Konge and Artino, 2020). A quantitative methodological approach is usually adopted. A researcher adopting a relativist ontological position, views knowledge as a creation of the research process, constructed by the interaction of the researcher and the

participant. In this approach, it is accepted that subjectivity is an inherent part of the research (Carter and Little, 2007). Transparency and trustworthiness are key determinants of the quality of research. This is achieved through reflexivity, in which the background and position of the researcher are explicated and other factors that may potentially influence the research process are highlighted (Malterud, 2001). This allows others to consider and interpret the research in an informed manner (Carter and Little, 2007). A qualitative methodological approach is generally considered the most fitting for this type of research.

2.2.1 Qualitative research

It has been argued that medical education research should seek to explore phenomena to provide richer and more complex understanding, stimulate debate and inform theory and policy, and to do this requires adoption of approaches used in the social sciences (Gill and Griffin, 2009; Monrouxe and Rees, 2009). Qualitative methods are widely used in the social sciences (Lune and Berg, 2017; Grønmo, 2019) and are accepted as a suitable approach for exploring complex areas that influence behaviours, such as beliefs, values, experiences, and motivations (Jones, 1995; Pope and Mays, 1995). A qualitative research approach provides ways to investigate phenomena, and supports the development of rich insights into learning, experiences, and behaviours, which can inform initiatives to bring about change (Berkwits and Inui, 1998). Black, (1994, p. 425) has stated that a *"qualitative approach - interviews, observation of activities, interpretation of written material - is most revealing when the variables of greatest concern are unclear".* Given that my research questions were exploratory in nature and aimed to investigate *"how's"* and *"what's",* I considered a qualitative approach to be the best fit for my research and to align with my

paradigmatic stance. I will provide further detail on methodological perspectives and the methods used in the methodology section of this chapter and in the individual data chapters of this thesis.

2.2.2 Socio-cultural theory

A socio-cultural approach to learning considers that *"all human mental functioning is inherently situated in cultural, historical, and institutional settings"* (Wertsch, 1989, p. 140). The use of theory allows for exploration of phenomena (Kumar *et al.*, 2022). Hence, the application of socio-cultural theories in education research affords opportunities to examine how individuals' learning and behaviour are influenced by social and cultural contexts.

Socio-cultural theories have their origins in Vygotsky's Social Development Theory (also known as socio-cultural theory of development) (McLeod, 2018). Lev Vygotsky, a Russian psychologist, born in the late 19th century, considered the development of higher mental function in an individual was mediated through social interactions, and that tools, in particular language, and signs were essential components of human interactions (Wertsch, 1989). Socio-cultural theories consider the 'mind' not to be contained within an individual, rather to extend beyond, spread across groups of people and artefacts. Cognition and memory are considered to be distributed, and the minds of individuals are seen to be points on a network that includes both the minds of other individuals and the use of shared tools (Packer and Goicoechea, 2000; Bleakley, 2006, 2021). Knowledge and tools have developed in social, historical, and cultural contexts. Viewed from a socio-cultural perspective, learning is mediated through the cultural and social context in which it is situated (Lave, 1988). Alfred (2002, p.5) has posited that *"it is from this socio-cultural environment that the individual*

acquires the tools, symbols, resources and strategies to manage the learning process". Adopting a socio-cultural approach to education allows us to take account of historical, social, and cultural influences on learning ((Bleakley, 2006; Dornan *et al.*, 2018). As palliative care, of which EoL care is part, developed as a practice that is quite distinct in these contexts from other medical specialties (Clark, 2018, n.d. a), I considered that exploring learning from this perspective was likely to provide valuable insights.

There were other reasons why I identified socio-cultural theory as a suitable choice for exploring learning in the area of EoL care. EoL care is a multifaceted and complex area of patient care (World Health Organisation, n.d.; Ryan *et al.*, 2014) that often involves uncertainty (Kennedy *et al.*, 2014; Kimbell *et al.*, 2016). It includes decision-making to identify dying without the option of confirmatory investigations, requires sensitive communication with patients and/or their families, which can result in unpredictable responses. It also requires ethical judgements to be made. Sallnow et al. (2022) identify death systems as a complex adaptive system that permeates through a wide range of healthcare and social systems and services. Complexity theory asserts that some systems cannot be explained by simply breaking them down into constituent parts and healthcare is one such system (Greenhalgh and Papoutsi, 2018; Khan, 2018). It has been argued that learning in medicine, much of which occurs in the healthcare workplace can best be conceptualised as a complex process that cannot be separated from the historical and cultural milieu in which it is situated (Bleakley, 2010; Dornan et al., 2018; Mennin, 2010). Bleakley (2010, p. 850) identifies the opportunities that social-cultural learning theories offer for the exploration of learning in the complex, *"messy and uncertain"* world of medicine. Furthermore, as

highlighted in Chapter 1 there is a paucity of research considering the topic from a cultural perspective.

2.3 Communities of Practice and Landscapes of Practice theories

I chose CoP and LoP theories as lenses to explore RQDs learning about EoL care. In this section I give a brief overview of the theories, identify the version of CoP theory that I have employed and explain key concepts within both theories. I lay out the affordances provided by these theories to my research and provide a high-level explanation of how I applied the theories in this body of work. Later in this chapter, I provide more detail on the application of the theories to data analysis.

Communities of practice (CoP) theory is a social theory of learning (Wenger, 1998) and has a firm foundation in socio-cultural theory (Lave and Wenger, 1991). It is a mid-range theory (Johnston, Bennett and Kajamaa, 2018) that allows the exploration of processes of learning and formation of identity through social participation in the practice of a community (Wenger, 1998). Historical and cultural contexts are reflected in the practice of a community and hence impact on learning and identity. LoP theory is a recent extension of CoP theory (Wenger-Trayner *et al.*, 2015).

The evolution of CoP theory over time, and the difficulties that have arisen from widespread use of the term in different ways and to mean different things have been highlighted (Li *et al.*, 2009; Tummons, 2017; Buckley *et al.*, 2019). Hence, I provide an account of which iteration of the theory I have used and how I interpreted it in my research. I used CoP theory as conceptualised in *Communities of Practice: Learning, Meaning and Identity* (Wenger, 1998) and LoP theory as described in *Learning in*

Landscapes of Practice: Boundaries, identity, and knowledge ((Wenger-Trayner *et al.*, 2015).

2.3.1 What is a community of practice?

Communities of practice have been described as *"groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly"* (Wenger-Trayner and Wenger-Trayner, 2015) The term CoP was first introduced by Lave and Wenger, (1991) in their book, *Situated learning: Legitimate peripheral participation*. Situated learning has its roots in the traditional apprenticeship model, where newcomers learn from experts and gradually increased participation in a practice. From this perspective, learning is conceptualised from social, cultural, and historical standpoints. Newcomers, according to Lave and Wenger are considered to be legitimate peripheral participants in these groups, which they called Communities of Practice (CoPs). Based on empirical research that he carried out in the setting of insurance claims processing, Wenger (1998) further developed the theory to focus on practice and identity in CoPs. The concept of CoPs co-existing in a complex wider landscape with others, resulting in boundaries, peripheries, shared practices, and connections received some attention. Subsequently, Landscapes of Practice (LoP) theory was developed from CoP theory (Wenger-Trayner *et al.*, 2015) and I will discuss this in more detail later.

Wenger (1998, pp. 73-85) has described three essential elements of a CoP: mutual engagement, a joint enterprise, and a shared repertoire. An overview of these is presented in Table 2.1

Table 2.1 Summary of elements of a community of practice

Element	Features/description
Mutual engagement	• Defines the community • Interactions of all forms (formal and informal) that occur between community members • Enables engagement in mutual practice
Joint enterprise	• The common area of endeavour or core business in which community members are involved • Evolves over time • Negotiated locally in the CoP (often tacitly) • Competence is defined locally in the CoP through negotiation of the joint enterprise, which includes what and how things should be done or not done, what should be ignored or what can be presumed, what is adequate or appropriate
Shared repertoire	• Created over time by members engaging in practice • Includes ways of doing things, concepts, discourses, and artifacts • Includes participation in practice • Elements of the repertoire may be intentionally or informally created

2.3.2 The landscape of practice

Wenger (1998 p. 118) introduced the concept of *"complex social landscape"* where communities of practice interact, overlap, share practices, and connect. He called it a *"Landscape of Practice"* where the *"landscape so defined is the weaving of both boundaries and peripheries"* . In the meantime, this aspect of CoPs theory has evolved and, in the book *Learning in Landscape of Practice*, Wenger-Trayner and co-contributors present key concepts illustrated by case studies, which provide deeper

and more nuanced insights into the complex area of learning in CoPs in relation to a profession (Wenger-Trayner *et al.*, 2015). The body of knowledge of a profession is constituted by multiple CoPs and the boundaries between them. This body of knowledge is complex and is viewed in terms of a landscape of practice (LoP) (Wenger-Trayner et al., 2015, p. 15).

In LoP theory, the implications of multimembership for learning and identity are viewed in terms of knowledgeability, boundaries, brokering and competence. Table 2.2 provides an overview of how these are conceptualised in CoP and LoP theory (Wenger, 1998; Wenger-Trayner *et al.*, 2015).

Table 2.2: Summary of key concepts in Landscapes of Practice theory

Concept	**Features**
Knowledgeability	• Learning and identification that develops from interacting with and negotiating multiple interconnected CoPs • An orientation to the wider landscape and to CoPs where the individual does not have a claim to competence • Requires one to look outwards from a CoP, to understand what other CoPs do and how this relates to one's own CoP
Competence	• Negotiated within a single CoP and defined in relation to the enterprise and repertoire of that CoP • Evolves over time • Changes in perceptions of competence can be a response to needs identified within the CoP or a practice introduced from another CoP by a newcomer or broker. Adoption of a new practice depends on the newcomer's legitimacy
Boundaries	• Represent discontinuities between the unique practices of each CoP, which have and continue to develop in a historical context.

	• Often problematic as CoPs have different understanding of competence and interpretations of meaning, hence negotiation is required at boundaries • Present opportunities for rich learning from the practice of other CoPs
Brokers	• Individuals who can bring an aspect of practice from a CoP into another one (Wenger, 1998, p. 105). • Perform a complex task in facilitation of learning and understanding across CoP boundaries • Must build legitimacy and trust to introduce new practice

2.3.3 Learning, participation and identity in CoP and LoP theories

Wenger (1998 p. 4) describes the main focus of CoP theory as *"learning as social participation"*. CoP theory allows the complexity of learning through participation in practice to be conceptualised from a socio-cultural perspective (Steven *et al.*, 2014; Gonzalo *et al.*, 2017; Molesworth, 2017). In CoP theory, learning and negotiation of identity are viewed as strongly interrelated processes (Farnsworth et al., 2016; Wenger, 1998). Individuals learn as they participate in practice and negotiate meaning and identity in tandem with this. Participation in the context of CoP theory has been described as:

> the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises. Participation in this sense is both personal and social. It is a complex process that combines doing, talking, thinking, feeling, and belonging. It involves our whole person including our bodies, minds, emotions, and social relations. (Wenger, 1998, p. 55-56).

Hence, participation in a CoP comprises both taking part in activities and social connection with others. Wenger (1998, pp. 164-169) outlines four main forms of participation in a CoP that influence identity formation. These are summarised in Table 2.3. Levels of participation are determined by an interplay between the individual and the community and they impact significantly on identity.

Table 2.3: Forms of participation in a community of practice

Forms of participation	Level and quality of participation
Insider	• Full participation
Outsider	• No participation
Peripheral	• Full participation is not expected • Non-participation enables participation as it is viewed as an opportunity for learning
Marginal	• Participation is restricted • Non-participation is problematic • Individual kept at the margins of the CoP

Viewed through a CoP and LoP lens, identity is what we do and what we don't do, what we are and also what we are not, and is continually negotiated through a process of forming and reforming in the course of our participation in social practices and the meanings we make from this (Wenger, 1998; Wenger-Trayner *et al.*, 2015). In both theories, three modes of identification are described that allow us to make sense of our place in the CoP and the LoP. These are engagement, imagination and alignment and are summarised in Table 2.4. Each of these modes can be identified or dis-identified, resulting in an ongoing negotiation of identity.

Table 2.4: Modes of identification

Mode	Description
Engagement	• Actively doing things in practice
Imagination	• Creating an image of the world • Orientating and locating ourselves within this world • Allows identity formation beyond our level of engagement
Alignment	• Coordinating our activities and perspectives when engaging in practice • Allows intention to be realised both within a CoP and in the broader landscape

2.3.4 Affordances of CoP and LoP theory in medical education research

CoP and LoP theories intuitively appeal as theories to explore both trainee and medical student learning from a socio-cultural perspective (Coakley and Bennett, 2020). CoP theory has been widely used over many years in medical education research (McGrath, Liljedahl and Palmgren, 2020). In recent years LoP theory has been identified as a useful theory for exploring medical education and training from a socio-cultural perspective (Coakley and Bennett, 2020; Hodson, 2020; Balmer, Rosenblatt and Boyer, 2021; Stalmeijer and Varpio, 2021; van Duin *et al.*, 2022).

Of interest to me were the affordances the theories offered in relation to informal trainee learning in the workplace about EoL care, where cultural aspects of practice are enmeshed with learning (Brennan *et al.*, 2010; Gibbins, McCoubrie and Forbes, 2011; Tait and Hodges, 2013; Crawford and Zambrano, 2015; Bharmal *et al.*, 2019). CoP theory has been identified as a useful theory for conceptualising medical

education (Bleakley, 2010; Mann, 2011; Cruess, Cruess and Steinert, 2018). The theory has been used to explore learning and identity formation in clinical contexts in both undergraduate and postgraduate medical education (Steven *et al.*, 2014; Fosse *et al.*, 2017; Gonzalo *et al.*, 2017; Renting *et al.*, 2017).

CoP theory allows exploration of how communities uniquely interpret their enterprise in their repertoire of practice, and the learning and identity formation that is associated with this (Wenger, 1998). However, RQDs and medical students are learning and forming identities as they navigate their way through a LoP, rather than on a journey into the centre of a CoP, and this presents a limitation to the use of CoP theory when exploring their learning and identity in the medical workplace (Hodson, 2020). LoP theory is a recent evolution of CoP theory and addresses this limitation of the theory. The use of LoP theory as a framework allows conceptualisation of the complexity of learning and identity formation in the medical profession, individuals can be seen to be developing and constantly renegotiating their identities as they move between, participate in, and interact with multiple communities of practice (Coakley and Bennett, 2020; Hodson, 2020; Rashid, Alexander and Griffin, 2020). LoP theory has been identified as a framework to underpin design of education in a range of areas such as interprofessional education (IPE) (de Nooijer, Dolmans and Stalmeijer, 2022) and online learning (Rashid, Alexander and Griffin, 2020). It has also been used in exploring learning about interprofessional collaboration (van Duin *et al.*, 2022) and the evolution of identity over time in physician educators (Balmer, Rosenblatt and Boyer, 2021).

2.3.5 Issues with CoP theory in medical education research

The design of coherent research requires that methodological and theoretical perspectives be aligned (Bordage, 2009; Alavi *et al.*, 2018; McGrath, Liljedahl and Palmgren, 2020). CoP theory has been widely used in research and has been applied superficially and inappropriately in a variety of settings (Buckley et al., 2019; Tummons, 2017, p. 3). McGrath et al., (2020) reviewed articles published in international medical education journals that used CoP theory. They reported that almost half used the theory in a potentially inappropriate way, either misrepresenting the theory or using it superficially in a cosmetic manner. They found 3 contexts in which CoP theory was satisfactorily employed: framing, lensing, and transferring.

My primary objective with respect to CoP and LoP theories was to use them as a lens through which to view the phenomena uncovered by my research. I hoped this would provide insights that might be transferable to other contexts of medical education or to education in other health professions. I required methods of data collection and analysis that would provide outputs that could be then explored from a CoP and LoP perspective. Hence my conceptual orientation towards the theories of CoP and LoP informed my methodology and choice of methods.

2.4 Supervised workplace based learning

It has been argued that most professional learning occurs informally (Eraut, 2007; Steven *et al.*, 2014). RQDs learn much about being doctors informally while working on physician teams in clinical learning environments (CLEs) under the supervision of senior doctors (Wiese, Kilty and Bennett, 2018). Each physician team's practice and CLEs have developed in historical, social, and cultural contexts. The mechanisms by which doctors in training including RQDs learn in CLEs can be viewed from a range of

theoretical perspectives. CoP and LoP theories are mid-range theories, which are useful as a lens to examine workplace based learning from a socio-cultural perspective (Johnston, Bennett and Kajamaa, 2018). However, they do not provide programme theory to explore on a more granular level the specifics of informal learning facilitated by supervisor and trainee interactions in the context of patient care (Davidoff *et al.*, 2015). As I engaged with data from study 3 (consultant interviews), I considered that CoP and LoP viewpoints would limit the insights I could gain from the data. Hence, I sought a theory that would support me to do this. (Wiese, Kilty and Bennett, 2018) drew on CoP and other theories of learning in the workplace to generate a realist theory of supervised workplace learning in postgraduate medical education, which provided a suitable framework to apply when analysing the data.

The theory of supervised workplace learning identifies three processes by which trainees learn informally while doing the job: supervised participation in practice, mutual observation of practice, and dialogue about practice. Each of these has two enabling mechanisms, which are described below.

2.4.1 Supervised participation in practice

Participation in practice is determined by two interdependent factors: entrustment and support seeking.

2.4.1.1 Entrustment

Entrustment is an important concept in workplace learning as it informs point of care decisions about trainee participation in clinical tasks. A range of variables that influence entrustment decisions were identified by (Wiese, Kilty and Bennett, 2018)in their realist theory. Supervisory styles are important as overly restrictive or relaxed

styles can result in trainees not being allowed to participate or feeling overly exposed by excessive responsibility for their level of capability. Trainee characteristics also influence entrustment decisions, these include stage of training, demonstrable ability, professionalism, awareness of limits, conscientiousness, and trainee agency. The task is also an important consideration in entrustment. Complex tasks, such as those involving ethical issues, transitions of care or perceived high stakes situations can inhibit entrustment decisions. Other factors identified by the realist theory that impact on entrustment decisions include local culture and practice, and characteristics of the physician team.

2.4.1.2 Support seeking

Support seeking is trainee led and involves interactions with supervisors with the aim of getting support in a variety of forms, including advice and reassurance. Support seeking can enhance or inhibit entrustment. Decisions by trainees to seek support are complex and requires trainees balancing safe practice with being perceived by seniors to be competent and trustworthy. Some critical tasks always require supervisor input. Once again social and cultural factors influence support seeking behaviour.

2.4.2 Mutual observation of practice

Observation of practice has two mechanisms: monitoring of the trainees practice and modelling of practice.

2.4.2.1 Monitoring

Senior doctors monitor trainees, primarily to ensure they are safe in their practice. This facilitates entrustment decisions. Often monitoring is indirect e.g., through discussions

about patient care. In some instances, e.g., in procedural based activities it is more common to have instances of direct monitoring through observation of practice.

2.4.2.2 Modelling

Modelling is defined in relation to that theory as *"observing the practice of any senior doctor and integrating that into one's own practice"* (Wiese, Kilty and Bennett, 2018, p.958)(. Trainees and trainers are often unaware that modelling is taking place. However, either or both parties may be consciously involved in the process. Trainees may actively observe the practice of a more senior doctor and deliberately attempt to integrate it into their future practice and senior doctors may explicitly use meaning making (see below) to facilitate modelling. Modelling affords trainees opportunities to learn about skills such as communication, teamwork, and professionalism, and to observe a variety of attitudes and behaviours.

2.4.3 Dialogue about practice

Dialogue about practice occurs informally in day-to-day work. The mechanisms in dialogue about practice are meaning making and feedback.

2.4.3.1 Meaning making

Meaning making is supported by involvement of trainees in dialogue with supervisors to analyse and make sense of clinical situations. Involving trainees in decision-making discussions is an example of meaning making, another example is supervisors making deliberations about dilemmas and complex cases visible to trainees.

2.4.3.2 Feedback

In relation to the theory, the feedback mechanism is a *"mutual construction of trainee performance and the means to improve it"* (Wiese et al., 2018, p. 960)

2.5 Methods

There are many ways to approach qualitative research. In this section I will outline the processes I engaged in and describe and justify the methods used. The decisions I made were based on the need to align my epistemological position, methodological approach, and theoretical perspectives. These all informed the specific methods selected.

2.5.1 Recruitment

Three groups of participants were recruited: RQDs, consultants and specialist palliative care consult team members. A more detailed account of sampling and recruitment in each study is provided in the individual data chapters. In all studies my initial contact with potential participants was via email with information about the study and an invitation to participate. All participants completed and returned a signed consent form prior to commencing their interview.

RQDs working in the teaching hospitals in Cork affiliated to University College Cork were purposively sampled. Potential participants were initially identified by members of faculty, provided with details of the study, and asked to contact me should they be interested in participating.

In the consultant study a list of consultants involved in clinical education of medical students in the Cork Teaching Hospitals, including their email addresses was obtained from the Medical School in UCC. Potential participants were purposively sampled.

For SPCCT member interviews, a mix of convenience sampling and snowballing was used to identify potential participants. Palliative care clinical nurse specialists (CNSs) and non-consultant hospital doctors working as part of the specialist palliative care consult services in acute hospitals in one city were interviewed. I had personal knowledge and contact details of several potential participants through previous working relationships. Others were identified by participants and by other SPC personnel known to me. In these cases, an initial approach about participating in the study was made by the person who suggested them and if permission was obtained, I was given their names and email addresses and I followed up directly with them.

2.5.2 Data collection

Qualitative research allows for the analysis of data of several types, which can be collected in a variety of ways (Silverman, 2017). For my research topics and questions, I considered interviews and ethnographic approaches. Interviews have the potential to provide rich data, which can be analysed and interpreted to identify patterns of meaning (King, Horrocks and Brooks, 2019). During interviews responses can be probed, clarifications made, and a variety of directions can be taken following an interesting response. Interviews are social interactions, and it is important to consider that what participants say is constructed in relation to the interviewer and their position (Holmes and Gary, 2020). Researcher reflexivity is important to address this.

Ethnographic approaches involve the observation of and/or interaction with individuals in their natural environments (Reeves *et al.*, 2013). In my studies this would have involved immersion in a hospital environment, observing and interacting with healthcare professionals in contexts relevant to my studies. This would have presented both opportunities and challenges for data collection. Being present in the environment allows observation of what happens in various situations and removes the reliance on recall by participants. However, the presence of the researcher in the realm of practice may also influence and alter behaviour (Khan, 2018). There would also have been significant ethical considerations with respect to having a researcher embedded in the clinical environment in the context of this research. In addition, the time required to perform a study of this type is considerable and would have had a direct impact on the feasibility of this approach for my research. Hence interviews were chosen for data collection.

The merits or otherwise of individual versus focus group interviews can be compared in terms of practicalities and the quality of data that can be generated. In respect of practical considerations, individual interviews are easier to schedule and transcribe than focus group interviews. The main factor influencing my choice of interview method was the quality of data I could potentially collect to address my research questions. In general, there is a lack of good quality research comparing individual and focus group interviews. It has been suggested that group interviews may result in more sensitive issues being disclosed by participants in some specific circumstances (Coenen *et al.*, 2012; Guest *et al.*, 2017). As there was a lack of evidence to support decision-making about the type of interviews best suited to my research, I was primarily guided by the topics, research questions and ethical considerations. In a culture where death can be perceived as a medical failure (Gawande, 2014; Sallnow

et al., 2022), EoL care can be a sensitive area for many doctors. There is evidence that doctors are often reluctant to identify that patients are dying and avoid discussions about palliative care and end-of-life issues with patients (Gawande, 2014; Brown and Miles, 2016). Delivering end-of-life care can have a strong emotional impact on doctors, with some junior doctors displaying evidence of post-traumatic stress disorder as a result of their experiences in this area of patient care (Bharmal *et al.*, 2019; Linane *et al.*, 2019). For these reasons it was considered that individual interviews were best suited for data collection in all 4 studies, which would involve discussing care of patients at the end-of-life, and the likelihood of participants revealing deeply personal opinions and perceptions relating to identity and experiences.

Data for the two RQDs studies were collected at the same interview. Initial interviews for the RQD studies and the consultant study were conducted in person but the onset of the Covid-19 pandemic in early 2020 necessitated that I switch to doing interviews online using UCC licenced Microsoft Teams software. Further description of how interviews were conducted is provided in the data chapters. In preparation for conducting interviews, I designed interview guides and discussed these with one of my supervisors DB, who was an experienced qualitative researcher and interviewer. In addition, I drew on *Interviews in Qualitative Research* (King, Horrocks and Brooks, 2019). Initial interviews were reviewed by DB in terms of my technique, and we discussed ways I could improve my interviewing skills. Following each interview, I made notes of my initial impressions that highlighted striking observations and surprises and I reflected on my perceptions of positionality in the interview. I transcribed some initial interviews from the RQD and consultant studies myself. As a relatively novice qualitative researcher, I found this process particularly useful in terms of drawing my attention to my interview technique and the use of language in

interviews. In addition, this assisted with immersion in the data. Due to demands on my time, I had subsequent interviews in these studies professionally transcribed. In study 4 (SPCCT), I used the transcription software integrated into Microsoft Teams to generate transcripts. I then reviewed each transcript, comparing it to the audio-recording, edited and corrected mistakes before performing thematic analysis as outlined later in this chapter.

I conducted interviews for the RQD and consultant studies contemporaneously. The order of interviews is presented in the relevant data chapters. Determination of the numbers needed in interview studies is a contested area (Vasileiou *et al.*, 2018; Hennink and Kaiser, 2022). The concept of data saturation is widely used to determine sample size and has been defined as: *"the point during data analysis at which incoming data points (interviews) produce little or no new useful information relative to the study objectives*" (Guest et al., 2020 p. 5). (Vasileiou et al., 2018 p. 16) in a review of individual interview studies, reported considerable variation in what was reported as a sufficient sample size and argued against *"a decontextualised application of sample size numerical guidelines"*, rather advocating for consideration of data adequacy. Morse, (2000) argues that factors such as the scope of the research question, the nature of the topic and the quality of data influence the numbers of interviews needed.

Braun & Clarke (2021) contend that concepts of data saturation and the quest for a point where additional data is redundant, aligns more with a realist ontological approach, involving top-down approaches to coding (e.g., using codebooks) and the identification of semantic themes. In their method of reflexive thematic analysis, which is interpretative in nature, analysis is never fully completed as coding and identification

of themes can be continuously revisited and revised and knowledge is considered to be constructed. In addition, themes and codes are context dependent. They contend that this position is not compatible with the concept of data saturation. Instead, they suggest a pragmatic appraisal is made about the adequacy of data, stating that "*researchers should then make an in-situ decision about the final sample size, shaped by the adequacy (richness, complexity) of the data for addressing the research question"* (Braun & Clarke, 2021, p.211). Varpio et al. (2017) have raised similar issues in relation to data saturation, questioning if it is in fact achievable. In addition, they suggest criteria based on Malterud et al. (2016) that should inform data adequacy decisions, which I employed in my research, I had relatively specific aims, was interviewing specific groups, using established theory, and had articulate participants and these considerations in addition to the quality of the data I had collected, informed my decisions of data adequacy and hence sample size. My supervisor DB was involved in this decision-making process.

2.5.3 Analysis

I required a method of analysis that would facilitate the integration of my chosen theories (CoP and LoP) and align with my paradigmatic stance. Thematic analysis (TA) as described by Braun & Clarke (2006), provides theoretical freedom to researchers. In recent years, their ideas and approach have evolved, and I selected what they now refer to as reflexive thematic analysis (RTA) for analysis of my interview data (Braun and Clarke, 2019, n.d.). This approach is interpretative and the *"coding process requires a continual bending back on oneself - questioning and querying the assumptions we are making in interpreting and coding the data"* (Braun & Clarke, 2019, p. 594). Themes are actively generated and constructed by researchers from

the data as part of the analytic process and are conceptualised as *"patterns of shared meaning underpinned or united by a core concept"* (Braun & Clarke, 2019, p. 593). A key concept in this approach is an acceptance that analysis is situated in relation to the positionality of the researcher. Outputs of the analysis are influenced also by participants and the context (Braun and Clarke, 2006). I considered this approach to TA to be aligned with my ontological and epistemological positions as laid out earlier in this chapter.

Criticisms have been levelled at TA. There has been a tendency to view thematic analysis as a less rigorous and less sophisticated qualitative research method than other approaches that are in fact methodologies with well-developed theoretical scaffolding for performing analysis (Braun and Clarke, 2006; Nowell *et al.*, 2017). The core processes of thematic analysis, in which data is initially decontextualised and subsequently recontextualised, is common to other qualitative research methods, and hence thematic analysis is sometimes viewed as more a foundational approach to analysis, rather than being a fully-fledged method in its own right (Boyatzis, 1998; Holloway and Tondres, 2003). In addition, the flexibility afforded by thematic analysis, can be regarded as a weakness as well as a strength and could lead to less rigorous or inconsistent approaches to developing themes (Holloway and Tondres, 2003; Kiger and Varpio, 2020). Braun & Clarke (n.d.), Kiger & Varpio (2020), and Nowell et al. (2017) have argued that if well applied, TA can produce trustworthy, robust, complex, and nuanced outputs.

For the reasons outlined above TA can be viewed as troublesome, and by some as an inferior method of qualitative analysis. In order to support the trustworthiness of my research, I will further justify my choice by explaining the alternative approaches I

considered, provide a detailed description of how I performed analyses and describe the quality assurance measures that I undertook (Nowell *et al.*, 2017; Kiger and Varpio, 2020).

2.5.3.1 Alternative methods

I considered other methods and methodologies when deciding on how I would analyse my research data. An interpretative phenomenological approach allows for a focussed in-depth study of the lived experience of participants (Smith, Flowers and Larkin, 2009). However, with a focus on experience I considered that integrating themes generated from analysis with a learning theory might be problematic. Discourse analysis was also considered at an early stage. However, I ruled it out as it focuses on the use of language to create meaning (Gee, 2014), and CoP and LoP are not discourse theories. I was not seeking to develop a new theory but rather to use existing CoP theory as a lens to explore the phenomena identified, hence grounded theory with its focus on construction of theory was not considered to align with the outputs I sought from this research.

Having weighed up its potential strengths and limitations and discussed with my supervisor DB, I believed RTA was the best fit for my research as it aligned with my paradigmatic stance and allow me to use CoP and LoP theories. Furthermore, I considered that as a relatively novice qualitative researcher, TA would be more accessible to me (Braun and Clarke, 2006; Terry and Hayfield, 2020).

2.5.3.2 Application of thematic analysis

In their seminal paper Braun & Clarke (2006) outline a six phase approach to TA. While this six phase approach still forms the basis of TA, they have updated some of

the terminologies they use in order to emphasise the concept that themes are generated rather than found in data (Braun and Clarke, 2019). My engagement with this six phase approach is described later. Braun & Clarke (2006) also outline four methodological decisions to be made about coding. I now describe the decisions which I made in order to align with my paradigmatic and ontological stances. These decisions are consistent with an RTA approach (Braun and Clarke, 2019).

Inductive versus deductive approaches

I undertook an inductive analysis. This approach focuses on developing new insights from first principles rather than testing pre-existing theories (Braun & Clarke, n.d.). In phases 1 and 2 where I made what I considered to be a notable observation in relation to the theory I made an annotation. For example, where a boundary was noted, a reification was observed, or a statement suggested legitimate participation or lack thereof. In the later phases of TA, I used the theories as a lens when generating, refining, naming, and writing up themes (phases 3 to 6). As a deductive approach is more theory driven, it would not have facilitated me in taking a broader perspective of the topic (Kiger and Varpio, 2020).

Semantic versus latent themes

I employed a latent approach in my analysis. In doing so I looked beyond surface meanings in the data, seeking concepts and assumptions behind the semantic content. This approach is often aligned with a constructionist stance (see below). The identification of themes requires interpretation and hence theory can be integrated into the analysis at this stage (Braun and Clarke, 2006). Semantic themes are more explicit (Boyatzis, 1998) and present a more realist perspective.

Epistemology: realist versus constructionist thematic analysis

In the constructionist approach described by Braun & Clarke (2006), meaning and experience are considered to be a product of the social context in which an individual exists, and are interpreted through a socio-cultural lens. Hence a constructionist epistemological approach to thematic analysis was coherent with the relativist ontology underpinning my research and my use of CoP and LoP theory. Identification of latent themes, is often, but not always informed by a constructionist paradigm. In general, the adoption of a realist approach to thematic analysis is associated with the identification of semantic themes.

Rich description versus detailed account

A rich description of the themes across a full dataset can be presented, or alternatively a more complex and nuanced detailed account of a limited number of themes can be provided. The latter can allow for a deeper analysis and can be effective in creating a focus on novel insights into an issue (Braun and Clarke, 2006; Braun, 2008). I report all 4 of my studies in the form of a detailed account. I chose this approach to support focussed exploration of the data in order to address the research questions, with the hope of gaining deeper and new insights. The analysis for each study was an iterative process in which data were reviewed recursively and the research questions were progressively refined. As a consequence, the final reports for each study do not present the breadth of the data sets that were obtained. I made decisions in collaboration with my supervisors to construct a final report that provided deeper and more nuanced insights of selected aspects of the data. One example of this was a focus in the RQD studies (Chapters 3 and 4) on participants' perceptions and

experiences post qualification rather than presenting a broader account of pre and post qualification experiences.

My approach to the 6 phases of RTA is outlined below and follows the guidelines provided in Braun & Clarke (2006). It should be noted that during the analysis process, earlier phases can, and according to Braun & Clarke (2021) should be revisited in a recursive manner. I revisited my data and revised my analysis several times for each study, often adding additional theoretical perspectives. Table 2.5 provides details of how I approached each phase of thematic analysis. For the two RQD studies (studies 1 and 2) a single data set was produced. I performed a common initial first pass analysis for phases 1 through 3.

I used NVivo software (QSR International, n.d.) software for data storage and for the first three phases of analysis in all studies. I used the memos feature to record ideas, thoughts and decisions and the annotations feature to note assumptions, observations, reminders, and comments with respect to data during phases 1, 2 and 3. In keeping with my epistemological stance, I coded manually in NVivo. Auto-coding features were not used.

My supervisors were collaboratively involved in the analysis of my data. I was fortunate to have supervisors who had expertise in health professions' education: Deirdre Bennett (DB), and palliative care from a clinical, policy and academic perspective: Tony O'Brien (TO'B). We met regularly (often virtually using MS Teams) and interacted between meetings via email. During the analysis phase, my supervisors reviewed transcripts, codebooks, codes, and themes and the write up of chapter drafts. They provided insights and advice at all stages of data analysis.

Table 2.5: Phases and approaches taken in thematic analysis

Phase	Approach taken
Phase 1: Familiarisation with the data	• Recordings of interviews were listened to several times • Transcripts of recordings were corrected • Transcripts were read and re-read, and notes were made of initial and striking observations, and patterns and meanings that were identified
Phase 2: Coding	• Following familiarisation, codes were manually and inductively assigned to the most basic pieces of data that could be meaningfully assessed • Latent meanings were sought in the data • All interviews were given equal attention • Codes were regularly reviewed and reorganised • Inconsistencies within codes were noted
Phase 3: Generating initial themes	• Following initial coding, coded materials were reviewed, and initial themes were generated (broader patterns of meaning). • Latent meanings were sought in the data • Relationship to chosen theories were considered
Phase 4: Reviewing themes	• Initial themes were tested with the coded data to ensure coherence • Problematic themes were reworked • Validity of all themes in relation to the full data set were considered • Data overlooked previously were re-coded and where considered relevant new themes were identified • Latent themes were refined and informed by the chosen theories
Phase 5: Defining and naming themes	• Themes that might potentially address the research question(s) were identified and refined • Narratives explaining and linking to the theoretical perspectives were written for each theme • Subthemes were identified
Phase 6: Writing up	• Themes and their subthemes that addressed the research question were selected and the result sections of relevant data chapters were written up

- Illustrative data extracts were selected and incorporated into the write up

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2.5.3.3 Application of theory to the studies

My justification for using CoP and LoP theories has been outlined above. I was sensitised to these theories from an early stage. This influenced the design of the studies and aspects of data collection, for example in the construction of initial research questions. The theory of supervised workplace learning in postgraduate training was used in the consultant study and was applied at the analysis phase. Hence the study design was not influenced by this theory.

Despite my early selection of CoP and LoP theory to inform the research, I used an inductive approach in analysis, and I have explained my rationale for this choice in more detail in the previous section. In brief, I wished to explore the topics from a broad rather than a more focussed, theory driven perspective (Kiger and Varpio, 2020). Hence, I engaged in open coding initially, adding notes and annotations where I was struck by an observation that related to CoP or LoP theory. As I organised codes into themes (phase 3 onwards) I started considering the theoretical perspectives in a more systematic way. As I recursively engaged in analysis and the final write up, I engaged in deeper and more nuanced ways with the theories.

There are many ways and levels at which CoP theory can be considered in the context of the medical profession, for example, a CoP can be viewed as consultant led team, a medical specialty within a hospital, a specialty within medicine (such as endocrinology or neurology), or medicine as a discipline distinct from others such as

surgery, psychiatry, or general practice. RQDs, consultants and SPCCT members are all members of a range of work-related CoPs. Accountability of members to a CoP is a key tenet in the theory (Wenger, 1998) and I used this in identifying what I considered to be most relevant work related CoPs to participants in applying theory in each study. I discuss these further in the relevant data chapters.

2.5.4 Ethics

I obtained full ethical approval for each study from the Social Research Ethics Committee (SREC) in UCC (relevant appendices are identified in the data chapters). Ethical standards were observed in all recruitment and data handling. Participants were recruited voluntarily (further details in data chapters) and were initially provided with the relevant participant information leaflet and consent forms by email. They were given an opportunity to contact me with queries in advance of their interview. At the beginning of each interview, participants were given details about how their data would be handled and stored and reminded of their rights to not answer specific questions, discontinue the interview, or have their data removed from the study within 2 weeks of interview (prior to final transcription). The consent form gave an option to give permission for the use of anonymised quotes to illustrate themes. I considered that participants in studies 3 (consultants) and 4 (specialist palliative care consult team members) were unlikely to experience emotional upset as a result of the interview process. However, in the RQD studies due to the subject matter being discussed and the relative youth and inexperience of participants, this was considered to be a distinct possibility. As a result, RQDs were specifically informed of support services available to them both verbally and in writing. After interviews were concluded and the recorders switched off, I debriefed all participants.

2.5.5 Data storage and handling

All research data was treated in accordance with UCC data management recommendations (*UCC Research Data Service*, n.d.). In the first 3 studies two audio-recordings were made (one for back-up purposes). In study 4 (SPCCT) a video recording using MS Teams and audio recording were made along with an auto-transcription. On completion of each interview, the quality of the audio recording was checked and if acceptable the second recording (video or audio) was deleted. The remaining audio recording was transferred to UCC licensed MS Teams and deleted from the recording device. Only my supervisors and I had access to the Team. For each study anonymised transcripts and copies of consent forms were stored in 2 separate files on my licensed UCC licensed OneDrive. The transcripts file was shared with my supervisors. All laptops and computers used to access data were encrypted and password protected. Audio recordings and transcripts of the interviews will be stored for 10 years and then destroyed by me. The transcription service used for some interviews was accredited and used a secure system for file transfer.

2.5.6 Reflexivity

Reflexivity involves considering how *"our beliefs, interests and experiences might have affected the research"* (King, Horrocks and Brooks, 2019). It is important that I give an account of what I brought to this body of research.

I am a medical doctor and academic. I originally trained and worked as a general practitioner and subsequently completed a research fellowship in palliative medicine in the United States, where I was involved in clinical (primarily quantitative) research. Following this I worked as a clinician in a long-term care facility associated with a hospice, where I had 17 years of experience of delivering clinical care to mainly elderly

patients, many of whom had non-specialist palliative care needs. In this role I cared for many patients at the end of life. When I was a recently qualified doctor, I found caring for patients at the end of life both challenging and rewarding. I had memorable experiences, both good and bad that have stayed with me. During a year as a GP trainee in the UK, I learned a lot about good EoL care from a Macmillan nurse, who was attached to our practice. From her and my trainer, I developed a greater awareness of the value of open communication and good symptom management. They both supported my learning about EoL care. In my work as a GP, for 5 years in an urban practice, I cared for patients who died at home with input from community palliative care. As I progressed through my working life as a clinician, I continued to have a keen interest in palliative and end of life care. I now serve as a board member of the local hospice.

I commenced work in a formal position in medical education in 2010. While my remit has not been specifically related to palliative care education, it is an area of interest for me. I co-ordinate an undergraduate interprofessional student selected module in palliative care. I also assist with organising classroom based tutorials for senior medical students. The topic of my research dissertation for an M.A. in Teaching and Learning in Higher Education (2014) was an analysis of student learning in the palliative care module that I co-ordinate with a focus on breaking bad news. Hence, I came to this body of research with an interest in this area and some pre-conceptions.

Like most individuals of my age, I have had personal experience of the deaths of close family members and friends as a result of life-limiting illnesses. These have included care in acute hospital and hospice settings.

All of these experiences and histories, I brought to my research. These influenced my interpretations of how participants may have experienced and understood events and concepts. My clinical and personal experiences have also informed what I believe to be good end-of-life care, particularly in the area of communication. These are impossible to remove from my data collection, analysis, and interpretation. However, by engaging in reflexive practice through discussions with my supervisors (DB and T O'B) and keeping a reflexive journal throughout this process, I have endeavoured to be mindful and aware of my position, open to participants' intended meaning and to seek alternative explanations in the data.

2.5.7 Positionality

Having explained my ontological and epistemological positions earlier in this chapter, it is also important to consider my position in relation to participants in my research and to be mindful of the nature of the topics under discussion. I now consider my position in each of the four studies I undertook as part of this body of work.

In the RQD studies I was a more senior doctor already known to some participants from their undergraduate days. My interest in this topic would also have been known to many. Whether or not I had a previous relationship with the participant, social desirability could have influenced what they said to me. I was conscious that participants might want to appear as caring and compassionate doctors or might want to appear professional and in control of their emotions.

In the consultant study, I was a peer, a fellow doctor and member of the local medical school faculty. I was older and clinically more experienced than some and younger than others. I may have been considered an outsider as I was no longer a practising

clinician and was not a local graduate. I knew some of the participants and had had clinical interactions with them during my time as a clinician. Again, given my relative experience and a possible association with the local hospice, for some I may have been viewed as someone with expertise in certain clinical areas or not. I was conscious that social desirability may have influenced responses.

In the SPCCT member study, I had various positions in relation to participants. Some had known me for several years through my time working in the local hospice, some had a passing acquaintance with me, and others would have had no prior knowledge of me. They were all engaged in the provision of SPC and had more expertise in this area than I had. As a doctor, it was possible that some nurses might have acted differentially towards me. I was more senior than the SPCCT doctors I interviewed and even though I had no other relationship to them, this might have shaped what they said. These were a group of healthcare professionals who were used to having a brokering role and negotiating recommendations regarding clinical care with doctors. Some I perceived might be particularly careful with their use of language and slow to offer criticisms.

I practised reflexivity by writing reflections and notes following each interview and discussed reflections and challenges with my supervisors. My supervisors and I held a variety of positions relative to the research topic, which allowed us to support each other's reflexivity. DB was a medical doctor, senior academic, researcher and expert in health professions education and TO'B was a senior consultant in palliative medicine, an experienced clinical teacher and researcher and had led on panels producing both clinical and service level reports and guidelines at national and

international levels. Through laying out my position in relation to this research I provide a means by which readers can evaluate its trustworthiness.

2.5.8 Trustworthiness

I have provided a detailed description of my methodology which supports my epistemological and ontological positions. I have described how I used theory as a lens to explore my data. I have also outlined how I engaged in reflexivity throughout my research.

All research methods have limitations, and an awareness of these by the researcher allows them to be carefully considered and addressed to the maximum possible extent. For thematic analysis, concerns about lack of rigour can be addressed by applying a reflexive and structured process to data analysis (Nowell *et al.*, 2017; Kiger and Varpio, 2020). Providing a detailed account of the methods used and choices made at the various phases of analysis are important aspects of demonstrating trustworthiness in thematic analysis. Nowell et al., (2017) have developed a structured approach for establishing trustworthiness in TA and provide an example of how it can be applied to the 6 phases of TA as outlined by Braun & Clarke, (2006). This is approach is based on the work of Lincoln & Guba (1986), who identified the criteria of credibility transferability, dependability, and confirmability for trustworthiness in qualitative research. In developing the structure, they also identify actions at each of the 6 Braun and Clarke phases, while acknowledging that TA does not follow a strict step by step approach. In table 2.6, I provide a summary of the steps taken as recommended by Nowell et al., (2017) to address the trustworthiness of my research.

Table 2.6: Actions taken to address trustworthiness

Phase of TA	**Means of establishing trustworthiness (**Nowell et al., (2017)*
Phase 1: Familiarisation with data	• I engaged deeply with the data over a prolonged period • I documented theoretical and reflective thoughts • I stored raw data in secure and organised online systems • I have kept a record of all transcripts and my notes
Phase 2: Generation of initial codes	• I debriefed with supervisors and kept a record of all meetings • Coding was reviewed by supervisors • I used NVivo 12 (QSR International, n.d.) for data management and to provide an audit trail of code generation. I did not use a coding framework as coding was inductive
Phase 3: Search for themes	• Themes were reviewed and triangulated with supervisors • I used diagramming to visualise and adjust the structure of themes • I applied theory when searching for and organising themes into hierarchies and kept notes on this • I used NVivo 12 (QSR International, n.d.) to organise data
Phase 4: Review of themes	• Themes were reviewed and triangulated with supervisors • I regularly returned to the raw data during this phase
Phase 5: Definition and naming of themes	• I engaged with supervisors to debrief and gain consensus on themes and their names
Phase 6: Production of the report	• In this chapter I have provided details of the processes I undertook and the theoretical, methodological, and analytical decisions I have made. • I agreed on the selection of themes for reporting with supervisors and they reviewed the final reports from their perspectives.

- I have engaged in peer debriefing by presenting this work in a number of fora, including conferences, a doctoral HPE (Health Professions Education) research group and a departmental research group.

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*Throughout all phases I kept records of supervisor meetings and continued to engage in reflexive journaling.

Chapter 3

Recently qualified doctors' learning about end-of-life care in their teams

"The biopsy was carried out competently by a surgical team who all looked disturbingly downcast after the procedure. None could address my increasing anxiety, except perhaps the most junior member of the team, who I sense in retrospect did not feel he had either the authority or life experience to discuss the diagnosis. I was told that while chronic infection could not be excluded entirely, tuberculosis was extremely unlikely, and, yes, mesothelioma could not be excluded."

(Sweeney, Toy and Cornwell, 2009)

3.1 Introduction

Providing end of life (EoL) care requires a doctor to have a range of clinical knowledge, interpersonal and intrapersonal skills. The need for recently qualified doctors to have appropriate levels of knowledge and the capacity and confidence to apply these at a generalist level (i.e. non-specialist) has been identified (National Advisory Committee on Palliative Care, 2001; Faull and Woof, 2002; McKeown *et al.*, 2010; Gómez-Batiste *et al.*, 2014; Linane *et al.*, 2019). However, there is substantial evidence that recently qualified doctors (RQDs) are generally not well prepared for attending to patients' and families' needs at the EoL, and that they find this aspect of practice difficult on many levels (Gibbins, McCoubrie and Forbes, 2011; Tait and Hodges, 2013; Redman *et al.*, 2017; Bharmal *et al.*, 2019; Gajebasia *et al.*, 2019; Linane *et al.*, 2019).

As outlined in my literature review, previous research in this area has identified deficiencies in the quantity and quality of medical education and the emotional effects on doctors of delivering EoL care. Learning in the workplace and the hidden curriculum in RQDs' learning about EoL care has received some attention (Brennan et al., 2010; Crawford & Zambrano, 2015; Gibbins et al., 2011; Tait & Hodges, 2013). Modern medicine is practiced in a cultural environment where death is often viewed as a failure of medicine and substantial thought and funding is put into the development of new approaches to care and treatment options that are primarily aimed at prolonging life (Gawande, 2014; Sallnow *et al.*, 2022). In addition, there is a tendency towards increased specialisation (Campbell and Dave, 2018; Srivastava, 2020) and evidence that concerns about litigation leads to increased investigations and procedures without necessarily improving patient outcomes (Frakes and Gruber, 2018). Cultural factors strongly influence the practice of medicine (Gawande, 2014; Pearl, 2021) and their impact on the attitudes, experiences and learning of recently qualified doctors in the delivery of EoL care has not been the focus of in-depth research. In this chapter and in Chapter 4, I will report the results and discuss the findings of studies 1 and 2 respectively (interviews with RQDs).

The aim of this study was to explore how local medical culture impacts on RQD learning and the practice of EoL care. I used a Communities of Practice (CoP) perspective to address my research question, which was:

What and how do recently qualified doctors learn within their physician teams about EoL care?

3.2 Methodology

My epistemological stance and methodological approach are described in detail in Chapter 2 (Conceptual Orientation and Methodology). My wish to explore social and cultural aspects of learning informed my methodological choices. The use of CoP and Landscapes of Practice (LoP) theories guided my research questions, research design and data analysis.

3.2.1 Recruitment

I recruited participants from RQDs (interns and senior house officers) working in the teaching hospitals in Cork, affiliated to University College Cork. I purposively sampled participants to ensure gender balance, a mix of direct entry and graduate entry medical graduates, Irish and non-Irish nationalities, and postgraduate clinical experiences. Following review and reflection on interviews, I identified further participant characteristics to ensure as much variation as possible. I included some participants who had worked as senior house officers (SHOs) in the local hospice and some who had completed an undergraduate student selected component in palliative care as I felt these individuals might have different perspectives based on their experiences and interests.

I discussed my research with colleagues working in medical education and postgraduate supervision to identify potential participants known to them in an educational context. I asked them to introduce my study to potential participants. The approach to inviting individuals to participate is detailed in the Ethics section below. Recruitment was stopped when my supervisor DB and I judged that data sufficiency as described in Chapter 2 (Conceptual Orientation and Methodology) had been achieved.

3.2.2 Data collection

Interviews were conducted between November 2019 and April 2021. The first 8 interviews were performed in person prior to Covid-19 related restrictions. The remaining 7 interviews were conducted using UCC licensed MS Teams software, following approval of a modification to the original research ethics proposal. Data for study 2 was collected in the same interviews. All interviews were audio recorded, transcribed verbatim and anonymised. RQD interviews were conducted contemporaneously with the interviews for study 3 (consultant study). Information on the order of interviews is presented in Table 3.1. This approach allowed an iterative approach to developing interview guides for both studies. Earlier RQD interviews informed changes to the consultant interview guide. The final interview guide for studies 1 and 2 is provided in Appendix A. Data handling and storage was in compliance with UCC data management requirements (*UCC Research Data Service*, n.d.).

3.2.3 Data analysis

Reflexive thematic analysis (RTA) using Braun and Clarke's 6 step approach was used for analysis of interview data (Braun and Clarke, 2006, 2019, n.d.). I used an inductive approach and chose this method for analysis as it afforded flexibility to explore the data through my chosen theoretical perspectives and aligned with my epistemological and ontological positions (Braun and Clarke, 2019; Kiger and Varpio, 2020). My approach to RTA is described in detail in Chapter 2 (Conceptual Orientation and Methodology) as is my supervisors' involvement in data analysis.

CoP theory is a socio-cultural theory, concerned with conceptualising learning from a social, cultural, and historical perspective (Wenger, 1998). LoP theory is a recent

evolution of CoP theory (Wenger-Trayner et al., 2015). The latter focusses on practice-based learning as individuals move between and interact with multiple communities of practice. Further explanation of both theories is provided in Chapter 2 (Methodology). To contextualise my use of CoP theory I will now provide details on how I conceptualised CoPs for the purpose of the two RQD studies.

As the concept of accountability of members to a CoP is a key tenet in the theory (Wenger, 1998, p81), it can be argued that the physician team on which a RQD was working was the most relevant CoP to their workplace learning and this informed my approach to analysis in this study. This CoP may be configured as a consultant led team, with a varying number of non-consultant hospital doctors (NCHDs) at different stages in training, or less commonly can be part of a larger specialist department level CoP with several consultants and a larger number of NCHDs, again at a range of stages in their training. I refer to these CoPs as local physician CoPs. The membership of a local physician CoP, whether it is a consultant-led team or a department, can be seen to be constituted of doctors who participate in a range of ways in the practice of the CoP and are on a variety of trajectories (Wenger, 1998, p. 164-169). In Table 3.1, I provide a general explanation of these in relation to a local physician CoP.

Table 3.1: Types of membership in a local physician CoP

Member title	Description of position and level of participation
Consultant	• Full participant • Central and long-term member of the local physician CoP
Specialist Registrar	• On an inward trajectory in terms of the specialty • Most central NCHD member of the CoP, but more peripheral than the consultant

	• Has greater competence, legitimacy, and power than other NCHDs • Usually spends 1 year in the local physician CoP
Registrar	• May or may not be on an inward trajectory in the specialty • More peripheral than an SpR • Competence and legitimacy variable but expected to be greater than that of a senior house officer • Usually spends 1 year in the local physician CoP
Senior House Officer	• Many are not on an inward trajectory into the specialty CoP • Usually more peripheral and less legitimate than the registrar • Generally spends 3 or 6 months in the local physician CoP
Intern	• Not on an inward trajectory into the specialty CoP • The most peripheral and least legitimate NCHD • Generally spends 3 months in the local physician CoP

In terms of CoP theory, RQDs (and medical students) are usually viewed as legitimate participants in the medical CoP (Wenger, 1998; Cruess *et al.*, 2015). They are considered newcomers, and according to the theory are likely to put considerable effort into forming an identity that is coherent with the CoP (Wenger, 1998).

In their local physician CoPs, RQDs were mutually engaged in their shared enterprise of patient care in the unique historical, social, and cultural contexts of that CoP. The practices the community participated in resulted in the development of a shared repertoire of resources by the community. This included how and what members did when providing patient care, the tools they used and the routines they engaged in.

Of course, RQDs are also members of other workplace CoPs (e.g., academic CoPs, recently qualified doctor CoPs, interprofessional ward level CoPs etc…), and these CoPs also impact on learning. The influence of moving between local physician CoPs and boundary encounters with other CoPs are explored in more detail in Chapter 4.

Due to the large volume of rich data obtained and to address the research question, I decided, in conjunction with my supervisor DB to report the results of the research as a detailed account rather than a rich descriptive analysis. A detailed account allows for a deeper exploration of specific themes, whereas a rich descriptive account provides a broader view (Braun and Clarke, 2006; Braun, 2008). I chose this approach as it allowed me to keep focussed on the research questions. NVivo software Version 12 (QSR International, n.d.) was used for data management purposes.

3.2.4 Ethics

Ethics approval for this study was sought and granted by the Social Research Ethics Committee (SREC) in UCC (Appendix B). After the first 8 interviews had been completed, due to restrictions resulting from the Covid-19 pandemic, an amendment was granted by SREC to allow online interviews using UCC Licensed Microsoft Teams.

As I worked in the local medical school from which most potential participants had graduated, I was conscious that invitations to participate needed careful consideration to prevent those invited feeling under pressure to participate. Hence potential participants were identified in individual discussions with education and clinical faculty. Faculty members then passed on details of my research and the participant information leaflet and consent form (Appendix C) to those we identified. RQDs willing

to participate were asked to contact me directly by email to avoid potential participants feeling under pressure to be interviewed. I did not give feedback to faculty on the details of who had agreed to participate. In some instances, individuals interested in participating contacted me back through my colleagues. I made email contact with each participant in advance of interviews to arrange suitable times and locations, and all were re-sent the participant information leaflet and consent form by email prior to interview. All participants provided written informed consent. I took care at the beginning of interviews to explain the process to participants and to explain their rights to not answer questions, to withdraw consent, and to withdraw their data within 2 weeks of completion of the interview. All participants were provided with information on supports available to them in the event that participation in an interview resulted in any ongoing upset.

3.2.5 Reflexivity

So that readers may assess the trustworthiness of this research, I have described my engagement in reflective practice and my position in relation to EoL care and the participants in this study in some detail in Chapter 2 (Conceptual Orientation and Methodology). In summary, I engaged in reflective practice throughout all phases of this research, seeking to maintain awareness of the potential influence of my experiences and position on how I conducted interviews and interpreted data. I kept a reflexive diary throughout the research process. I also met with my research supervisors DB and TO'B regularly at all stages of the research (sometimes online and sometimes in person) to plan and discuss data collection and analysis. In addition, we discussed the write up and they provided feedback on written drafts. We supported

each other's reflexivity, and they facilitated me in considering alternative meanings when interpreting the data.

3.3 Results

I conducted 15 RQD interviews. Table 3.2 summarises participant information and the order in which RQD interviews were conducted. Participants were at various points in the 4 years following qualification. Seven were interns and these participants were between 5 and 10 months into their internship. Of remaining 8, 3 were first year, 2 were second year, and 3 were third year senior house officers (SHOs). Of the 8 SHOs, 6 were at the time of interview engaged in structured basic specialist training posts. These are three- or six-month posts, which are part of a structured training scheme overseen by a postgraduate training body. The remaining two were working in non-training posts, which would have been six- or twelve-month positions. Participants expressed interest in pursuing careers in a range of specialties in medicine, surgery, general practice, and psychiatry. One expressed an interest in a career in palliative medicine. Fourteen of the 15 interviewed had completed their medical degrees at the local University. One had worked for a year in a different region of Ireland, and 1 had spent a year working abroad. Three participants were non-Irish. Interviews 1 through 8 were conducted in person and 9 through 15 were conducted using Microsoft Teams due to the onset of the Covid-19 pandemic and the resultant restrictions on face-to-face meetings.

Table 3.2: Participant demographics, interview order and duration

RQD Number	Overall Interview order*	Gender Male (M) Female (F)	Course Graduate entry medicine (G.E) Direct entry medicine (D.E.)	Year post qualification	Duration: Minutes (m) Seconds (s)
1	3	M	DE	1	38m 05s
2	4	F	GE	1	38m 37s
3	5	F	GE	1	68m 14s
4	7	F	GE	1	58m 21s
5	9	M	GE	1	52m 51s
6	10	M	DE	3	49m 10s
7	11	M	DE	4	64m 23s
8	12	M	DE	1	49m 10s
9	16	M	DE	4	51m 20s
10	17	M	GE	3	51m 17s
11	19	M	DE	4	70m 14s
12	20	F	GE	2	50m 04s
13	21	F	DE	2	43m 21s
14	24	M	GE	2	48m 07s
15	25	F	DE	1	67m 59s

*Out of 29 RQD and consultant interviews

Two themes were identified that address the research question: end of life care is not core business and emotions and learning. End of life care is not core business had two subthemes: dying is a binary concept and justifying lack of engagement in EoL care. These subthemes provide evidence of how EoL care is regarded in relation to the enterprise of local physician CoPs. Emotions and learning had three subthemes. Two of these: moral distress and left to figure it out, highlight how lack of capability, support from seniors and powerlessness in relation to EoL care, impacted emotionally on participants. The third, observation of practice focuses on how behaviours and skills, modelled by senior doctors had an emotional impact and led to RQD learning. An overview of these themes and their subthemes is summarised in Figure 3.1.

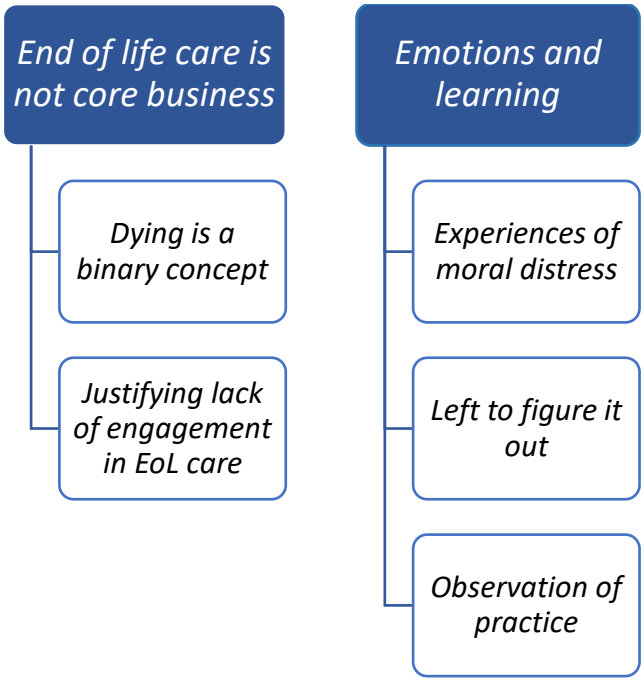


Figure 3.1: Overview of themes and subthemes.

3.3.1 End of life care is not core business

Dying is a binary concept

RQDs, in keeping with the practices of their local physician CoPs, often identified dying as a binary concept. Patients were viewed as either being for *"active"* management or dying. A diagnosis of dying resulted in a major and often abrupt change in the approach to patient care. The reification *"making palliative"* was used by several RQDs to signal this change of approach when a patient was identified as dying:

> *"We'd have a lot of patients who are actively dying from dementia who we'd make palliative" RQD 2*

Making palliative as part of the repertoire of practice, resulted in a re-categorisation of the patient, withdrawing what the CoP viewed as *"active"* management and commencing palliative drugs, with a focus on ensuring comfort at the EoL. Patients

were either dying or not dying, and hence the focus was either on prolonging life or ensuring a comfortable death. There didn't appear to be an in between option for care:

> *" My version of that would be stopping active management, stopping all their drugs and charting Midaz, Hyoscine, Buscopan, and what's the other one … Morphine… that's my version of being made palliative" RQD 2*

> *"Interviewer: Becoming palliative, what do you mean by that term?*
>
> *Participant: Um, that no active treatment would be of benefit for this patient, that when you appraise the whole situation in the grand scheme of things, the most appropriate, course of treatment was, would be to palliate this patient through their passing I suppose." RQD 5*

Misconceptions about palliative care were common and it was viewed by many RQDs as synonymous with EoL care. This misconception is widely held at a societal level (McIlfatrick *et al.*, 2014; Krau, 2016; Flieger, Chui and Koch-Weser, 2020) and when observed in clinicians, reflects a lack of knowledge and understanding of this domain of practice.

RQDs described how the role of the local physician CoP in patient care was often seen to change when a patient had been *"made palliative"* and was imminently dying. This change meant that for some CoPs the care of the patient was no longer perceived as part of the enterprise of the community. Consultants on ward rounds generally didn't spend much time with patients who were dying. The term *"short stop"* was often used to describe what happened on a ward round when a patient was dying. Sometimes the consultant paid a brief visit with perhaps one other doctor from the team, usually someone senior, or sometimes they didn't go in:

"… you just go around close the curtains and be like 'okay he seems comfortable', 'how are things going?' and then leave it would be very brief." RQD 2

" Often uh the stop on a ward round where, for a patient who's end-of-life is very short… it's kinda 'are there any changes to be made? No', a quick update from the nurse who's looking after them, and then it's moving on" RQD 1

Family members have important roles and many needs that require the support of healthcare professionals when a member is dying, including explanation, preparation, affirmation, and reassurance (National Health Service, 2013; Sallnow *et al.*, 2022). Participants accounts of the practices of many local physician CoPs around EoL care, did not suggest that the needs of the patients' loved ones were actively considered.

Justifying lack of engagement with EoL care

RQDs commonly identified that more senior doctors lacked knowledge and skills in EoL care:

"...there can be a big variance between consultants in terms of how, but I suppose maybe in general there's, it's still something that… they have a lack of experience in you know…I think it's probably the situation that you might appreciate the most that they have a lack of experience in." RQD 7

Participants commonly justified this, citing lack of experience and workload pressures or not being within their area of interest:

" … these teams are under, operating under really heavy workloads … SpRs, consultants are under loads of pressure to be publishing, to be researching,

teaching, on top of everything else … I feel they don't have time or, at least, they feel they don't have time to be dealing with these kind of, you know, these events." RQD 6

Workload pressures that were described included other aspects of patient care, academic, and administrative commitments.

It could be argued that as experienced clinicians, consultants could reasonably be expected to have cared for many patients at the EoL. However, lack of engagement of senior doctors with EoL care and deficits in knowledge and skills in this area was accepted without question by many RQDs. This provides further evidence that EoL care was not considered part of the core business of many local physician CoPs and might explain why many RQDs had no expectation that consultants should have basic knowledge and skills or engage meaningfully in EoL care.

In some instances when the specialist palliative care team (usually via the clinical nurse specialist in palliative care) had been involved in advising on care, the local physician CoP appeared to virtually hand over care, thus providing another justification for the primary physician team's withdrawal from care:

"… we'd turn up at nine, would print off the list of our consultant's patients and then we'd divvy up who's going to see who and then sort of, um, the patient who was palliative would always be somewhat of a footnote, um, because in our heads, I suppose, the palliative care nurse was, um, had put a decent management plan in place and although the patient was on our patient's, our consultants list of like, roster of patients, um, it was always somewhat a footnote because they was nothing we were actually treating, um, and we would just go

in, one of us would go in on a daily basis, just as a formality, to say hello to the patient." RQD 5

Some participants believed that a different repertoire of practice was appropriate at this point; one in which care was de-medicalised. So long as patients were well symptom controlled, some RQDs seemed to view this reduction in medical interactions between doctors and dying patients as desirable, as it allowed for the family to spend uninterrupted time with the patient:

"…. I suppose, it's sometimes quite a peaceful time I think because when those patients are imminently dying, you know, thankfully they have medication on board that keeps them, you know, peaceful and not in pain and I suppose, it's nice that families get to spend time with them in their kind of, last kind of hours or days so generally the medical interaction from my point of view, I suppose, is minimal. " RQD 14

Another suggested that at least part of the diminution of medical interaction with dying patients was a recognition of the limits of what medicine and doctors could offer:

"…ah I don't know, futility of staying um, and knowing that you're not able to do anymore for them, um a sense of leaving them ... in some sort of peace, I guess, ah or a knowledge you know you're not doing anything for them or able to do anything for them ..." RQD 1

This suggests a culture where the doctor's role is limited to diagnosing and providing medical interventions and doesn't take account of the possibility of the doctor's presence and support offering anything to the patient or family in that situation.

3.3.2 Emotions and learning

Experiences of moral distress

Moral distress *"is the experience of cognitive-emotional dissonance that arises when one feels compelled to act contrary to one's moral requirements"* (Berger, 2014 p. 395). There were a number of situations related to EoL care where RQDs described experiences that resulted in moral distress.

RQDs spent more time involved in direct patient care than more senior doctors and described experiences where they were the first member of the local physician CoP to identify that a patient was deteriorating and might be approaching death. However, there was a strong power dynamic in local physician CoPs. It was widely accepted by participants that consultants had greater experience and expertise, and as the senior and only permanent member of the local physician CoP, the consultant was ultimately the decision-maker about EoL care practice. In these situations, many RQDs struggled to speak out and to have their opinions considered in decision-making about the direction of patient care:

> *"I think it is ultimately the consultant who will, makes that decision. It is kind of difficult, I think as a junior to be like do you know, maybe we should start withdrawing or be a little less active." RQD 10*

Participants were confronted and constrained by lack of experience and confidence in their clinical judgement, and their low level of legitimacy. They frequently described trying indirect and tentative approaches in the hope that a more senior doctor on their team would notice the patient's deterioration, and decide or at least consider the possibility that the patient was dying:

"I would have been able to hint at it, you know, saying that 'oh geez, Mr X is, you know, he hasn't responded very well' or 'his bloods haven't been improving' or, you know, 'he looks less well',... I might voice my interpretation of the situation, but I think I kind of acknowledge that I could be wrong so I wouldn't be too forceful in it, and I would be kind of open to their interpretation as well." RQD 11

Some had learned to say nothing.

Failure of the senior members of the CoP to recognise that patients were approaching death and lack of provision of adequate symptom control had an emotional impact for RQDs as they experienced ethical conflict between what they considered to be appropriate care and the care actually provided:

"... it's frustrating because ... you feel like they need something like a syringe driver a continuous infusion of pain relief ... so there's kind of a delay in adequately managing that … You feel upset for the family members as well coming in you know not just one day, for a couple of days and seeing … their family member in kind of constant pain, it's difficult …" RQD 1

One RQD who had increased self-efficacy in palliative care and who identified strongly with the specialist palliative care CoP in her hospital, described trying a more direct approach to influence the focus of care for those she considered would benefit from palliative care input:

"I find I do it at the start of each rotation, where I once or twice suggest 'should we get a palliative consult on this, even get the CNS up um just for symptom control or just so that they are on their radar, that they are on their books?' And

they kind of turn to look at, to look at you, going 'no no no, there's no need.' And you're going 'it can only benefit the patient' ..." RQD 15

She went on to say:

"Yeah, and it has been shut down on say almost every time I've said it, as almost as a daft suggestion you know, and maybe once or twice it was, but I don't think I've been wrong every time ..." RQD 15

When asked how this made her feel she said:

"… it makes you feel useless because it's the one thing I feel like I can confidently bring to someone. I feel like I know enough about palliative care as a junior doctor to appropriately bring it to the patient and to the team, and for somebody to turn around who probably knows less than I do just by virtue of the career that they've chosen, dismiss it so quickly, you're kind of going, oh God do I have to wait until I'm at that stage to impact somebody's care like that? ….. when something happens like that you feel that you're so not worthwhile, it makes you feel like you're the jobs monkey again …." RQD 15

Constrained in her efforts, the experiences reported by this RQD suggests that even stepping forward confidently with suggestions about palliative and EoL care was not likely to influence the direction of patient care.

RQDs appreciated that diagnosis of dying was a big decision, and they did not want to take responsibility for making that call:

"But I would feel that there is a hierarchy there and I'm kind of... I would feel as though I'm there to follow instructions as well. So that is a factor. But I'm happy enough to be in that position, knowing that I'm inexperienced." RQD 11

Despite this many tried to have their opinions considered in decision-making. However, the mechanisms open to them were often indirect and ineffective. Notwithstanding their knowledge of patients, their views were not sought in the context of EoL care. One participant described how as a more senior SHO, he had been given opportunities to influence practice, but this was not extended to decisions about changes in focus of care towards the EoL:

"As an SHO, I experience it more now that consultants will turn to you for advice and kind of speak to you on a level with regards to lots of medical things, albeit anti-hypertensive regimes or adding in or taking away diuretics, but less often, or never really they will turn to you and say 'what do you think of that?' in terms of an end of life care plan, or 'this is how far we are going to go with treatment.' And I don't really know why that is…" RQD 14

RQDs lack of responsibility for the making of decisions that patients were dying was not problematic and was enabled by their peripheral position in the local physician CoP. However, their non-participation in the decision-making process was problematic. In relation to EoL care, they were kept in a marginal position, powerless and lacking legitimacy. This marginality resulted in situations where RQDs experienced cognitive-emotional dissonance as a result of being unable to have their opinions considered and to influence the focus of patient care.

Several RQDs, in particular interns, talked about powerful emotional experiences of being conflicted when they were compelled to follow instructions to arrange or perform investigations and interventions that they considered to be burdensome and without prospect of benefit, on patients they perceived to be dying:

> *"… there was a patient who, this patient was 100 years old, and I was called to see them while I was on-call on nights and they had no documented plan for going forward, they were very septic, they were very unwell, and I contacted the Reg [registrar], and I said I think this person is dying … I was advised to just treat them anyway with, treat them anyway with antibiotics … That was a very, that was a very tough one because like I didn't think it was appropriate like, but in this certain scenario, I was the only doctor on the site at the time … As I said your job is to keep them alive to the next day…" (RQD 10)*

Powerless to influence the direction of care, the intern, the most peripheral member of the team and the one who did the most menial tasks, was often the one placed in this position:

> *"I was called one night to do repeat potassiums on a man every three hours who was like GCS [Glasgow Coma Scale] of 3 ... I was like this isn't fair, the two kids were on the bed sleeping with him and I was like why am I waking him up at 3 o'clock in the morning to do a potassium like, what are we going to do if the potassium is high or low ... He was still being actively managed ... soon as the team came in and decided to stop active managing him, he was dead within three or four hours...he also had awful access and stuff ... small things like that, turning the light on trying to get blood, that's stressful for everyone." RQD 2*

These RQD accounts illustrate moral distress.

Left to figure it out

As interns, RQDs were often confronted by deficits in their knowledge and skills in EoL care and described experiences of being left to figure it out on the job. Awareness of the challenges of providing EoL care often came from first-hand experience after qualification and this frequently was not considered before they entered the workplace. Participants frequently highlighted situations related to communication, where their undergraduate education and specifically lack of clinical exposure caught them unprepared and left them without a repertoire of skills needed for them to practice as they would have wished. They had been taught frameworks for breaking bad news and been involved in role-plays, however what they had been taught often did not align with the real world of practice. A surgical intern outlined his experience in the following excerpt:

> *"Yeah. I suppose the whole like, we've had sort of breaking bad news set-up and we have those for OSCEs [objective structured clinical exams] and stuff, but, um, the premise for like breaking bad news scenarios for OSCEs is, you know, you're in a room … everyone's there, you've … you'd have the set-up, you have asked them 'oh, do you want to bring someone to have a conversation with you?' ... but that's not how it is … You're on an 8-bedded ward, um, you have the curtains, that's it. Sometimes then there's relatives around, um, you just don't have the time to engage the patient as you would have, um, sort of a breaking bad news scenario in an OSCEs. Um, it's really difficult and then you walk out and they're in tears and … sometimes there's not even a nurse to be*

present when you've, sort of, break that bad news as well, so yeah, it's very difficult in practice." RQD 5

Even though RQDs were not usually the doctor delivering initial bad news, they had to manage complex communication challenges from early in their careers. Sometimes they were the doctor who had to explain to a patient or their family that they were being referred to palliative care and what this meant. Participants and their teams did not seem to identify this as breaking bad news. RQDs were the most accessible member of the physician team as they spent a lot of time on the wards. They were often expected to have unplanned informal conversations with patients and family members. They could be approached by nursing staff or directly by a patient or family member, and found it very difficult to refuse or defer these conversations:

"… I hate the, I really hate them being sprung on me, the surprise 'here's a doctor' meetings." RQD 4

One scenario that was frequently highlighted by interns as difficult, was being asked questions, which they could not answer due to their lack of knowledge and skills:

"I had no idea how to answer her, cos she was, like I didn't know whether, like I didn't know how much she knew … I didn't know how to talk to her without giving her false hope ... you're left in that situation a lot as an intern" RQD 2

or legitimacy or experience:

" If you're having those conversations or, uh there is always the … the idea or the suspicion in the back of my head that well maybe something will change in the management plan, maybe there'll be another scan booked, or maybe they'll

be another um discipline involved who will um suggest something else … so I suppose for those reasons I'd be reluctant to have those conversations, yeah." RQD 1

Participants often described that as interns, they were left unsupported and expected to get on with managing the care of patients who had been identified as dying. They were unprepared for the practical aspects of EoL care such as prescribing medication:

" I think as an intern you, when somebody is, you know, in the dying, it kind of feels like, it's kind of not in the NCHD handbook or, do you know. It feels like it's above you, but the people above think it's below them because there's no active treatment." RQD 4.

Pronouncing death was another one of these aspects clinical practice:

"I was surprised about pronouncing death cos it's once again, that is something that seems to be done on-call from the intern side of things ... remember just having to look up online about what I have to do again, and how do I approach it. There is a certain amount of anxiety with it but … it has to be done and we just get on with it." RQD 1

These incidents where interns were left to get on with EoL care and were out of their depth were emotionally impactful:

"Interviewer: And you, you used the word 'useless' earlier on I think ... Is that how you were feeling?

Participant: … you're kind of in a limbo, and they go 'just chart PRNs' and you're actually not even taught what PRNs are..." RQD4

One RQD related his reaction to a tutorial on EoL care from a SPC nurse:

> *"… like she's telling me stuff that I've already processed so much, because I remember being an Intern on-call … I was doing twenty-four-hour call and a paramedic brought a woman who was dying of a brain tumour to [hospital]. And having to manage that, that was ridiculous do you know, it was a ridiculously exposed situation … And then I'm getting this tutorial about, you can give Morphine, or you can give Midaz and I'm like this is a waste of time, do you know what I mean? This isn't representative of my reality ... I was working a few months when it happened so like do you know. I'm working three years now." RQD 9*

He had responded to being exposed and unsupported in a particularly challenging situation, soon after qualification, by developing cynicism to what for him was too little, too late.

Often left to interns who were unprepared for delivering EoL care, RQDs tacitly learned that this was not important work:

> *"There's no need for the registrar to go and see if they're really busy dealing with more sick patients that need more active acute medical management, so it was OK for me to just go and see and see that everything was fine." RQD 5*

RQDs responses frequently downplayed or disregarded the emotional impact and difficulty of this kind of work and the interview process presented an opportunity for some to reflect. The intern above responded as follows to a further question

"Interviewer: And you mentioned there that the registrars and the SHOs or more senior doctors might be off doing more difficult work …Where so do you consider this on the scale of difficult work?

Participant: The most difficult." RQD 5

Another more senior RQD remarked:

"I just have, more just a comment, not a question … it's, it's kind of, it's weird reflecting on all this stuff now actually, like when it is actually put to you, it is just like, yea, it is a difficult job really, going in as a junior doctor to do all that stuff." RQD 10

Observation of practice

Participants experienced positive emotions and powerful learning in response to what they perceived to be appropriate EoL care. When RQDs witnessed good practice modelled, it could be a very impactful learning experience. Positive role models played an important role in the acquisition of knowledge and skills in this area of patient care. Observing good communication skills was identified as very useful by many participants and they often described feelings of gratitude, admiration, and reassurance, and learning when it was done well:

"… I definitely think that some people are better at it than others … when I was an intern actually one of my Reg's, he was extremely good at it ... it is one of those things you are almost thanking him after … and so I have probably picked up quite a bit from him, just like, maybe I was kind of relaying back what he did,

... Like, I remember even some of my co-interns just being like, it is like watching a master class…" RQD 10

A smaller number mentioned observing proactive diagnosis of dying, which sometimes came as a surprise at first but could promote reflection and a motivation to learn:

"I admire the consultants who are really good at doing it and at saying enough is enough and being holistic about the whole thing and de-medicalising it and saying what are we actually achieving here. And I suppose, you know [Name] said something on the first day and I was like oh really? But like now when I dwell on it, I see what he means. ... so, I really admire those who are good at doing it and I think, it just takes a little bit, I think of experience and exposure to get comfortable with doing that." RQD 14

Witnessing poor communication skills evoked strong emotions and was also identified as a valuable opportunity to learn:

"… even if they do it incorrectly… in a way that you might find unpalatable, that's just as useful as watching someone who's amazing at it, because I've often seen doctors talk to patients and talk to their families and thought to myself I would hate for someone to speak to me like that or my family like that, and I make almost a mental note, I'm never doing that." RQD 6

An experienced SHO described his response to an incident where bad news was badly broken by someone more senior:

" … to be honest I thought the breaking bad news was a bit of a car crash from the Reg [registrar] … I was inclined, I wanted to rush in to say something

instead but, anyway he kind of gave the news. They were completely shocked, just beyond surprised and anyway I just kind of stayed around just a little bit longer, and I kind of went through it with them afterwards and I think I salvaged a bit" RQD 10

One participant provided an account of an incident unrelated to communication, that had evoked a deep emotional response:

"Even the, you know the end-of-life symbol, like there was one situation where another consultant pulled that down from the door of a patient saying, misunderstood what it meant, they thought the that symbol being on meant he couldn't treat them anymore, um, which it's not, ... everyone was quite shocked … because what we consider as a symbol of, you know, just please be respectful on the ward, you know, don't be unnecessarily taking bloods or, you know, that kind of stuff. I was, um, yeah and he just ripped it down." RQD 4

These reports highlight affective learning from observation in the clinical workplace. While observation may not be considered to provide as valuable a learning opportunity as participation, it is apparent from these accounts that the strong emotions triggered by what participants witnessed, provided opportunities for reflection, and resulted in learning.

3.4 Discussion

3.4.1 Principal findings

Participants learned about EoL informally in the workplace. Culture was a powerful mediator of learning. Through changes in the engagement of senior doctors and their levels of knowledge and skills in EoL care, RQDs learned that EoL care was not a core

part of the business of many physician teams. Hence, RQDs justified senior doctors' disengagement and lack of capability in EoL care. They perceived from the practices they participated in that patients were either living or dying and the approach to medical care was determined by how the individual was categorised. EoL care was not a priority and could often be left without senior support to be delivered by RQDs who lacked experience, knowledge, and skills.

Participants encountered a range of challenges and negative emotions through their involvement in providing care to patients who were at EoL and identified it as difficult work. However, when they witnessed senior doctors engaged in good EoL care, they could experience positive emotions and learn from this. The topic of emotion and learning will be given further attention in the final discussion chapter (Chapter 7).

3.4.2 Learning from practice

Insights into what and how RQD learned about EoL care in the workplace can be gained by considering how local physician CoP participated or did not participate in this area of practice. Participants' descriptions of the practice of many physician teams implies that patients were considered to be either living or dying. When identified as dying, the approach to medical care changed abruptly and the term *"making palliative"* was often used to signify this. Making palliative was perceived to be the withdrawal of active care and prescription of medicines to manage symptoms at the EoL. The implication of this is that EoL care is passive and it overlooks the need for careful and ongoing active assessment of comfort and treatable causes of discomfort such as pain, anxiety, dry mouth, and urinary retention, if good EoL care is to be achieved (Neuberger, 2013).

The term *"making palliative"* represents a conflation of palliative care with EoL care and represents a discourse that is very common (McIlfatrick *et al.*, 2014; Krau, 2016; Flieger, Chui and Koch-Weser, 2020). Underlying this is a lack of recognition of the potential benefits of palliative care and a failure to recognise that it can be integrated with approaches that are perceived to be focussed on disease management (Ahmed *et al.*, 2004; Parikh *et al.*, 2013). There have been efforts in recent years, including publications in well regarded general medical journals (Temel *et al.*, 2010), and initiatives (AIIHPC, n.d.; Ryan *et al.*, 2014; Seymour, 2018) to alter this perception of palliative care and it also receives attention in formal undergraduate medical curricula. However, the dominant workplace culture in which RQDs were immersed did not view palliative care in this way and didn't support or reinforce this perspective.

Once dying was identified, the senior doctors in many local physician CoPs were seen to disengage with patient care. Coupled with the disengagement of senior doctors was a general lack of recognition of the importance of caring for and engaging with the family (National Health Service, 2013) at this time. Patients were commonly referred for specialist palliative care input at this stage and the RQD was left to attend to medical aspects of care. The terms *"footnote"* and *"short stop"* used by participants are reifications for this reduced participation by senior doctors in EoL care.

RQDs were often expected to provide the medical aspects of EoL care and act as the point of communication between their physician team and the patient and their family. They felt unprepared by their undergraduate education for EoL care and lacked the requisite knowledge, skills, and experience. They were often unsupported by more senior doctors and were left to get on with figuring it out for themselves. Other studies have reported similar findings of unpreparedness and lack of support (Gibbins,

McCoubrie and Forbes, 2011; Tait and Hodges, 2013; Redman *et al.*, 2017; Linane *et al.*, 2019). This practice of disengagement by consultants implies tacitly that EoL care is not viewed as part of the business. Identity from a CoP perspective, is influenced as much by what is not engaged in as by what is (Wenger, 1998). Hence RQDs are likely to have learned that EoL care is not the business of senior doctors and since it could be delegated to those most inexperienced and unprepared, it was not a critical area of care and not one that was going to gain them legitimacy or a claim to competence in the CoP.

Participants sometimes identified what they considered to be poor attitudes and practice and from this reported learning how not to do things. However, even when RQDs were aware of deficiencies in care provided to dying patients or witnessed poor practice demonstrated by senior doctors, in many instances they accepted and defended this citing lack of experience or lack of interest in the area.

RQDs justifications for non-engagement of senior doctors in EoL care, further supports the assertion that EoL care was not considered part of the enterprise of most physician teams. They cited consultants' inexperience to rationalise their lack of knowledge. They excused disengagement by seniors, referring to the other *"important"* demands of their jobs. Some mentioned that de-medicalisation at this point was a positive, which allowed patients and families time together without medical interference. This suggests that the identity of a doctor was viewed as someone who does something to patients rather than someone who might at times accompany them. Whitehead (2014) has described this phenomenon as action versus presence mode. The finding of lack of consideration for the needs of family in the context of EoL care is coherent with this view. If doctors perceive that they are not doing anything for the patient, they may not

think they have anything to offer the family. Another justification for disengagement was the involvement of the specialist palliative care consult team, which participants reported was commonly viewed by their teams as a handing over of patient care. Price & Schofield (2015) similarly reported that decision-making was delegated to SPC teams once a palliative approach was adopted and Ewing et al. (2009) found that provision of psychological care, even at a basic level was often handed over to them.

3.5 Conclusion

RQDs learned informally about EoL care through their experiences of participation in their physician teams. Socio-cultural aspects of the workplace influenced what and how RQDs learned about EoL care. At the point of qualification participants were often poorly prepared to deliver EoL care by their undergraduate education, they found it a difficult and emotionally challenging aspect of their role. The practice of their physician teams often changed as patients approached the EoL; patients were seen to move from active management to being *"made palliative".* For many teams, EoL care was not core business and senior doctors were seen to disengage from patient care when patients were dying. Sometimes EoL care was ostensibly outsourced to the specialist palliative care team. Participants justified this disengagement of seniors from EoL care even though it left them to attend to dying patients' medical needs.

Chapter 4

Recently qualified doctors learning about end-of-life care in their workplace

4.1 Introduction

In Chapter 3, I applied Communities of Practice (CoP) theory to gain insights on how recently qualified doctors (RQDs) learn about and experience the provision of end-of-life (EoL) care within their physician teams. Most RQDs move every three to six months between these teams, usually remaining as peripheral participants until they are more senior and pursuing training to become a specialist in a particular field (Wenger, 1998). They simultaneously have membership at a variety of levels of several other work-related CoPs, such as RQD CoPs and interprofessional ward level CoPs. In addition, in work settings they have boundary encounters with other CoPs, both within their institution (e.g. administrator CoPs) and further afield, such as training and regulatory body CoPs (Wenger-Trayner & Wenger-Trayner, 2015). Hence, RQDs work and live in a complex system in which they have multimembership of several CoPs and in addition, the main CoP to which they are accountable changes frequently. This constitutes a LoP (Wenger-Trayner et al., 2015).

The affordances of Landscapes of Practice (LoP) theory in medical education research has been highlighted (Coakley and Bennett, 2020; Hodson, 2020; Rashid, Alexander and Griffin, 2020). In their day-to-day work, RQDs have boundary encounters with many CoPs. These are rich learning opportunities but present

challenges (Kubiak *et al.*, 2015). Moving from one local physician CoP to another, when they rotate posts, is a boundary crossing. This brings with it many challenges, including assessing the terrain and adjusting their practice to adapt to the local environment (Fenton-O'Creevy, Dimitriadis and Scobie, 2015). From a LoP perspective, RQDs are sojourners, having high levels of participation for the relatively short time that they are members of a local physician CoP (Fenton-O'Creevy *et al.*, 2015). In crossing boundaries between local physician CoPs, they are confronted by what they do not know and cannot do, and are constantly required to emphasise or de-emphasise elements of practice and in doing so they re-negotiate their identity (Coakley & Bennett, 2020; Hodson, 2020; Wenger-Trayner et al., 2015). The modulation of identity across borders in boundary encounters and boundary crossings requires RQDs to negotiate how identity that has been shaped in another context can be expressed in the current CoP. This reconciliation of identity requires emotional work (Fenton-O'Creevy, Dimitriadis and Scobie, 2015).

In this chapter I report the results of study 2, where I use LoP theory to interpret data from RQD interviews.

The aim of this study was to explore how the social and cultural environment in which RQDs work impacts on their learning and approach to EoL care.

My research question was:

How do recently qualified doctors navigate the wider landscape of practice when caring for patients at the EoL?

4.2 Methodology

My methodological approach is described in Chapter 2. I collected a single data set for both RQD studies (studies 1 and 2). Recruitment, data collection, ethics and reflexivity are described in Chapter 3. I used Braun & Clarke's (n.d., 2006, 2019) 6 phase approach to reflexive thematic analysis and did a common initial first pass analysis for phases 1 through 3. Again, the primary workplace CoP to which RQDs were accountable was considered to be their local physician CoP. Analysis is described in detail in Chapters 2 and 3.

4.3 Results

I conducted 15 RQD interviews. Table 4.1 summarises participant information and the order in which RQD interviews were conducted. Participants were at various points in the 4 years following qualification. Seven were interns and these participants were between 5 months and 10 months into their internship, three were first year, two were second year, and three were third year senior house officers (SHOs). Of the eight post internship doctors, six were at the time of interview engaged in structured Basic Specialist Training posts. These are three- or six-month posts, which are part of a structured training scheme overseen by a postgraduate training body. The remaining two were working in non-training posts, which would have been six- or twelve-month positions. Participants expressed interest in pursuing careers in a range of specialties in medicine, surgery, general practice, and psychiatry. One expressed an interest in a career in palliative medicine. Fourteen of the fifteen interviewed had completed their medical degrees at the local University. One had worked for a year in a different region of Ireland, and one had spent a year working abroad. Three participants were non-Irish. Interviews 1 through 8 were conducted in person and 9 through 15 were

conducted using Microsoft Teams due to the onset of the Covid-19 pandemic and the resultant restrictions on face-to-face meetings.

Participant details were reported in Chapter 3. Demographic and interview details are duplicated here for the convenience of the reader.

Table 4.1: Participant demographics, interview order and duration

RQD Number	**Overall Interview order***	**Gender Male (M) Female (F)**	**Course Graduate entry medicine (G.E) Direct entry medicine (D.E.)**	**Year post qualification**	**Duration: Minutes (m) Seconds (s)**
1	3	M	DE	1	38m 05s
2	4	F	GE	1	38m 37s
3	5	F	GE	1	68m 14s
4	7	F	GE	1	58m 21s
5	9	M	GE	1	52m 51s
6	10	M	DE	3	49m 10s
7	11	M	DE	4	64m 23s
8	12	M	DE	1	49m 10s
9	16	M	DE	4	51m 20s
10	17	M	GE	3	51m 17s
11	19	M	DE	4	70m 14s
12	20	F	GE	2	50m 04s
13	21	F	DE	2	43m 21s
14	24	M	GE	2	48m 07s
15	25	F	DE	1	67m 59s

*Out of 29 RQD and consultant interviews

Three themes were identified that addressed the research question (Figure 4.1): figuring out consultant's approaches to EoL care, interactions and learning from the specialist palliative care CoP, and managing EoL care when on-call.

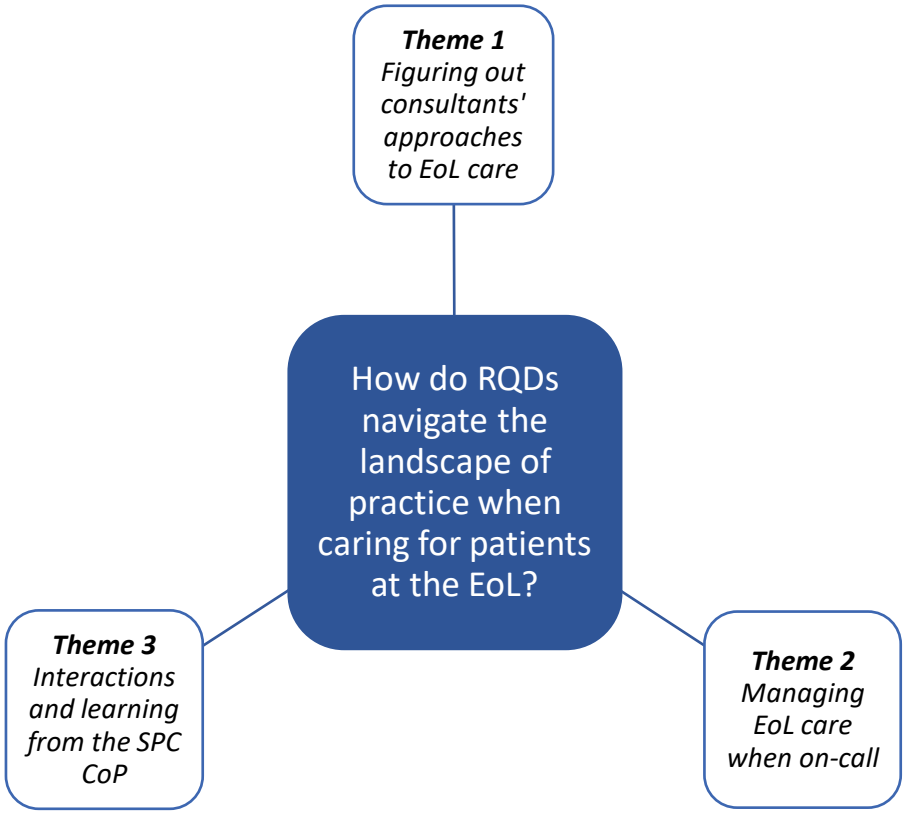


Figure 4.1: Overview of themes

4.3.1 Figuring out consultants' approaches to EoL care

There was considerable variation between consultants in their attitudes and approaches to, and knowledge of EoL care. In a local physician CoP, the consultant's approach to EoL care determined what was done, when it was done and what was not done:

> *"There's a line between active management and palliative care, but it's not really a line, it's …. like a whole strip of, you know, grey area and it's open to interpretations. So, I suppose allowing for that, some consultants and some doctors will err on one side or the other…. The consultant that I worked with in [Hospital] was inclined to be more aggressive in managing cases and less*

inclined to withdraw treatment than some of the other consultants I've worked with." RQD 11

There were also reported differences at specialties level in approaches to EoL care. Based on their experiences, RQDs identified some specialties as having greater knowledge about EoL care and being more open to identification of dying. Several participants mentioned that surgical specialties were generally slow to refer to palliative care and identify dying:

"I think to be fair the medical versus surgical, like medical teams are very quick to get palliative care involved, to be fair they are very good, straight away they'd get them in for symptom control. I think surgeons are a lot slower to do that … We had a fella with pancreatic cancer and he was very unwell like, very sick, we all didn't think he'd make it through the weekend and the surgical team were waiting until the biopsy results came back, which takes about three to four weeks, to kind of get palliative care involved, despite the fact that he had mets[mestatases], like everywhere, like he was quite clearly palliative." RQD 13

Gerontologists were identified by some participants as having competence in this area. One experienced SHO commented:

"….depends on the speciality do you know like, geris [geriatrics] are much more quicker to let people go like do you know? … Even onc[ology], do you know onc[ology] would just give him chemo[therapy] like until they, like the chemo[therapy], they'd rather kill him with chemo[therapy] than they would let them die like sometimes ... But haem[atology] is a bit different, but again you're

like jeez, I've only, I'm working a job six weeks and you're only trying to get a grip of preferences of the consultant at that stage you know?" RQD 9

Further illustrating the variation between individual consultants, another participant reported that the oncologists he had worked with were proactive in identification of palliative care needs as patients were becoming more unwell:

"Most patients who reach that point have been, um, identified, kind of, previously, and, you know, have been set up by the palliative care far before that … where I work, it's common knowledge between both NCHDs and consultants, that involving palliative care at an early point has better outcomes for the patient …" RQD 6

CoP theory suggests that boundaries between CoPs can be lower when their practices have more in common (Wenger, 1998, p. 114). However, to add further to the complexity for RQDs, there were tensions and rivalries between some local physician CoPs, who considered palliative care and EoL care as part of their enterprise. Some RQDs commented that they perceived a reluctance on the part of some consultants in gerontology to refer to palliative care:

"They don't mesh well together, the particular departments I worked in, the geriatrics consultant I worked with specifically said that we (the geriatrics department) can palliate just as well as palliative care. He said that. I thought that was ... that kind of stuck with me, that was confusing because I thought a whole specialty dedicated to palliation would probably be at the cutting edge of that ..." RQD 11

This RQD indicated that he believed the gerontology service offered good palliative care to patients at the EoL but went on to state:

> *"I didn't really have a problem with it, but I did think it was striking at how strongly they felt that they could palliate people just as well as the palliative care team." RQD 11*

RQDs must adapt to these variations in approaches and personal preferences as they navigate their way in the LoP. The practices that RQDs participate in, impact on their identity and learning (Wenger-Trayner et al., 2015; Wenger, 1998). On joining a new local physician CoP, RQDs took time to figure out the preferences of the consultant so that they could adjust their practice to the local regime of competence and in doing so they negotiate their identity in relation to their new community:

> *"The whole dynamic… is this a consultant who likes to have a conversation about their decisions? Is this a team that does a thing a certain way do you know? Like, I might need a reference off this person do you know? This is the problem. These are the things you have to think about." RQD 9*

One experienced SHO who was coming to the end of a 3-month position in the local hospice, had already learned what would not be considered appropriate in the next local physician CoP that he was going to join. As a result, he was going to de-emphasise what he had learned when he moved to cardiology. It seemed that what was considered part of the regime of competence in a specialist palliative care (SPC) CoP, would not be regarded in the same way when he crossed the boundary to another CoP, and as an SHO he was not likely to be in a position to introduce new practices:

" I suppose I'm still at a stage where I kind of have to answer to other people (laughs slightly) ... you want to take a certain approach with, but you have to take a lead from whoever do you know is above you, you know. So I think certainly if I was in a situation where I, do you know, had the freedom to kinda do that, I think it definitely would affect my… management of people ... just from experience from beforehand do you know, I think if I was suggesting some things to people, they they'd probably wouldn't take me up on it, you know." RQD 7

The emotional work in negotiating one's identity in relation to each local physician CoP is highlighted by these RQD accounts of their experiences. Moving from being a member of one of these CoPs to another can mean reconciling an identity as a doctor who attends to the biopsychosocial needs of patients, with one in which the doctor focuses on disease assessment and treatment at the expense of the other aspects of holistic care.

4.3.2 Managing the on-call LoP

The landscape of practice is different on-call. RQD roles change, and RQDs must deal with more uncertainty and more responsibility. An intern described her work during normal hours in terms of being a secretary:

"… we're trained yeah in doing, like being a secretary for a year." RQD 2

And described different roles and responsibilities when on-call:

"…do you know seriously like, cause as the intern like, we're constantly asked to do family meetings on-call like, for patients we've never met, which is like absolutely outrageous…." RQD 2

RQDs moved from being a peripheral participant in their local physician CoP, to a more central position in an on-call CoP. Participants described having more involvement and responsibility in clinical decision-making about deteriorating patients and the communication which resulted from this. The often referred to out-of-hours scenarios where a seriously ill patient had deteriorated and there was an absence of documented plans for this eventuality:

"…there wasn't as clear documentation and those were obviously the more difficult scenarios to deal with because you don't have a senior opinion to guide you so you have to go on what the nurses are saying, on your own assessment and then on whatever advice you can get on the night…" RQD 8

They frequently expressed concern that in the absence of adequate information, their decisions might not be aligned with the wishes of the primary consultant and the practice of the local physician CoP:

"... you know the primary team are probably trying to guide the patient's care uh along a particular trajectory um and you don't get a handover on what that trajectory is, so you end up potentially changing the trajectory of their care in a way that might disagree with what was planned by the team." RQD11

Another SHO described a difficult situation that occurred at night where the most senior member of the on-call team could not be contacted:

" ... there are occasions where you, you have a redirection of care at, you know, out-of-hours, it could two in the morning, that you say, … this is not, this is not improving and this patient now needs palliation, needs more urgent symptom control … one time that it caused, um, a lot of almost conflict was, um, a patient…. who had become extremely unwell ... and basically became unresponsive and, kind of, alternated between being unresponsive and agitated overnight, and to me ... she needed symptom management, you know. We couldn't, I couldn't in in, conscientiously leave her like this. The problem is her, um, the consultant on-call wouldn't answer the phone for hours and hours, and I suppose at my stage, although I know the basics, starting, you know, a syringe driver or starting palliative measures, it's not up to me to make that call". RQD 6

The discontinuity between normal working hours and on-call highlights the differences between the practices of local physician CoPs and the need for better planning and documentation of intentions for care, including ceilings of care.

Despite the increased responsibilities and challenges that come with being on-call, one RQD described an opportunity that was sometimes presented to practise medicine differently:

"Participant: … Sometimes, on-call you do, um, if you're on-call and, you know, someone has their syringe driver, they're a palliative care patient, um, and you're called to, oh will you just review this patient … then you might just sit with them, be like oh how are you doing? … and they might chat with you or something and I feel like it's during on-call that you can have like um, like it's

your job, that's when it's your job to kind of comfort the patient in that moment, um, it's short but like I guess that's when I would do that. Yeah.

Interviewer: And what's the difference between that and the daytime? What makes it different at that time?

Participant: Because in the daytime I guess you have your seniors there, um, and they'll send you to do other things" RQD3

4.3.3 Interactions and learning from the specialist palliative care CoP

Exchanges of information in acute hospitals about patient care between the local physician CoP and the specialist palliative care (SPC) CoP were often through an interaction between a RQD (usually an intern) and the SPC clinical nurse specialist (CNS). It is standard practice for the SPC CNS to discuss the patients they review with the doctors in their SPC CoP and make recommendations back to the referring doctors. However, participants described considerable variability in the levels of interactions between RQDs and the SPC CNS. In some situations, there was an interaction in person between the two, but in others, interactions were mainly mediated through the use of reifications such as notes left in charts. According to many participants, recommendations made by the SPC CNS tended to be followed without questioning by anyone in the local physician CoP:

"Participant: I was just grateful that there was a palliative care nurse that knew what was going on and knew how to do It … I would see a yellow sticky note on the Kardex and then …make the changes, um, but always she would always put I suggest, I suggest, but to be honest I'd ah normally just follow it down to the letter, I wouldn't question what her suggestions were.

Interviewer: Yeah, and would anyone else question it further up the team?

Participant: No.

Interviewer: Would they look at it?

Participant: No. No-one had, um, no one in my team really had an interest in palliative medicine." RQD 5

In situations where there was verbal follow up (either in person or via a phone call) between the SPC CNS and the RQD, participants reported better opportunities for learning:

"…but I think a lot of what I've picked up has been from getting the consult from the CNS…. then closing that loop back to us and saying we're doing this because, and they always say because and they'll explain …" RQD 15

The SPC CNS was viewed as a welcome source of support by many RQDs:

"I suppose we are very well looked after in that palliative care are always at the end of the phone and very quick to come and very quick to give advice, that we are quite sheltered I suppose but well, supported I suppose is another word." RQD 14

In some circumstances the SPC CoP members were described as having more of a brokering role, facilitating the learning about EoL care and the adoption of practice across boundaries. The following excerpt was in the context of an oncology practice where in some situations the barriers between the two practices were likely to be lower:

"… the, um, palliative care clinical nurse specialist, along with, um, the palliative care consultant would come, and they review the patient, but they don't change the medications, they suggest … which then, I suppose, the primary consultant can either take on advice or ignore. Typically, they do take their advice always. ... as NCHDs we chart up everything, and just after doing it a few times you, kind of, get a bit more familiar … There was once or twice I've just started, made a decision clinically to start someone on a syringe driver … Now, they would have been already in the palliative route." RQD 6

Another SHO highlighted how through interactions with the SPC service he had learned more about identification of patients who were approaching death:

"I saw those decisions being made on a more frequent basis and the palliative care team in the hospital … we worked closely with them, a lot of patients went from our service to the hospice from there and I suppose I was exposed to it a lot more then and I probably felt as though that line became slightly more of something I understood, you know, from it being a known unknown to, I guess, a known known." RQD 11

RQDs who had experience of working in a SPC post in the local hospice were asked about what they had learned and might take with them when they joined other physician teams. They indicated they had learned about recognising dying, managing dying patients, communication and reading situations:

"I'll have a better sense of dying, first of all. So, if a patient comes into the emergency department um and you know you assess the patient and it looks like they are going to die, I feel I'll be more confident in managing the subtleties

of their own situation … I think I'll probably be better at reading patients and maybe some of the dynamics there and I'll be better at dealing with families and discussing ... breaking bad news and um and that's just an experience thing I suppose …" RQD 11

4.4 Discussion

4.4.1 Principal findings

For RQDs caring for patients at and approaching the EoL, the landscape of practice was difficult terrain requiring skilful negotiation. Participants regularly crossed boundaries as they moved between local physician CoPs and experienced a large amount of variation in the knowledge, attitudes, and skills of consultants in relation to EoL care. Some specialties and some local physician CoPs identified palliative care needs and dying earlier than others. For some, palliative and EoL care was a more recognised part of their regime of competence, and some referred to SPC services while others didn't. RQDs had to adjust to these differences as they navigated the landscape of practice. They had a variety of boundary encounters with the SPC team, usually through the SPC CNS. The SPC CNS was an important support for many RQDs, however learning and adoption of SPC practices in providing EoL management across boundaries was variable. The on-call landscape of practice was even more complex to navigate with RQDs taking up more central roles requiring a wider and deeper repertoire of practice, often in the absence of guiding information. In navigating these boundary crossings and encounters RQDs develop knowledgeability (Wenger-Trayner et al., 2015).

4.4.2 Boundary crossings and boundary encounters

Wenger-Trayner & Wenger-Trayner (2015, p. 18) contend that boundary encounters and boundary crossing provide rich opportunities for learning and developing knowledgeability and should be recognised as such by confronting *"explicitly the problematic nature of boundary crossing and the potential tensions or conflicts between practices as sources of accountability. It does so in order to bring out the potential of boundary encounters to generate new insights."* Therefore, it is important that medical educators recognise the challenges encountered by RQDs frequently changing physician teams and its potential impact on learning.

The decision that a patient was dying and to implement an EoL care approach resided with consultants. This is in keeping with recommendations (Neuberger, 2013), and RQDs widely recognised the appropriateness of this as they considered identification of dying to be a big decision. However, the resultant assortment of practices dictated by consultants' attitudes and approaches to EoL care that participants encountered had implications for how they experienced and engaged in practice on their trainee odyssey.

Some specialties were seen to be more likely to diagnose dying earlier or later. Surgical teams were identified by several RQDs as identifying dying late and not prioritising symptom management, resulting in delayed referrals to SPC and implementation of EoL care. This is consistent with other research (Olmsted *et al.*, 2014; Rodriguez *et al.*, 2015; Redman *et al.*, 2017; Lee *et al.*, 2019; Chapman *et al.*, 2021). Whereas other specialties, where patient deaths are more commonly encountered, were perceived to have greater competence in this area. Gerontology was often singled out as a specialty where EoL was managed well. Price & Schofield

(2015) reported similar findings, and they also singled out oncology as a specialty that supported learning about EoL care. In my study, participants reported considerable variation in oncologists' approaches, with some embracing the concept of early palliative care and others continuing active disease management until death was imminent. Variation in oncologists' approaches have been reported by others (Jackson et al., 2008). Differences in individual consultant's approaches regardless of specialty were frequently highlighted by participants in my study.

RQDs had to consider their practice when they joined a new physician team. RQDs typically have high levels of participation in these teams, and it seemed that those interviewed accepted without question that they would have to make changes to practice when they moved from one physician team to another. They described taking time to figure out how things were done in the new team and adapted their practice accordingly. This was particularly relevant in relation to EoL care, where the range of practices were wide. What is considered competent practice in one CoP may not be considered appropriate in another (Wenger-Trayner et al., 2015; Wenger, 1998).

According to Wenger (1998 p.149), *"there is a profound connection between identity and practice*". Hence, the adjustment of one's practice to align with that of a new team, is a renegotiation of identity and involves emotional work (Fenton-O'Creevy, Dimitriadis and Scobie, 2015). This is noteworthy when consideration is given to the fundamentally diverse approaches to EoL care that participants encountered on their training pathway. Crossing a boundary between one physician team and another requires a RQD to figure out how much of their previous practice they can take with them. An example of this can be seen in the case of RQD 7 who had experience of working in SPC and indicated that he would like to use a palliative care approach in

his future practice but anticipated that he would de-emphasise what he had learned when he moved to cardiology as that practice would not be regarded as appropriate. On their training journey, RQDs depend on consultants to sign off on logbooks and provide references, hence engagement and alignment with the practice of each physician team they join is necessary in order to progress through various checkpoints in the landscape (Royal College of Surgeons in Ireland, 2018; Royal College of Physicians of Ireland, 2019). Hence, there is pressure on RQDs to adapt and modify practice to fit in with the regime of competence of the new team when they cross a boundary.

My study also found that the landscape shifted and reshaped on-call and the dynamics were different. Inexperienced RQDs had to attend to acutely and seriously unwell patients that they didn't know. They had to change gears and get involved in decision-making and communication with and about these patients. A patient's situation might have changed very significantly over a brief period of time, and the approach being taken by the primary CoP was sometimes considered inappropriate for the patient's current situation. Other circumstances were described when patients deteriorated acutely, and ceilings of care had not been documented. The RQD was now working in an on-call CoP and often had to rely primarily on reifications such as the patient's clinical notes, which often lacked the necessary detail to guide decisions about patient management. RQDs found these situations particularly challenging as they tried to reconcile what they thought might be best for a patient with the perceived wishes of the primary consultant. The difficulties that RQDs experience in providing patient care out-of-hours is not restricted to EoL care (Zarkali *et al.*, 2014; Monrouxe *et al.*, 2017; Nagrecha, Rait and McNairn, 2020). The importance of documentation and handover in relation to EoL care for RQDs has been identified (Redman *et al.*, 2017).

The on-call landscape can present opportunities for significant learning as RQDs take on more responsibility (Cygler, Page and Ginsburg, 2021). There may also be an element of freedom presented to step off the beaten path away from completing tasks and from the oversight of those more senior as illustrated by RQD 3 where she described getting time to talk to a dying patient, in the way she had imagined as a medical student. In doing so she got to express an aspect of her identity that usually wasn't possible as it did not align with the practice of her community.

In the acute hospital setting, all RQDs had interactions at some point with the SPC service via the SPC consult service. From a LoP perspective this constitutes a boundary encounter. RQDs, on the instruction of their consultant, made referrals for consults to the specialist palliative care consult team (SPCCT) by completing the standardised referral form and making an accompanying phone call to the SPC CNS who acted as a broker between the two teams. Following assessment of a patient, the SPC CNS left a note in the patient's chart with recommendations, and sometimes followed up with a phone call or in person to explain the rationale for their recommendations.

The expertise of SPC services in EoL care was widely recognised by RQDs and the support of the SPC CNS was greatly appreciated. RQDs have identified SPCCT members in acute hospitals as an important source of support and informal learning about palliative and EoL care (Gibbins, McCoubrie and Forbes, 2011; Price and Schofield, 2015; Kawaguchi *et al.*, 2017; Redman *et al.*, 2017; Frearson, 2019). Their advice was generally followed without question, and it was the RQDs who implemented their recommendations. Verbal handovers from the SPC CNS were identified by participants as better learning opportunities than written

recommendations, and this was also reported by Price & Schofield (2015). Participants reported that while SPC CNS input might result in learning about basic prescription of EoL medication, it did not go as far as influencing broader changes in the practice of the referring team. Participants described experiences where some teams acted as though responsibility for EoL care of patients had been handed over to the SPC team in the hospital.

On their training journey through encountering and crossing multiple boundaries, participants experienced a wide range of practices of EoL care that influenced their development of knowledgeability about the place of EoL care within the LoP. Boundary crossings and encounters in relation to EoL care practice were problematic. van Duin et al. (2022) found that junior doctors' learning about interprofessional collaboration through boundary encounters was implicit and inadequate, and because it wasn't identified as an *"explicit learning goal"* it received little attention. There are parallels with EoL care which is not seen to be part of the core business of many physician teams and specialties and therefore is likely not to receive explicit attention.

The place of EoL care in the LoP and opportunities for the brokering role of SPC healthcare professionals to be enhanced to support learning and change EoL care practice will be explored in Chapter 7 (Discussion) of this thesis.

4.5 Conclusion

RQDs do a lot of identity work around EoL care as they navigate the LoP. Each physician team has its own practice around death and dying based on the consultant's preferences and there is wide variation in these. Upon joining a new team, RQDs have to figure out the lay of the land and adjust their engagement in practice. This results

in the emotional work of an ongoing renegotiation of identity. On-call, the landscape shifts and is often more obscured and challenging, however this also presents opportunities for engagement in practice, negotiation of identity and development of knowledgeability.

Chapter 5

Consultants' Perspectives on Supporting Recently Qualified Doctors' Workplace Learning about End of Life Care

"Doctors and nurses need to communicate with patients and relatives or carers far more honestly about the difficulties in diagnosing the dying phase, admitting to, and being explicit about uncertainty and dealing in likelihoods, not certainties. The need for good communication at all times in end of life care is an issue that arose."

(Neuberger, 2013, p.20)

5.1 Introduction

Postgraduate medical education is based on an apprenticeship model, where doctors in training learn on the job under the supervision of more senior practitioners (WFME, 2015). For recently qualified doctors (RQDs) in Ireland the majority of their early years of training takes place in acute hospitals under the supervision of consultants (Medical Council, n.d.)

A substantial amount of learning at postgraduate level in the workplace happens informally (Eraut, 2004, 2007; Wiese, Kilty and Bennett, 2018). Socio-cultural theories consider that learning cannot be separated from the social and cultural environment in which the learning occurs (Lave, 1988; Alfred, 2002). Hence from this perspective, RQDs learn about being a doctor and form their identities from the ways in which practice is or is not engaged in in their workplace communities of practice (CoPs)

(Wenger, 1998). Their training journey involves frequent moves, often every 3 or 6 months, to join new physician teams. Hence in their training they encounter and have to negotiate the culture of many CoPs. Their legitimacy in these CoPs determines what activities they participate in, and how and to what degree they are supported in learning about practice (Wenger, 1998).

Wiese, Kilty and Bennett, (2018) drew on CoP and other theories of learning in the workplace to generate a realist theory of supervised workplace-based learning in postgraduate medical education. They identified three processes by which trainees learn informally while doing the job: supervised participation in practice, mutual observation of practice and dialogue about practice. Each of these has two enabling mechanisms which are described below.

Supervised participation in practice includes entrustment by the supervisor and support seeking by the trainee. Entrustment is an important concept in medical training. Ten Cate et al. (2016, p. 196) identified a goal of medical education as *"readiness for unsupervised practice"* and posits that for trainees to develop this readiness, they require clinical experience, which includes being entrusted with patient care activities. Supervisors must make decisions about trusting individual trainees to perform a particular task and how much participation to allow (Ten Cate *et al.*, 2016; Wiese, Kilty and Bennett, 2018). There are several factors that influence entrustment decision-making, including supervisor and trainee characteristics, the relationship between the two, broader team characteristics, the nature of the task, the context and local culture and practice circumstances (Ten Cate *et al.*, 2016; Wiese, Kilty and Bennett, 2018).

According to Wiese, Kilty and Bennett, (2018), in addition to their role in entrustment, supervisors also facilitate learning in the clinical workplace through monitoring trainees and modelling practice (both consciously and unconsciously). Trainees can then assimilate what they have observed being modelled into their own practice. These two mechanisms constitute the mutual observation of practice learning process. The third process identified was dialogue about practice, which includes meaning making and feedback.

In considering RQD and medical student learning about end of life (EoL) care and their development of capability, it is important to consider how consultants support workplace learning in this complex area (Dornan *et al.*, 2018). EoL care presents many challenges in relation to diagnosis of dying and communication (Neuberger, 2013). Identifying that a patient is at the EoL can be difficult; frequently there is a period of uncertainty where a patient may be dying but reversible causes need to be ruled out. When a diagnosis of dying is made, it is often unclear when death is likely to occur. These factors make communication with patients and their families challenging. It is the responsibility of the consultant to make the decision that a patient is likely to be dying and to communicate uncertainty when it exists (Neuberger, 2013). Added to these challenges is the gravity of the information for those receiving it, the existential distress and suffering that it potentially brings, and the unpredictability of responses (Sajja and Puchalski, 2018; Tarbi *et al.*, 2021; Sallnow *et al.*, 2022).

Approximately half of deaths in Ireland occur in acute hospitals and around 75% of these deaths are expected (McKeown *et al.*, 2010). Those who die in this setting usually remain under the care of their primary consultants. Therefore there should be good opportunities for RQDs and medical students to learn informally about care of

patients approaching and at EoL in acute hospitals. What they learn is related to the practices they do or do not participate in in their consultant led teams. The perspectives of consultants have not been well studied to date and I identified this as an area I wanted to explore.

At some, if not multiple points in the weeks, days, or hours prior to the death of many patients, there are breaking bad news consultations. A considerable amount of the published literature on learning how to break bad news focuses on it as an initial event (Baile *et al.*, 2000; Vandekieft, 2001; Narayanan, Bista and Koshy, 2010). Research from patient and family perspectives support the importance of considering BBN as an ongoing process (Marschollek *et al.*, 2019; Brouwer *et al.*, 2021). This involves follow up after an initial BBN consultation and can include providing clarifications, dealing with further questions, and offering emotional support (Rabow and McPhee, 1999; Minichiello, Ling and Ucci, 2007). While consultants often deliver the initial bad news, RQDs may find themselves in a position where they are dealing with the aftermath of this.

Many BBN conversations that consultants engage in are not about imminent death. They may for example occur following an initial diagnosis of a potentially life-limiting illness, a sudden death, or detection of a fatal foetal anomaly. Therefore there are multiple opportunities across a wide range of clinical specialties for RQDs and medical students to learn about BBN. Hence informal learning about BBN in a wider context was considered for this research.

The aim of this study was to explore consultants' views on their role, experiences, and practices in supporting both NCHDs and medical students learning about EoL

decision-making and communication of bad news to patients and families. My research question was:

How do consultants support RQD and medical student informal learning about end of life care?

CoP theory and the realist theory of supervised workplace learning were used to provide insights into how this learning was or was not supported in the clinical learning environment. An overview of these is provided in Chapter 2.

5.2 Methodology

My epistemological position is presented in Chapter 2 (Conceptual Orientation and Methodology). In that chapter I also provide a detailed description of my methodology using Braun and Clarke's Reflexive Thematic Analysis, CoP, and the realist theory of supervised workplace learning.

5.2.1 Recruitment

I recruited consultants who were involved in clinical education of medical students in the teaching hospitals in Cork affiliated to University College Cork. Potential participants were identified in discussions with my supervisors DB and TO'B, and occasionally during conversations with those I had interviewed, and were purposively sampled to ensure a mix of specialties, hospitals, gender and career stages. I also sought to include participants who had experience of working in other healthcare systems. Potential participants were invited by email to participate. They were sent a participant information leaflet and consent form (Appendix D), which included information on the nature of the study, the voluntary nature of participation, and what was involved in taking part. Participants were recruited over a 26-month period and

recruitment was stopped when my supervisor DB and I judged that data sufficiency had been achieved.

5.2.2 Data collection

Semi structured interviews were conducted with all participants. A mix of in person and online video (using Microsoft Teams) was conducted. All interviews were audio recorded, transcribed verbatim and anonymised. Data collection was conducted concurrently with the RQD studies (Studies 1 and 2). Initial analysis of all three studies was commenced during the data collection phase. During this time, I familiarised myself with the content of interviews, made observations, performed some initial coding, and identified broad thematic areas. I reviewed, discussed, and reflected on early interviews and thematic areas that I was identifying with my supervisor DB.

When I initially conceptualised this study, my interest was in exploring how consultants supported RQDs' and medical students' learning about EoL care. As a result of observations and analysis during the data collection process, and in response the areas that RQDs were identifying as most challenging, the interview guide was iteratively modified as the study progressed. Thus, the focus moved more towards how consultants supported RQD and medical student learning about decision-making at the EoL and communication of bad news to seriously ill patients and their families. Another change was the introduction of a question about consultants' level of comfort with being observed while engaging in conversations with patients or families around the diagnosis of dying or EoL care. The final interview guide is included as Appendix E. All data were handled and stored in compliance with UCC data management requirements (*UCC Research Data Service*, n.d.).

5.2.3 Data analysis

Data was analysed using Braun and Clarke's 6 phases of Reflexive Thematic Analysis (Braun and Clarke, 2006, 2019, n.d.). As described in some detail in Chapter 2 and informed by Braun & Clarke (2006), I adopted an inductive, latent, and constructionist approach to data analysis, which was guided by my ontological position and research question. CoP theory was used from the conceptual stage of this study. The theory of supervised workplace-based learning theories was applied during the analysis phase. A detailed account of the analysis process and my supervisors' involvement in it is provided in Chapter 2.

5.2.4 Ethics

Ethics approval for this study was sought and granted by the Social Research Ethics Committee (SREC) in UCC (Appendix F). After the first 4 interviews had been completed, due to restrictions imposed in response to the Covid-19 pandemic, an amendment was granted by SREC to allow online interviews using UCC Licensed Microsoft Teams software.

As I worked in the School of Medicine, I was conscious that individuals who had honorary or academic appointments might feel some obligation to participate in my research. I was not in a position of power in relation to any potential participants in this study. I took care with the wording I used in emails inviting individuals to participate and did not follow up if I didn't get a response to an initial email. Given that participants were experienced doctors at consultant level and the nature of the questions I was asking them, I did not consider that participants were likely to need support following interviews. I explained at the outset of interviews that the participant could choose not

to answer questions or to terminate the interview at any time and to withdraw their data within 2 weeks of completion of the interview.

5.2.5 Reflexivity

I engaged in reflexivity throughout all stages of this study. Details of my position in relation to this subject area and the participants in this study is detailed in Chapter 2 (Conceptual Orientation and Methodology). I consulted with my supervisors DB and TO'B regularly during the analysis phase, via online and face to face meetings and email. My supervisors provided advice, insights, and feedback during the data analysis process by reviewing transcripts, codes, themes and the write up of drafts of this study. My reflexivity and that of my supervisors was supported through this reciprocal engagement as we sought to consider and reflect on interpretation of the data and presentation of its analysis. In addition, I kept a reflexive diary throughout the research process.

5.3 Results

I conducted 14 interviews between November 2019 and Dec 2021. Participants included consultants across a range of disciplines at a variety of levels of experience and seniority (including professors, department heads and honorary senior lecturers). The participants had appointments to larger and smaller, public, and private sector hospitals. All participants had spent time working abroad. Countries where participants had worked included England, Scotland, USA, Canada, and Australia. Four had been consultants for over 20 years, eight had been consultants for between 5 and 20 years and two had been consultants for less than five years. Table 5.1 summarises participants gender, specialty, career stage and duration of interviews and represents the order in which interviews were conducted.

Table 5.1: Participant demographics and interview duration

Order	Overall interview order*	Specialty	Gender	Duration(M:S)
1	1	Palliative Medicine	Female	23:07
2	2	Emergency Medicine	Male	40:52
3	6	Geriatric Medicine	Male	34:43
4	8	Emergency Medicine	Male	49:44
5	13	Geriatric Medicine	Female	30:30
6	14	Neonatology	Male	64:05
7	15	Obstetrics & Gyaecology	Female	62:39
8	18	Paediatrics	Female	33:25
9	22	Oncology	Female	22:58
10	23	Palliative care	Female	43:15
11	26	Gastroenterology	Male	54:30
12	27	Renal Medicine	Female	38:52
13	28	Surgery	Male	40:20
14	29	Oncology	Male	39:49

*Out of 29 interviews conducted in studies 1 and 2

Three themes were identified that addressed the research question: *intentional strategies to support learning, trusting the learner, and tacit learning.* An overview of these themes and their subthemes is summarised in Figure 5.1.

The *intentional strategies to support learning* theme had two subthemes: *opportunities to observe and participate* and *revealing thought processes*. This theme considers how participants consciously supported learning. The subthemes describe how participants went about doing this by providing opportunities to observe or participate in practice and deliberately explaining their thoughts and rationale. *Trusting the learner* relates to how entrustment decisions were made and had two subthemes: *recognising risk and accountability in high stakes encounters*, and *working with hierarchies of trustworthiness and legitimacy*. These subthemes consider a range of factors that

influenced participants' trust of learners, including hazards associated with BBN, responsibility to patients and learners, and the seniority of trainees. *Tacit learning* considers potential unintentional messages and learning and had two subthemes: w*hat's done in practice* and r*ecognising the value to the learner*. Both of these subthemes look at how consultants' supervision of trainees and medical students in EoL care contexts might have inadvertent consequences for learning.

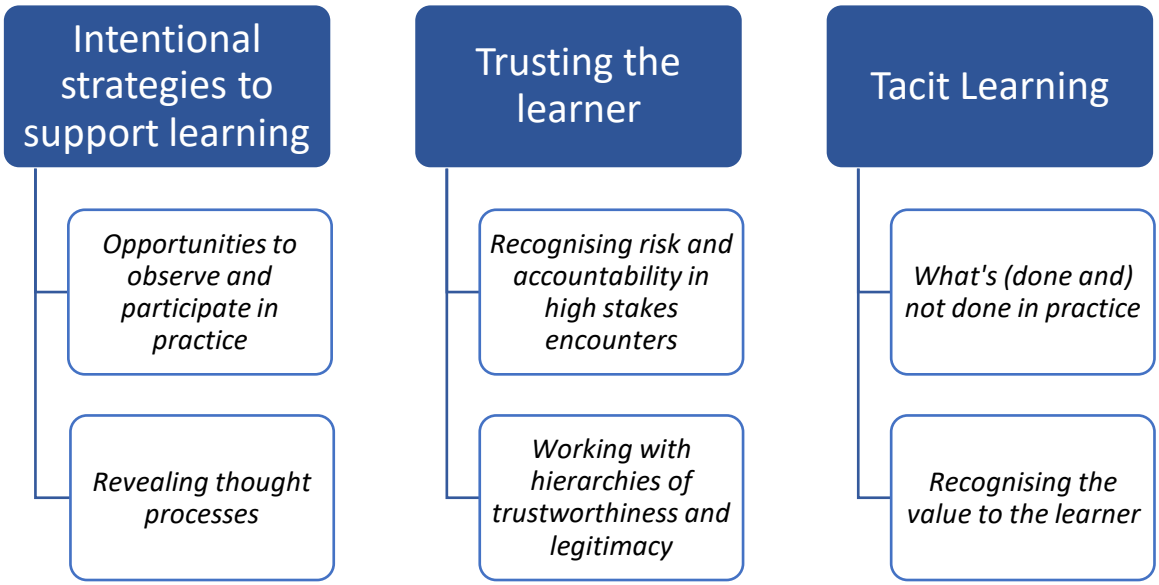


Figure 5.1: Overview of themes and subthemes.

5.3.1 Intentional strategies to support learning

Opportunities to observe and participate in practice

Participants reported that they had developed their own knowledge and skills in breaking bad news from watching it done well and badly by others and through their own trial and error. Some talked about the importance of trainees having opportunities

to observe BBN consultations to learn from the experiences of witnessing a variety of approaches to delivering it:

> *"I think that what is important really is that, as a trainee that you observe how different people actually have those conversations, learn what you think worked well and what didn't work well and then craft your own, sort of, style I suppose …." (Consultant 9)*

And also, to learn from seeing different reactions of patients and relatives to receiving such news:

> *"… and the families we're dealing with are all very different and so exposure to the, the variation in that is important for our trainees." (Consultant 6)*

Some described how they modelled good practice that they considered could not be taught as effectively in other ways, thus providing opportunities for observers to gain insights into this nuanced and complex area of practice. One consultant described how she consciously displayed good communication skills on ward rounds in an EoL care context:

> *"… and then model to them how you might engage the dialogue with family around that and what kind of words you would use, you know having a conversation outside the room in case the unconscious patient can hear you for example. All those pieces of learning, yeah so, I mean they do have an opportunity to learn very profound practices actually…" (Consultant 1)*

Another identified how a student or trainee might learn about communicating clearly and carefully, and to respond to patients and families' questions and emotions by sitting in with her for an BBN encounter:

> *"... but are they going to be able to explain that appropriately, as black and white as is necessary, and giving people the time? That's the bit that people learn from sitting in with you, is how you manage that… how you deal with the anger and how you deal with the emotion …. And that's something I think that you only, you learn. I mean sometimes some people are better at it than others intrinsically, but you learn that as you go along, you learn the impact of your words." (Consultant 7)*

However, as illustrated by the above quote, it was considered by many that there was more potential learning from participation than observation. A few participants, mindful of trainees learning needs, said that they would occasionally make a deliberate decision to allow an NCHD to take the lead in BBN conversations:

> *"… the Registrar would, would go in generally …. I'd get them to lead it, if I want them to, kind of practice that." (Consultant 5)*

Where learning in this area was intentionally supported by participants, it was more commonly through observation than participation.

Practical considerations, such as a lack of suitable facilities and time constraints impacted on the provision of opportunities for trainees or medical students to be present. The physical environment is considered an essential element of setting up BBN encounters (Buckman, 1992). Finding a suitable private and quiet space in which

to have difficult conversations was another challenge highlighted by several participants and this acted as a barrier to having trainees or medical students present:

> *"…usually it's the nurse manager's office, that's the breaking bad news office, it's the multifunction, it's the only room that's not a clinically in use room, and sometimes there, there's only seating for two or three, so by definition they can't go in." (Consultant 5)*

Rather than risk overcrowding the room during a sensitive conversation, many consultants described limiting the numbers of medical personnel present. The time pressures described by many participants sometimes resulted in concerns with getting the job done efficiently rather than identifying learning opportunities for NCHDs, which might have added to the time needed to perform the task:

> *"I think we could probably do a better job of that here, if you know what I mean. Things tend to be quite busy in the hospital and then we end up just trying to get the job done sometimes rather than saying 'let's think about who we should have here from a training perspective' and that's a little unfortunate." (Consultant 9)*

The lack of identification of the need for suitable facilities and prioritisation of time for such conversations in hospitals, represents a wider healthcare and organisational history and culture where the importance of this aspect of patient and family care is not recognised and therefore not prioritised.

Revealing thought processes

Some consultants, not relying solely on observation to guide learning in these aspects of patient care, described having deliberate discussions about decision-making and approaches to BBN with NCHDs. One consultant described how he deliberately set about supporting learning in relation to the complex area of goals of care decision-making with NCHDs:

> *"It's difficult to learn it, it took me a long time to learn it, um working in oncology coming up as a junior doctor and even as a consultant, to be able to recognize when the goals should shift. So, it's important to kind of talk about that with the junior doctors and say, 'right what are, what should our goals be at this point and what's a realistic expectation at this point for this patient?'" (Consultant 14)*

Planned encounters with patients and families provided opportunities for this type of learning. Discussions could take place before and after the encounter, which facilitated students or trainees in gaining understanding of how decisions were made and how to approach these conversations. While there were some consultants who described using this approach with RQDs and medical students, it was more commonly used with senior trainees:

> *"I would come up to the Registrar before going in to say; this is what I'm going to say, this is our narrative, this is what I'm going to do. And then we would sort of had maybe five minutes on our own, afterwards and say to each other: 'well, what are we going to do now?' Or 'did that go badly or well?', 'What shall we do now?' So, yes, I very much viewed it as a training opportunity for the Registrar, yes, very much so. (Consultant 11)*

These approaches constitute meaning making activities and often involved consultants using questions to bring trainees attention to relevant information (Wiese, Kilty and Bennett, 2018). They also allowed nuanced areas of decision-making to be explored. Scaffolding learning in this way has also been identified as a useful way to support medical students to develop capability (Dornan *et al.*, 2018). While these encounters could have presented opportunities for consultants to canvas trainees' opinions on a patient's condition to inform consultants in EoL decision-making as recommended by the General Medical Council (2010), participants did not identify this as their purpose.

5.3.2 Trusting the learner

Recognising risk and accountability in high stakes encounters

A conversation with a patient and family about approaching EoL and changes in the focus of care, was viewed as a challenging task and the responsibility of a senior doctor. Most participants wanted to lead these conversations and were reluctant to delegate them. Other conversations that were considered more straightforward or routine (such as giving results that didn't alter prognosis or even resuscitation status) might be assigned to those who were more peripheral in the CoP:

> *"In terms of leading those conversations, and I would say that would be the hardest part of my role to relinquish …. there's lots that you know, I have a bond with em … and I would find it very hard to have that conversation ... it's a very definitive conversation where you need to make a decision about goals you know. Resuscitation and things yes, so registrars all the time would discuss resuscitation status, which is a more straightforward thing …" (Consultant 12)*

It was widely considered by participants that to communicate bad news well, required learning, skill, and experience:

> *"You know this is not something that comes naturally to everybody either and it's something that I would say very much that, yeah, I'm still learning all the time as to how to get this right, and I do things a little different now than I did ten years ago, and similarly than I did fifteen years ago before I was a consultant." (Consultant 7)*

Many participants acknowledged that even for experienced practitioners, communication of bad news could be challenging and complicated, and the response of patients and their loved ones to it unpredictable. It had the potential to have a significant emotional impact on the doctor delivering it:

> *"… sometimes these conversations are going to go badly no matter how prepared you are and how experienced you are. So, you know, the difficult conversation doesn't always end in a nice neat conclusion and a consensus doesn't always happen, and that can be very difficult to deal with." (Consultant 11)*

An additional challenge was posed by uncertainty in prognostication:

> *"I think my challenges are those kind of medical challenges where, you know, you're 99% sure this person is dying today and you want to prepare the family, and yet there's a little thing at the back of your head saying: 'well what if they don't?', and I've certainly got it wrong at times … my worry is really about the technical aspects of it." (Consultant 5).*

It was notable that those who were asked, without exception, indicated that they felt confident in their abilities to conduct these conversations. However, some indicated that having students or RQDs observing them, added extra complexity:

> *"… and again in some ways it's easier for me to do those without a student present because um I'm, when I have a student present I have to think about um you know how this conversation is impacting on the loved one or the family, but also am I doing a good job you know, am I doing a good job in terms of being medically correct, and am I being professional and so on in front of the student. So, I did find it a little more challenging at the start …" (Consultant 14)*

It wasn't just trainee participation that was risky, allowing trainees or medical students to be present to observe also carried risks. A key factor considered when identifying trustworthiness, was knowing the trainee or medical student. What their capabilities were, and how they might react to witnessing a difficult encounter with a patient or their family. Medical students were more of an unknown quantity. Having a student on placement with a consultant for a sufficient length of time afforded more opportunity for a relationship to form and for them to develop legitimacy in the local physician CoP and be entrusted to observe practice:

> *"I think you know, I guess initially they should participate on very little until you see them in action em….and to make sure that they understand what their role is, you check what their goals are, what they want to learn, but also maybe where their deficits are. By right, you know within a few days …" (Consultant 12)*

Knowing the individual learner was particularly relevant in relation to the perceived potential risks of exposure to EoL care. A few participants mentioned the possible negative emotional impact of observing sad and difficult situations. Some were concerned that a lack of knowledge could result in misunderstanding of the context for decisions and could lead to misconceptions that certain actions or decision about care were hastening or causing death:

> *"… and more so for the student, you know in one sense, because something might be very obvious to them, that isn't obvious at all you know? And the detail, they're not aware of, and so they their perception of what has happened … is wrong or potentially wrong. So, they don't get the really important nuances that, that a more senior person gets. And that's one of my fears always, is that somebody eh leaves and thinks, they just they did something here you know? And it's like no, but it's the opposite of what you're actually thinking you know?" (Consultant 6)*

Participants identified reasons why they didn't get to know medical students sufficiently well, including short placements and increased numbers of students. Another factor was the configuration of physician teams into larger specialty-based entities with several students attached, rather than a smaller team led by a single consultant with one or two students. Addressing potential misunderstandings in these situations would require consultants or other senior doctors on the team to engage in debriefing students following these events.

Accountability is a key factor in entrustment decisions (Ten Cate *et al.*, 2016). Most participants identified their accountability as first and foremost to patient care. Learning needs of trainees and medical students were secondary to this. This clear

identification of responsibility to patient care determined consultants' approaches to the provision of learning opportunities to RQDs and medical students.

There was substantial evidence that participants considered the diagnosis of dying to be a critical decision and one that should be made by a consultant. This is acknowledged to be appropriate practice and in keeping with recommendations (Neuberger, 2013). Similarly, communication of bad news, particularly in relation to approaching death with patients and/or their families appeared for many participants to be a part of the enterprise that was too crucial to entrust to those more junior. Participants accounts suggest that they were particularly sensitive to their accountability to patients and families when it came to communication that a patient was approaching death and that the focus of care would be changing:

> *"You know, these are once in a lifetime things for that family. They're things that happen to us a lot and we need to remember that all the time you know? So, for that family, that's one moment in their life that they will never forget you know?" (Consultant 6)*

Participants often highlighted a need to protect seriously ill and dying patients and their families from excessive numbers of observers during BBN conversations. They were cognisant of the additional stress that having RQDs and medical students present might cause during these interactions.

> *"… we had somebody who had been admitted the day before who deteriorated maybe rather quickly, quicker than we would have expected and he was unconscious and clearly dying yesterday morning with a very distressed family sitting with him and it would have felt intrusive." (Consultant 1)*

Perceptions and experiences of patients and families were considered to be important. Some consultants spoke about putting themselves in the shoes of the patient/family and the influence this had on their practice. One consultant spoke about the challenges of having additional observers such as medical students or RQDs at BBN in the emergency department:

> *" ….. let's imagine it's you with your spouse or your, one of your children or, you know, and something terrible has happened to them, you know. Um, now sit in that seat for a minute, do you want to see a consultant come in or, certainly someone very senior like, you want to see that? Um, do you want to see a whole bunch of people coming in otherwise?" (Consultant 4)*

Along with protection of patients and families at vulnerable times, there were other considerations for restricting numbers of observers. One consultant identified another aspect of accountability in terms of the potential therapeutic benefit of a consultation being limited if too many people were present:

> *"The patient's wellbeing has to come before teaching, yes, you take every opportunity to teach but the patient's wellbeing has to come before that and if there is incidences where you feel they are really uncomfortable and they won't get the benefit of having that therapeutic relationship and those conversations you have to ask that the junior doctors and students step outside." (Consultant 10)*

For a small number of participants, the importance of these encounters as learning opportunities for medical students were identified and balanced against the potential

risk to patients. These individuals took an approach of including patients and families in decision-making about students being present during EoL consultations:

> *"I would always have had the worry that the relatives would feel that we were in some way taking advantage of their parent's or their loved one's death you know and using it as a teaching opportunity. That they might feel that that cheapens the death or so on. But actually, again I've tried to move away from that and just actually not made decisions on behalf of patients and relatives and actually kind of broached the subject in a 'we have students with us on the ward round is it OK if they come in?' and we have started to bring the students into those rooms." (Consultant 14)*

Working with hierarchies of trustworthiness and legitimacy

In many instances, perceived legitimacy with respect to the local physician CoP was a key factor in determining who was entrusted with an opportunity to observe or participate in practice when consultants were interacting with a patient or family in a BBN or EoL conversation. Several consultants described an assumed stratification of NCHDs in terms of seniority and hence legitimacy, which often determined who got exposure to these scenarios. It was common for only those who were judged to be able to meaningfully contribute to the encounter in some way, often the most senior NCHD and the nurse in charge to be present for these types of interactions with patients and their families:

> *"I would bring the most senior of the junior team, the registrar, usually, and the most senior nurse available, as part of a sort of trio who would conduct these so-called difficult conversations ... I would bring the Registrar along as the*

person who might be able to fill in if I was caught out on 'but what did mummy's ECHO show?'" (Consultant 11)

Or those who were most senior and on an inward trajectory into the specialist CoP:

"… you kind of know the registrar is very imminently is going to have to be the one having this conversation, so you want to make sure that they are competent, you know, because they're your geriatric trainee, they're going to be your colleague in four years' time or three years' time." (Consultant 5)

Hence specialist registrars and registrars were usually chosen for these experiences, whereas RQDs were not often given opportunities to witness these interactions. Interns in particular were considered to be in service type roles:

"… the interns are used for service, you know, for jobs that don't need to be done by interns." (Consultant 9)

However, considering legitimacy in isolation does not represent the complexity of practice. In the real world, patients' conditions can deteriorate rapidly, and doctors are busy. Occasionally impromptu discussions of this nature occurred on ward rounds or in an unplanned manner when RQDs or medical students were present. Hence, opportunism sometimes played a part in who was given a chance to observe these conversations:

"… it is really whoever is engaged with the case, you know, and who is available, so I don't have a problem with anybody coming in if they are knowledgeable of the case and if they are around" (Consultant 9)

5.3.3 Tacit learning

What's not done in practice

To provide good EoL care it is important where possible to identify dying in a timely manner and have appropriate conversations with patients, families and those involved in providing healthcare to the patient (Ryan *et al.*, 2014; Sallnow *et al.*, 2022). There were several factors identified that had the potential to mitigate against timely identification of dying. A senior consultant who had given this topic a lot of consideration, spoke about possible reasons for late or lack of identification of dying and avoidance of discussions about EoL, that from his experience were all too common:

> *"… I don't know why there's this resistance. Is there this feeling that, you know, death is somehow a failure of our technological intervention? I can understand the major obstacles to this conversation are logistical. The average chest, cardiology, liver clinic, 50, 60, 70, people; where are you going to have this conversation? When? With who? How? So I think that's maybe the major obstacle to it; people just don't have the time, they don't have the sort of spiritual or psychic energy to go off doing that on a regular basis, you know? And it's not viewed as a core part of our job, is it? Nobody is saying 'this is a core part of your job'… This is not a difficult conversation, this is an essential conversation, and it's not a once-off conversation at a time of crisis near the very end; it's a process and it goes on and it should begin as soon as possible." (Consultant 11)*

Participants considered that prognostication and recognising dying were challenges. One consultant commented on how deterioration in patients with chronic conditions might go unnoticed:

> *"… it's more the people I think that are coming in and out of the hospital, you know getting an antibiotic for a week, going home again. I think it's those people that you know, I guess maybe fall under the radar and they're not as obviously dying as somebody with metastatic cancer." (Consultant 12)*

Another commented on how in an oncology setting, long term relationships with patients could cloud a doctor's vision:

> *"I find it's very easy for me to recognize when the goals have changed on one of my colleagues' patients. It's very easy to be very kind of um objective and unemotional when you're dealing with your colleagues' patients … and I find it much more difficult to recognise when it's my patient, and of course some of these patients might be here 11 years … so you get a little bit, you get ah a little bit of tunnel vision, you can't see what's happening…" (Consultant 14)*

If the approaching deaths of patients with life-limiting illnesses are not identified until late, and proactive communication with patients and their families is not part of the practice of many physician teams, these will not be considered part of the repertoire of practice or an important competence for doctors outside of a few notable specialties. This has important implications for RQD and medical student learning and is likely to result in tacit learning that timely identification of dying and communication of this to the relevant parties is not something that needs to concern them.

Recognising the value to the learner

There was substantial variation in what participants considered to be the value of teaching RQDs and medical students about communication of bad news, identification of the approaching death of a patient or communication at the EoL. For many participants it appeared to receive little attention, for few it was considered important. One consultant in a discussion about RQD learning stated:

> *"But I wouldn't, I'd probably teach more about other topics than that you know, like if I'm teaching, I probably don't to be honest think about that as being something that I would prioritise for them to teach on the day." (Consultant 12)*

Several participants did not seem to regard learning about EoL care, and in particular communication of BBN or discussions about goals of care as particularly relevant for RQDs or medical students. It tended to be considered more useful for more senior NCHDs:

> *"…. then maybe it percolates down a bit to the SHO, um, whereas, it's awful, but I actually think that probably I don't think about the intern needing to know that as a skill, … they are very busy, they've lots of other jobs to do, so unfortunately … we probably say go off and will you run down to x-ray and book that MRI now and we're going to go into the person who's dying…. And the problem is then, when do they learn, you know, at some stage then they are that Registrar and they've been blocked from it, yeah." (Consultant 5)*

Many participants did not appear to consider out-of-hours scenarios where RQDs might be in a position where they had to step up to have conversations about changes in goals of care or a diagnosis of dying. In the course of the interviews, several

participants appeared to be prompted to think in more practical terms about the value of learning about EoL care and the need to prepare RQDs to have these conversations. This finding suggested that this was not something they had given a much thought to previously:

> *"… and some of them are very good, maybe we should be getting them to do it a bit more… You're making me think then we expect them to suddenly be able to do it when they're consultants… Maybe we should be letting them do that a bit more." (Consultant 8)*

Most participants did not identify learning about EoL care as being relevant to medical students. For a minority of consultants, including but not limited to those in palliative medicine, it was considered an important aspect of learning on placement. However, some of those in specialties that commonly provided care to patients with chronic and life-limiting illnesses, and who appeared to engage with proactive management of patients approaching the EoL in their own practice, did not identify this as a key area of learning for medical students, especially when balanced against patients' needs. One consultant in gerontology, where death is a relatively common occurrence, described her approach on ward rounds when a patient was actively dying:

> *"… I think that's what I do, over and over again, I leave them outside on the corridor because I, I, it's not that I didn't, I never thought of their learning need. Again, I overly focused on the family and what it looks like to have a troop coming in." (Consultant 5)*

Another consultant who frequently cared for patients with life-limiting illness described her thoughts on having medical students witness BBN conversations:

"I guess I wouldn't have thought that this was a high yield learning opportunity for them, or you know, I guess I'm probably more fixated on the patient and breaking it to them and discussing with the family." (Consultant 12)

This suggests that in relation to EoL care, what may be seen as a part of the enterprise of a local physician CoP, is not always identified as important learning for medical students. Another consultant described how on deeper reflection his thoughts had evolved:

"Now they don't from a medical point of view, they don't learn a lot in those rooms because frequently the patient is unresponsive.... Um and to me our interventions are relatively simple… But I realised then that for the student it's very important that they see how the approach changes at the end of life and how the focus becomes very much on symptom control and quality, and how we still have to treat the person with respect and dignity. And I think um the students hopefully see that that relationship remains there even when the patient is dying and beyond death as well with the family ..." (Consultant 14)

This consultant, reflecting on his role in patient care and his role as an educator, had become aware that practice which initially might not be seen to be a priority for student learning, was in fact important. It is noteworthy that this consultant was working in oncology, where boundaries between practice may be lower with respect to palliative care than in many other specialties.

There was evidence from interviews that accountability to a specialty level CoP impacted on what was viewed as valuable learning and perhaps subconsciously influenced perceptions of the value of students learning about EoL care. In order that

students might view the specialty in a positive light and consider it as a possible career option, it seems that some consultants may have unconsciously directed students towards patients who were doing well and away from those who were approaching or at EoL:

> *"… what's in the back of your head is you want, you know, you're thinking of med students potentially being the future consultant in geriatric medicine, you're always trying to, promote, … so, if you had actually patients dying, you know, or a few patients dying on the ward, if anything you would not be highlighting that because you're trying to be very positive, you're trying to show the person who came in very unwell and after rehabilitation and good comprehensive assessment how they improved. You're kind of trying to promote that positive image… So, that may actually subconsciously influence us a little bit as well…" (Consultant 5)*

This can be seen as a reflection of contemporary healthcare culture, where death is seen as a failure of medicine and something shameful to be hidden from view (Sallnow *et al.*, 2022).

If workplace learning about EoL care is not recognised as valuable and not supported, and in some instances a hidden part of the enterprise of the local physician CoP, there is likely to be tacit learning that EoL care is less important than other aspects of patient care.

5.4 Discussion

5.4.1 Principal findings

Participants described supporting learning about EoL decision-making and communication of bad news through the provision of opportunities to observe and participate in practice. Some also described talking through their decision-making thought processes with more junior doctors on their teams. However, breaking bad news was considered a critical task and the bar was set high for entrustment. When participants described supporting learning, it was often restricted to observation by the most senior NCHDs. The need for RQDs' to learn about this area was frequently under-recognised and those most junior (interns) were not given access to learning opportunities. Furthermore, EoL care was generally not identified as a key area of learning for medical students and this, along with their lack of established relationships with consultants and low level of legitimacy on physician teams limited opportunities for learning about EoL care on clinical placements. The lack of supported learning for RQDs and medical students in these areas can lead to tacit learning and has implications for the development of capability. Participants also identified reasons for late diagnosis of dying and delayed communication of this to patients and families, which have additional implications for RQD and medical student learning.

5.4.2 End of life care communication is a critical task

Several factors impact on entrustment decisions in the workplace and clinical tasks that are complex, uncertain or carry risk are less likely to be entrusted (Ten Cate *et al.*, 2016; Wiese, Kilty and Bennett, 2018). Breaking bad news is one such task. Participants described several factors that influenced entrustment decisions in communication of bad news and at the end of life. These included consultants' sense

of their responsibility to patients, prognostication difficulties, skills required for BBN, unpredictability of patients' and families' responses to receiving bad news, and trainees'/medical students' level of legitimacy.

Several factors contribute to the complexity of communication of bad news to patients approaching and at the EoL and their families. Breaking bad news can be stressful for doctors (Shaw, Brown and Dunn, 2013; Studer, Danuser and Gomez, 2017). Even in the last days and weeks of life, there is inherent uncertainty in prognostication. Despite the development of various algorithms and tools, predicting the timing of death is inexact and continues to rely on clinical judgement (Chu, White and Stone, 2019). It has been recommended that this uncertainty be acknowledged in conversations with patients and families, but this is often not adequately done (Neuberger, 2013). Further considerations include the skills needed to communicate with sensitivity and honesty in appropriate language for the patient. Concerns about the patient's and the doctor's response are also relevant (Stanford School of Medicine, n.d.; Buckman, 1984). There are potentially multiple risks in entrusting this task. There is a risk that if not done well, damage will be done to a patient or a family. Risk to patient safety raises the bar for entrustment (Ten Cate *et al.*, 2016; Holzhausen *et al.*, 2017). If things do not go well there is potential to damage the consultant-patient relationship, the reputation of the consultant, hospital, or medical profession, and to harm the trainee (Buckman, 1984; Fallowfield, 1993).

The findings of this study suggest that participants considered communication of bad news, particularly at the EoL to be an area of practice that was too critical to entrust to RQDs, and often they were not afforded opportunities to observe, much less participate in such interactions. Another factor mitigating against entrustment may be

that this is a task that if not going well, is difficult for a supervisor to intervene in or take over. When something has been said it cannot be unsaid. Participants also seemed conscious of the message conveyed to patients and their family members if they delegated this task. Perceived risk to stakeholders of allowing medical students and RQDs to observe communication of bad news warrants further exploration.

5.4.3 Providing opportunities to learn

Observation of supervisors' practice is a key mechanism identified in workplace learning (Wiese, Kilty and Bennett, 2018). Through observation, practice can be modelled and integrated either unconsciously or consciously into trainees' own practice. Modelling has been identified to be particularly relevant for developing knowledge, skills, and attitudes about communication (Wright and Carrese, 2001; Passi *et al.*, 2013; Côté and Laughrea, 2014). While observation is an opportunity to learn, its affordances are limited when compared to participation. According to Wenger (1998, p. 100):

> Observation can be useful, but only as a prelude to actual engagement. To open up a practice, peripheral participation must provide access to all three dimensions of a practice: to mutual engagement with other members, to their actions and their negotiation of the enterprise, and to the repertoire in use.

Some participants described how they supported learning by deliberately providing opportunities for RQDs or medical students to observe elements of practice such as BBN conversations. These chances to observe were however frequently reserved for senior NCHDs who were more central in the local physician CoP. Opportunities to participate in supervised BBN conversations were occasionally afforded to more

senior NCHDs. The focus on observation and participation opportunities for senior trainees suggests that legitimacy and hence entrustment for this task was often based on the level of training rather than what was perceived as individual trainee capabilities. Presumptive entrustment based on seniority has been reported by others (Tiyyagura *et al.*, 2014; Ten Cate *et al.*, 2016).

In considering observation of modelling of communication skills, it is important to note that those observing need to know how to discern what has been done well from what was not optimal. For example, not upsetting a patient might be construed as a sign of good practice in a BBN consultation, when in fact the patient has not properly understood what was said or was not supported to express emotions, both of which are considered key elements of BBN (Baile *et al.*, 2000). Hence considering other elements of education such as facilitation of debriefs and theoretical knowledge of communication frameworks, are important in supporting appropriate learning from modelling. The time needed to debrief learners following observation of decision-making or BBN communication is likely to be a barrier to busy doctors engaging in this.

Participants were protective of patients and families and often made presumptions that having RQDs or medical students present for certain conversations would be intrusive or could send out the wrong message. This raises the question of whether consultants were overly protective in some circumstances and if more consideration should be given to involving patients and families in decision-making about who might be permitted to be present. There is evidence that patients with life-limiting illnesses approaching the end of life are often well disposed to being involved in medical education and can find it personally beneficial (Finlay, Maughan and Williams, 2005;

Arolker *et al.*, 2010; Hayes, 2012; Harris *et al.*, 2015). There are limitations in the applicability of these studies to the imminently dying scenario. Furthermore family perspectives have not been well studied to date. However, it appears that with careful consideration of situations and attention to obtaining appropriate consent, more RQDs and medical students could be allowed opportunities to observe these types of interactions.

To deliberately support learning in a potentially risky area, a supervisor must see the value in taking a risk. If value to the learner is not identified, there is little point in adding potential challenges to an already unpredictable situation. Several participants identified the value of having a senior trainee present at BBN consultations, both from a trainee learning perspective and to support the consultant in terms of filling in knowledge gaps about the individual patient. Fewer appeared to identify a significant learning value for RQDs, particularly interns in observing these interactions and fewer still considered learning about EoL care to be of relevance to medical students.

Discussions with many participants indicated that they did not consider that RQDs needed to know about this area of patient care to any significant extent. This influenced their decisions about providing opportunities to observe practice. From a CoP theory viewpoint, the lack of access for RQDs to this area of the practice of the community represents marginalisation, as it prevents the possibility of engagement in practice and learning (Wenger, 1998). The interview process appeared to have prompted several participants to reflect on the need for RQDs to understand decisions that were being made and to learn about communication of bad news. Drawing consultants' attention to this aspect of the RQD role might result in consultants seeking opportunities for RQDs to observe and even to participate in BBN consultations. In

addition, it could highlight the usefulness of explaining decision-making processes around goals of care towards the EoL with RQDs.

Some participants consciously taught trainees and medical students about decision-making by deliberately discussing their thought processes in relation to EoL care. The use of dialogue to make sense of situations allows trainees to gain new insights and can facilitate the development of clinical reasoning skills (Wiese, Kilty and Bennett, 2018). Sharing of thoughts by the expert with those more peripheral in the workplace is a way of providing insights into the shared repertoire of practice of a CoP, thereby providing access to the community, and increasing legitimacy. Wenger (1998, p. 100) states: *"… there is a big difference between a lesson that is about the practice that takes place outside of it, and explanations and stories that are part of the practice and take place within it."*

5.4.4 Unintentional learning

Informal workplace learning is very powerful and can be consciously or unconsciously supported (Wiese, Kilty and Bennett, 2018). While entrustment and dialogue about practice are usually conscious, modelling is often unconscious on the parts of both supervisor and trainee. CoP theory considers that what is not done is as much a part of practice as what is done (Wenger, 1998). Hence when areas of practice are not seen by or not emphasised to RQDs and medical students, there will be learning, which is often unintentional. If consultants do not recognise the value to RQDs or medical students of learning about elements of EoL care, and consequently RQDs and medical students do not witness or participate in this area of practice, tacit learning is likely to occur. There may be learning that this is not an important part of the enterprise of doctors. There are also likely to be deficits in attitudes, knowledge, and

skills of RQDs when they are called out-of-hours to attend to a patient with EoL care needs or speak to their family members. Wang et al. (2019) found that inadequate workplace supervision of senior medical students engaging in goals of care discussions with patients, resulted in ethical dilemmas, negative emotional responses, and changes in values from those originally considered desirable by students. Learning from the informal and hidden curriculum about palliative and EoL care has also been noted in other studies (Billings *et al.*, 2010; Gibbins, McCoubrie and Forbes, 2011; Tait and Hodges, 2013). Previous research has found that RQDs perceived that discussions about death and dying were off-limits (Gibbins, McCoubrie and Forbes, 2011), that the goals of medicine were at odds with the goals of humanistic care (Tait and Hodges, 2013) and that they were encouraged to disengage from dying patients (Brennan et al., 2010).

5.5 Conclusion

Participants described supporting trainees learning about EoL decision-making and communication of bad news through observation and less commonly through participation. Such opportunities were predominantly reserved for senior trainees above the level of RQDs. This was considered a critical and difficult area of practice and was reflected in entrustment decisions. Participants seemed unaware of the value of this learning to RQDs and medical students, and in order to protect patients and families, they often excluded these learners from consultations where there was communication of bad news. This gap in supported learning may have led to unintentional learning.

Chapter 6

Specialist palliative care consult team members' perceptions of recently qualified doctors' capability and learning about EoL care.

6.1 Introduction

Recently qualified doctors (RQDs) learn informally in the workplace landscape of practice (LoP) when they have boundary encounters with other communities of practice (CoPs) (Wenger-Trayner et al., 2015). In relation to end of life (EoL) care, RQDs frequently interact with members of acute hospital specialist palliative care consult teams (SPCCTs) and have identified them as an important support for learning about EoL care (Gibbins, McCoubrie and Forbes, 2011; Price and Schofield, 2015).

These SPCCTs in Ireland and the UK are primarily constituted of clinical nurse specialists (Jack, Oldham and Williams, 2003; Connolly *et al.*, 2021) who work under the supervision of a consultant in palliative medicine (National Advisory Committee on Palliative Care, 2001). Hence not only do RQDs encounters with SPCCTs expose them to the practices of another community, they also bring them into contact with healthcare workers from another professional background.

Nurses can be an important source of informal interprofessional learning for RQDs (Burford *et al.*, 2013; Varpio *et al.*, 2014; Jansen *et al.*, 2021). RQDs can learn about roles and skill development from nurses (Burford *et al.*, 2013) and have been reported

to sometimes find nurses more approachable than their medical supervisors when they have uncertainties (Jansen *et al.*, 2021).

In terms of Communities of Practice (CoP) theory, SPCCT members can be viewed as a part of a local hospital based CoP or they can be viewed as part of a wider SPC CoP. Either way, interactions between members of the SPCCT and local physician CoPs constitute boundary encounters between two CoPs. Boundary encounters offer rich opportunities for learning and introduction of practice into a CoP (Wenger-Trayner et al., 2015; Wenger, 1998). The SPCCT members can be seen as brokers who have frequent and multiple boundary encounters with many different local physician CoPs. These boundary encounters have the potential to introduce elements of the SPC repertoire of practice to other CoPs (Bornbaum *et al.*, 2015). Boundary encounters between two communities are facilitated by boundary objects. Boundary objects allow for translation of meaning between communities of practice and can be real or virtual, and have been described as being *"both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites"* (Star & Griesemer, 1989, p. 393). The national standardised referral form (Health Services Executive, n.d.), patient notes, prescription charts and the WHO Cancer Pain Ladder (World Health Organisation, 1986) are examples of boundary objects in the context of interactions between local physician CoPs and the SPCCT.

Many acute hospitals in Ireland have specialist palliative care consult teams (SPCCTs). A SPCCT is part of a wider regional specialist palliative care (SPC) service (National Advisory Committee on Palliative Care, 2001). A regional SPC service usually includes some or all of the following in addition to SPCCTs in each acute

hospital: a SPC inpatient unit (either on a remote site or co-located with an acute hospital), out patients, day care and community services. The SPC service as a whole, is an integrated service that is set up to allow continuity of care, regardless of where the patient is located. The report of the National Advisory Committee on Palliative Care (2001, p. 81) recommended the formation of SPCCTs, whose purpose was identified as providing *"advice on symptom control, psychosocial support and problems relating to quality of life"*. The role of the SPCCT is to support other hospital teams through role modelling, collaboration and sharing of knowledge and skills. It was highlighted that this team should not lead to deskilling of other clinical teams.

Much of the day-to-day clinical work of the SPCCT is performed by clinical nurse specialists (CNSs) who practice under the direct supervision of a consultant in palliative medicine. Some teams also have non consultant hospital doctors (NCHDs) based in the acute hospital as members of the SPCCT. It is recommended that as a minimum they also have a social worker and administrative support (National Advisory Committee on Palliative Care, 2001). CNS and NCHD members of the SPCCT liaise with primary physician teams. They screen and triage referrals, in addition to performing initial and ongoing patient assessments. The SPCCT act in a supportive and advisory capacity and do not take over the care of patients from the primary team. The referring team may choose to implement the advice offered by the SPCCT fully, in part, or not at all. This is an important element in the overall governance of the service and is designed to ensure that all clinical decision-making is directed by the senior responsible referring clinician. While consultants or senior doctors from the primary team may make informal referrals to palliative medicine consultants, all referrals must be formally made on a standardised referral form (Health Services Executive, n.d.). These forms are often completed by RQDs and it is required that the

person completing the form indicates whether the patient and their family are aware of the referral. If the patient has capacity to understand this information, the SPCCT will not see them until they have been informed of the referral by the referring team. How accurately and to what degree this information is presented to patients has been found to be variable (Pini *et al.*, 2021). After a patient has been assessed, recommendations made by the SPCCT are communicated back to the primary teams (Health Services Executive, n.d.) in writing, and sometimes also verbally. Discussions regarding the advice offered and the rationale underpinning such advice may take place informally. These discussions provide an opportunity for information exchange and education. Discussions may also occur in the more formal setting of a structured multi-disciplinary meeting involving relevant disciplines such as medical oncology, radiation oncology, interventional pain, liaison psychiatry and palliative medicine. In some instances, members of the SPCCT also attend multidisciplinary clinics with other teams engaged in the care of patients with life-limiting illnesses, most commonly in the context of cancer care (Ewing, Farquhar and Booth, 2009).

RQDs have identified SPCCT members in acute hospitals as an important source of learning about palliative and EoL care (Gibbins, McCoubrie and Forbes, 2011; Price and Schofield, 2015; Kawaguchi *et al.*, 2017; Redman *et al.*, 2017; Frearson, 2019)**.** In addition, the role of the SPCCT in supporting EoL care through suggesting and coordinating care plans and communicating with family members has been highlighted (Redman *et al.*, 2017). There has not been much research into RQD learning from SPCCTs in acute hospitals. I considered that exploring the perspectives of members of these teams who interact regularly with RQDs could provide valuable insights into RQDs' learning about EoL care.

The aim of this study was to explore, from a socio-cultural perspective, the experiences and perceptions of SPCCT members of RQD capability and learning about EoL care.

My research questions were:

1. How do SPCCT members perceive RQDs capability and involvement in the provision of EoL care?
2. How can acute SPCCT members support RQDs to develop capability in EoL care?

Communities of Practice (Wenger, 1998) and Landscapes of Practice (LoP) (Wenger-Trayner et al., 2015) theories were used as a lens to explore the findings. I have provided a detailed discussion of these theories in Chapter 2 (Conceptual Orientation and Methodology).

6.2 Methods

A detailed description of my methodology using Braun and Clarke's Reflexive Thematic Analysis and CoP and LoP theories is outlined in Chapter 2.

6.2.1 Recruitment

Palliative care CNSs and NCHDs working as part of specialist palliative care consult services in acute hospitals in one city were purposively sampled. Sampling was designed to allow for participation of individuals with a variety of levels of clinical experience from a range of hospital sizes. Gender balance was not attempted as the vast majority of healthcare professionals in both categories are female. I identified potential participants and obtained their contact details in a few ways. Firstly I had

personal knowledge and contact details of several individuals through previous working relationships. Secondly, I obtained names and contact details of other potential participants through SPC personnel such as consultants in palliative medicine in the local service. In the latter instance, permission was obtained before contact details were sent on to me. I sent invitations to participate by email. Information on the nature of the study and what was involved in participation were provided in the form of an attached participant information leaflet and consent form (Appendix G). All participants completed and returned signed consent forms prior to commencing their interview.

6.2.2 Data collection

Semi structured interviews were conducted with all participants using online Microsoft Teams (MT) video technology. All interviews were video recorded and an additional audio recording was made. Following a check of the quality of the audio recording the video recording was deleted. Audio recordings were given an anonymous label and stored in a secure file on MT. The transcription function in MT was used to generate an initial transcript of each interview. Inaccuracies in the transcripts were identified by cross checking with the audio recording of the interviews and corrected. Data collection was conducted following completion of data analysis for the RQD and consultant studies. Questions on the interview guide were iteratively modified as the study progressed in order to allow further exploration of new insights gained. The final interview guide is included as Appendix H.

6.2.3 Data analysis

Data were analysed using Braun and Clarke's 6 phases of Reflexive Thematic Analysis (Braun and Clarke, 2006). My approach to analysis is detailed in Chapter 2

(Conceptual Orientation and Methodology). The following is a brief overview of my approach. I immersed myself in the data by listening to the recordings of interviews, and through reading and correcting all interview transcripts. I conducted an inductive analysis. I sought latent themes by adopting a constructionist stance to interpret data in their social context. CoP and LoP theories were used to refine the final themes. The final themes selected for reporting were those that addressed the research questions.

6.2.4 Ethics

Ethical approval for this study was sought and granted by the Social Research Ethics Committee (SREC) in UCC (Appendix I). As I had previously worked in a service co-located with the SPC inpatient unit, I already knew several potential participants for this study and had their contact details. When I identified potential participants from this group I took care to approach them by email to reduce the chance of them feeling under pressure to participate. When seeking contact details for those that I did not already know, I asked individuals that I knew and who were known to potential participants to seek permission to pass on email addresses to me. I also invited these participants by email.

As participants were experienced SPC healthcare professionals and given the nature of the questions I was asking them, I did not consider that participants were likely to need support following interviews. I explained at the outset of interviews that the participant could choose not to answer questions or to terminate the interview at any time and to withdraw their data within 2 weeks of completion of the interview.

6.2.5 Reflexivity

In order that readers may assess the trustworthiness of this research, I have described my engagement in reflective practice and my position in relation to EoL care and the participants in this study in Chapter 2 (Conceptual Orientation and Methodology). To minimise the effect of my own experiences and position on the way I conducted interviews or interpreted data, I engaged in reflective practice throughout all phases of this research. I kept a reflexive diary throughout the research process. I also met with my research supervisors DB and TO'B regularly (sometimes online and sometimes in person) to discuss analysis. They also provided feedback on written drafts. We supported each other's reflexivity and they facilitated me in considering alternative meanings when interpreting the data.

6.3 Results

I conducted 12 interviews between January and June 2022. Participants included a mix of CNSs and NCHDs who were current members of or had previously spent time in a SPCCT. Table 6.1 summarises demographic information and duration of interviews. Participant numbering represents the order in which interviews were conducted.

Table 6.1: Participant demographics and interview duration

Order	SPC Professional Role	Duration
Participant 1	NCHD	41:51
Participant 2	CNS	48:43
Participant 3	CNS	42:10
Participant 4	CNS	41:21
Participant 5	CNS	39:09
Participant 6	NCHD	41:52
Participant 7	CNS	36:09
Participant 8	NCHD	39:57
Participant 9	CNS	44:12
Participant 10	CNS	36:16
Participant 11	CNS	48:14
Participant 12	NCHD	58:04

All participants were female. The mean length of time spent on a SPCCT by the eight clinical nurse specialists was 10.5 years (range 2-19 years). All NCHDs had worked for three months on a SPCCT in a single hospital. Nursing participants had been members of SPCCTs in at least one of three different public sector hospitals in one city. Some had worked in more than one hospital as a SPCCT member. One of the hospital was large and incorporated a maternity hospital (820 beds), and two were smaller (340 and 260 beds). All were part of the same regional SPC service. In combination, the participants had experiences of working on a SPCCT that was led by one of four consultants in palliative medicine. One participant had retired and the remainder were all still working in a variety of SPC settings. The average interview duration was 43:16 minutes.

Two themes were identified that addressed the research questions. The first theme: *constraints on RQDs participation in EoL Care,* relates to research question 1: How do SPCCT members perceive RQDs capability and involvement in the provision of EoL care? This theme identified several issues that were barriers to RQDs

participation in EoL care. It had three subthemes. This theme and its subthemes are summarised in Figure 6.1. The first subtheme: *willing but not able,* represents how RQDs were perceived to be limited in providing EoL care by a lack of knowledge, skills and experience. The second subtheme: *not supported,* highlights how participants viewed the position of RQDs in relation to EoL care in their medical teams. The third subtheme: *seeking formulaic approaches,* represents doctors seeking simplistic approaches to symptom management at the EoL.

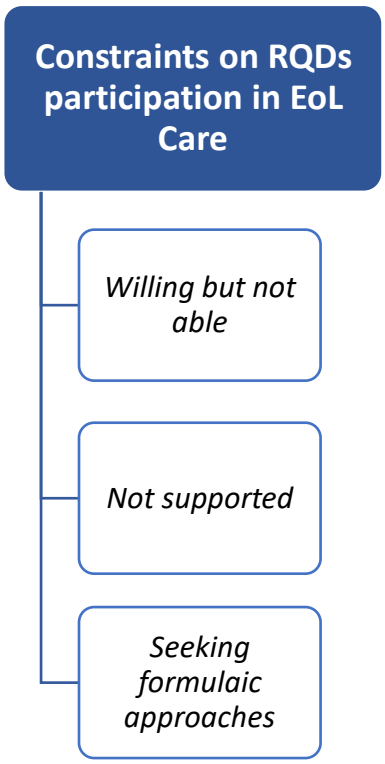


Figure 6.1: Theme 1 and its subthemes.

The second theme: *ways of facilitating learning,* relates to research question 2: How can acute SPCCT members support RQDs to develop capability in EoL care? This theme had four subthemes. The second theme and its subthemes are summarised in Figure 6.2. The first of these subthemes: *building relationships and legitimacy,* identifies the attitudes of senior doctors that SPCCT members encounter, how these

are perceived to affect the learning of RQDs on their teams, and how SPCCT members go about building trust and legitimacy to try to influence practice and informal learning. The second subtheme: *intentional support of learning,* describes how SPCCT members consciously support RQD learning in a range of areas. The third subtheme *providing emotional support,* highlights participants' perceptions of the emotional demands of EoL care on RQDs and how they provide support for affective learning. The fourth subtheme: *missed opportunities,* identifies ways in which participants thought RQDs could be supported to learn about EoL care.

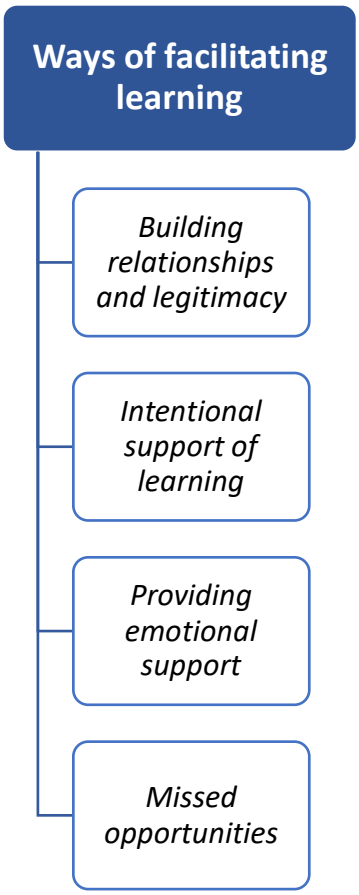


Figure 6.2: Theme 2 and its subthemes

6.3.1 Constraints on RQDs participation in EoL care

Willing but not able

Through their interactions with RQDs, members of the SPCCT gained insights into their EoL care knowledge, skills and attitudes. RQDs were usually perceived to be willing to deliver EoL care and to learn about it, but were constrained by their lack of knowledge and skills.

When given advice, many RQDs were considered to be willing to participate in palliative and EoL care and to be eager to learn, particularly in the area of symptom management and pharmacotherapeutics:

> *" I think that the interns for sure…. they were like a sponge, the most of them, for trying to learn absolutely everything that they could when, when they're dealing with palliative care." Participant 2 (CNS)*

Consultants made the decision to refer to the SPCCT. However, completion of the referral form and the phone call that accompanied a referral request, were usually the responsibility of an RQD, often an intern. Based on experiences of receiving referrals, participants commented that many RQDs and in particular interns, did not appear to understand what the SPC service offered or what palliative care entailed:

> *" … whenever anyone refers to me, I'd say, you know, what's your clinical query? And there's often a big a big silence of, but they're, they're, just they're palliative. Is it symptom control? Is end of life? And at times I suppose people*

don't know really what they're, what they're asking us for. And I think a lot of people don't know what we actually do." Participant 6 (NCHD)

An RQD was commonly the primary member who was required to explain to the patient and their family that they were being referred to palliative care. Hence, this lack of understanding of the SPC service was seen to have a negative impact on patients and their subsequent interactions with the SPCCT:

"...and probably the more junior they are, sometimes it can be, it's quite clumsily managed and the doctor doesn't know how to approach or to say it … I think the more senior the person is talking to them about it, the better start we have when we get there, the better concept of what's involved." Participant 4 (CNS)

Participants had experiences of interns struggling with pronouncing death for the first time. One participant who was NCHD recalled encountering an intern who had been called to confirm a patient's death:

"…she was terrified because she'd never, she'd never done, as she didn't know how to do it. And um thought that I had come along to, to do it for her, you know…. But you know that's, that's another, another piece, I suppose of the dying process that's just been sort of left to, to Dr Google to, to take care of." Participant 8 (NCHD)

Issues such as a lack of experience as well as knowledge and skills deficits were identified. Participants reported that often RQDs did not recognise the signs of active dying and were fearful about identifying dying:

"We come across a lot of junior medics who are absolutely terrified. Some of them have never experienced or been with somebody who is dying, and we find a lot of them really struggle to diagnose dying" Participant 3 (CNS)

Medication use in palliative and EoL care needs to be quite tailored to the individual (Neuberger, 2013; Hodgkinson *et al.*, 2016) and participants identified that this was a significant area of deficit for many RQDs:

"I wouldn't think they'd have been prepared, a lot of them wouldn't really have a lot of the basics in the medications used in you know, end of life and interactions and all those kind of things ... And the reason why you would choose one drug over another, we'll say antiemetics or something like that, where you choose one over another. I think they needed more training." Participant 4 (CNS)

Participants considered that RQDs frequently encountered situations where they needed to have good communication skills, but again deficits were commonly noted:

"A lot of the time I suppose it would be the consultant that would break the bad news to patients. But then you could have relatives, different relatives turning up at different times and wanting to talk to a doctor and that and lots of times it would be left maybe to an intern or a SHO, to come and talk to them, you know? So and they wouldn't maybe have the best of communication skills." Participant 5 (CNS)

The involvement of RQDs in the follow up to BBN conversations conducted by consultants, highlights the importance of viewing BBN as a process rather than event.

Not supported

Participants commonly reported that they experienced disengagement of senior doctors from patients who were approaching or at the EoL. This lack of involvement of senior doctors posed problems for RQDs and the SPCCT. For RQDs, lack of support and guidance from seniors in combination with their own lack of confidence in this area, limited their ability to engage in EoL care. This could lead to RQDs pursuing disproportionately aggressive management of patients who were approaching death when a less interventional approach might be appropriate:

> *"We would quite often come across a very junior feels, this patient is deteriorating. But isn't getting the support from higher members of the to guide them in regards to which direction they should be going or how aggressively they should be managing. And so because they don't have the confidence or the experience you find it, they tend to be quite aggressive in their management because um they're afraid of making mistakes. They're afraid of getting their knuckles rapped..." Participant 3 (CNS)*

The primary consultant ultimately has responsibility for decision-making about patient care. If the consultant does not specify a change in approach to care, RQDs are left to follow the assumed wishes of the consultant, and this will usually result in continuation of current care.

When consultants acknowledged that patients were dying, RQDs were often left unsupported to get on with providing whatever medical care was provided at the EoL:

"… but it could be the intern that is nearly sent as a break away from the ward round to check in and just to write the notes rather than the team coming." Participant 2 (CNS)

RQDs were also unsupported in other ways by the practice of primary teams. Some of those interviewed identified issues around poor documentation of decisions that they knew had been made about ceilings of care for patients with advanced and life limiting disease. The lack of clear documentation of decisions that had been made by the primary team, were seen to cause difficulties for RQDs in on-call situations when they were called to assess and manage patients who had deteriorated. It was perceived that well documented ceilings of care plans would have supported RQDs to make decisions in line with the intentions of the primary team in out of hours situations:

"… if it was clearly documented that this patient was not for any further antibiotics, if they weren't for escalation of care, I think they would feel much more confident in their decision-making to go with comfort measures." Participant 3 (CNS)

From their experience of interacting with physician teams, participants perceived that there was wide variation in the amount of involvement RQDs were allowed in decision-making about EoL care. While participants reported that most consultants didn't afford RQDs opportunities to get involved in clinical decisions about the care provided to patients at the EoL, there was a minority who might in certain circumstances. One participant described how RQDs might be trusted on some physician teams and caught in the middle between the SPCCT and senior doctors on others:

"… but there are certain consultants where the junior is let take the lead because they are the ones who are on the wards day in, day out ... They're the ones who've been asked to link with us. So we've been linking with them. They have an idea where the care plan is going. Um, but there are other teams that they really struggle because yes, they may agree that the patient is dying, but a senior member of the team would have a more aggressive approach to the individuals care ..." Participant 3 (CNS)

Many perceived that doctors below registrar level weren't in a position to make certain decisions based on a SPCCT member's recommendations. RQDs went to someone more senior on their physician team to check before implementing what had been suggested:

"…. we suggest that then, and the intern speaks with the usually it's the registrar, the registrar level. They would decide, you know below that, SHO or intern, no. I actually felt if I might say this: the interns were much more following orders." Participant 9 (CNS)

Sensing that RQDs didn't influence decision-making, this participant described how when making certain recommendations about patient care, she bypassed more junior doctors, in particular interns, in favour of speaking to those more senior:

"... if we, we are suggesting a syringe driver for the first time, I would call the SHO, Reg you know. Am but if it is laxatives for example for a patient that is getting a bit more constipated from opioids or something, I might tell the intern." Participant 9 (CNS)

While RQDs were left to get on with delivering some aspects of EoL care, they were limited in the extent to which they could influence decisions about patient care. This type of participation in practice suggests that rather than being legitimate participants in the context of EoL care, RQDs were marginal participants in their local physician CoP, with limited access to practice (Wenger, 1998).

Seeking formulaic approaches

Participants described examples of RQDs and more senior doctors in their local physician CoPs seeking and adopting a simplified one size fits all approach to EoL care prescribing:

> *"…you'd have the occasion where just whatever the last recommended prescription was, is restarted without actually correlating to the individual in the bed or being individualised." Participant 2 (CNS)*

The knowledge of senior doctors about medication use at the EoL is also called into question by this finding. In some instances there were potential problems when RQDs or other doctors on their teams introduced elements of practice in EoL prescribing without appropriate knowledge or understanding. One example was widespread use of a particular opioid without due regard to an individual patient's condition:

> *"… they have patients with an eGFR [estimated glomerular filtration rate] of 2 and they'd be on huge doses of morphine, and I used I, you know I'd be like 'oh no, no', you know very nicely of course. But now they've completely switched over and nearly every one of their patients is on Fentanyl instead you know, yeah." Participant 8 (NCHD)*

Prescribing sedative medication which could lead to an altered clinical picture was another:

> *"… I think he'd gotten two 600 stats of hyoscine hydrobromide and two 25 stats of levomepromazine and I didn't actually know if he was dying or he was very, very sedated, you know so. That was a little bit um, yeah, a little bit concerning, I suppose. As it was just very hard to know what was going on really." Participant 8 (NCHD)*

In many instances, participants welcomed adoption of elements of SPC practice by physician teams as it was felt to lead to better patient care. However, implementing practice in a routine and inadequately considered way could be problematic. Failure to holistically assess patients along with a lack of understanding of potential medication side effects and interactions, could have negative consequences. As highlighted by Wenger-Trayner & Wenger-Trayner, (2015), boundaries between two CoPs are fertile areas for learning, however the potential for misunderstandings is high.

6.3.2 Ways of facilitating learning

Building relationships and legitimacy

In order to influence practice and actively support learning, SPCCT members in their brokering role must build trust and legitimacy with other CoPs in the LoP (Kubiak et al., 2015). The brokering role of members of the SPCCT was identified by participants. Several described deliberately engaging in practices to foster the development of relationships with local physician CoPs:

"So our thinking was always we need to be the right hand of oncology, we need to be here and, and then kind of went about driving that." Participant 2 (CNS)

Participants described doing this by having a visible presence, being approachable and following up with members of the local physician CoP after reviewing a patient:

"… I bleeped them to say look, this is what Dr [name] has recommended or this is what we think would work … you know if you need to chat it out more, we're here. This is my bleep. And I think we were always very present on the ward. I think we were always really accessible. And so I do think a lot of it is the therapeutic relationship both with the patient but also with the junior doctor you know that they don't feel am kind of intimidated um approaching the palliative care team…" Participant 7 (CNS)

This cultivation of relationships can be seen as a means of building trust through contribution to patient care and support of the local physician CoP. In developing these relationships brokers have opportunities to demonstrate their knowledge and expertise. The building of trust is an important element of brokering (Wenger-Trayner et al., 2015).

The flip side of the SPCCT being available and responsive was enabling disengagement of the primary team from patient care. There was also a perceived risk of them becoming deskilled in basic EoL care:

" … I worry that when we see the non-complex patients like are we absolving other physicians, you know their responsibility to be part at the end of life you know that. They, I think there's that piece that you do kind of have to be careful about that you know, it's everybody's responsibility and while not everybody

can provide specialist palliative care, everyone should be providing kind of general palliative care." Participant 8 (NCHD)

Often when they experienced senior doctors' disengagement from patient care at the EoL, it was as though the primary responsibility for care of patients had been handed over to the SPCCT:

"I met somebody last Wednesday who was referred for advice. I met them, did the consult, did the note. Came back … on Monday and nobody else had been to see the person, documented anything in the notes. Um and I suppose it just tends to be, OK they're palliative now." Participant 11 (CNS)

Those interviewed described having to make deliberate ongoing and proactive attempts to keep boundaries on their role of advisors to primary teams.

Another aspect of building trust as a broker is getting to know and appreciate the repertoire of practice of another community and this was described by some participants:

"… you get to know the person that bit better and you get to know the team so that you could know their working and their thinking as well that … I won't suggest this now because am I bet you he's going to come along tomorrow and suggest surgery, refer to surgery or something. Um and so it just makes life easier when you all know each other's ways I suppose, really." Participant 2 (CNS)

Some elements of relationship building were beyond the control of the SPCCT. Attitudes of senior doctors towards palliative care and the SPCCT were perceived to

impact on the practice of the entire local physician CoP and hence on RQD learning. These attitudes were reported by participants as being very variable. Some consultants were very positive about the SPCCT's role in patient care, and others weren't. Positive attitudes expressed by consultants conferred legitimacy and trust on the SPCCT:

> *"The attitude that junior doctors have towards palliative care depends on the attitude that consultants, the team has for palliative care. So oncology consultants um stop us in the corridor and talk about patients … and so the junior team is doing it. And the teams who mightn't do that, we wouldn't have the same relationship with the junior teams, so they're not learning it from the senior doctors you know." Participant 4 (CNS)*

Some consultants were perceived as having ambivalent or even more overtly negative attitudes towards palliative care that influenced the practice of the whole local physician CoP. One participant described the impact of lack of regard for what the SPCCT could offer in the following excerpt:

> *"… we found it quite hard to go back to that patient because our role was so diminished, I suppose by the team. Um I'm not sure how much benefit they think that we give …" Participant 12 (NCHD)*

Another participant described an incident where the attitude of the consultant was also reflected by a nurse who was present. The following quote illustrates a culture where the enterprise of specialist palliative care, while considered important on one level was disrespected and disregarded on another:

"Participant: And I was called sort of as a as an emergency, you know, 'he's actively, he's going to die quite shortly. You must come immediately.' So I went up then. I was talking to one of the nursing staff and I actually saw the consultant … I went to speak with him really about, you know, what was the prognosis, what was going on. And, and he sort of looked at me, you know, in askance. And one of the nurses said 'oh it's, it's only palliative care…'

Interviewer: What was the subtext there?

Participant: I just think that I, you know, was extremely unimportant, despite the fact that I've been called and, you know, a flurry, and I must see the patient, and I must be involved, I was somehow belittled into a very peripheral part in a very unimportant part of this patients care." Participant 8 (NCHD)

Some participants discussed experiences of a small minority of consultants who were openly hostile towards SPCCT. Newcomers to the SPCCT were warned about these consultants and on the rare occasions where they received a referral to see one of their patients, the SPCCT took great care to ascertain that the consultant was aware of and had sanctioned the referral.

If senior doctors have negative attitudes towards palliative care, those more junior on the team may also develop similar attitudes. If the most senior member of the physician team doesn't respect or regard the potential contribution of SPC as valuable, there is little chance that juniors on their teams will adopt elements of a palliative care repertoire of practice. Whereas consultants with positive attitudes may support the adoption of elements of practice by their teams.

Intentional support of learning

Participants highlighted education as a key element of their role. They described occasional involvement in formal educational initiatives such as teaching sessions with interns on EoL care. They regarded informal education throughout their day-to-day encounters with RQDs as an important opportunity for RQDs to learn. They described intentionally supporting learning about how to identify dying, medication use at EoL, symptom assessment and control, and communication. They did this in a variety of ways. They left notes in charts, engaged in discussions with doctors about patient management, gave them written guidelines on medication use, and provided advice on and modelled approaches to communication:

> *"Part of our role would be to look at and encouraging the junior medics in particular to develop their own knowledge base and so that they can manage the straightforward natural dying process and then hopefully they would only need to call on our services when there is a more complicated physical psychosocial issue, so there's a huge educational piece, huge supportive role and a role modelling role as well just in and around communication, but also the symptom management and the assessment." Participant 3 (CNS)*

The aim of education was often identified in terms of encouraging primary teams to introduce elements of SPC practice into patient care. Several participants mentioned their belief that non-SPC physician teams should be able to manage uncomplicated dying without needing SPC input.

Participants reported that they put in a lot of effort to communicate recommendations and the reasoning behind them to RQDs through verbal feedback. Where necessary

they also fed back to more senior physician team members. This was considered to be more valuable than just leaving a note in a patient's chart:

> *"… so I think maybe the education piece gets a bit lost there because … you're suggesting Maxolon 10 TDS, but there's no talk about, because of the prokinetic effect. What we're hoping is because of delayed gastric motility, you know there's none of that bit … I think it's harder to get someone to do something if they don't understand it." Participant 7 (CNS)*

Relying on a reified boundary object such as written recommendations to convey information from one CoP to another can be problematic. The meaning negotiated within the receiving CoP may not be that intended by the one in which it originated and there is no opportunity afforded to correct this (Wenger, 1998). Introducing a participatory element in the form of a conversation facilitates a two way flow of information and a more nuanced negotiation of meaning. From a LoP perspective, the follow up phone call or meeting in person after a consult represents practice that supports the development of knowledgeability across a boundary between two CoPs.

Participants described their efforts to support attitudinal learning about honest communication alongside skills learning. Avoidance of collusion was a key part of the practice for SPCCT members, and something they were keen to pass on to RQDs. An example was their practice of not seeing patients until they had been informed by their primary team that they were being referred to palliative care:

> *"I got a couple of calls, you know, kind of asking us to see the patient without kind of saying that we were from palliative care... That's obviously tricky and you don't want to really, you know you don't want to be colluding and you have*

to be honest with the patients. It's very hard to come out and do a full assessment when they don't know where you're from or what your role is." Participant 1 (NCHD)

Another example of how they supported learning of attitudes and skills was through modelling. Some described providing RQDs with opportunities to observe them interacting with patients. Although these did not appear to be frequent occurrences, they were considered to provide a valuable learning opportunity for RQDs and were viewed as a very worthwhile and positive experience by participants. One CNS described an intern coming to her to ask her to speak to a patient who was refusing to complete a course of radiotherapy to which he was having a good response:

"And we did a visit together. It was great. It was really great. He was just there listening and at my back, you know. But at the end he was supporting what I was saying." Participant 9 (CNS)

When asked what she thought the intern had learned from that experience, she responded:

"Maybe there is listening time that needs to be given. And there is a relationship that you need to build to be able to let, to allow the patients to talk to you and to express themselves freely, you know and that this takes time. Not coming, take bloods and going out, that he will trust you and that he will open to you, that you need to develop that." Participant 9 (CNS)

Some described that when they picked up on RQD uncertainty or distress, they deliberately enquired about what was underlying this. Participants explained how they

talked through communication approaches with RQDs. A common example was how to tell a patient that they were being referred for specialist palliative care input:

> *"I suppose enabling them as to how you go about the conversation you know that it's not a case of you know like well, how are you feeling right now you know that it might be like 'Where are you in the middle of this? You've obviously been through an awful lot, I've been here for the last few weeks and I've put you through loads of tests. How are you doing, with it all?', or 'what are you hoping for yourself?' And I think it's given them the, the narrative and given them the words really…" Participant 7 (CNS)*

Several considered that many RQDs were not familiar with common signs that suggested that a patient might be dying and that this was something that did not seem to be taught to them by more senior doctors. One NCHD said:

> *"… senior doctors are all about pointing out this clinical sign, that clinical sign when you're on ward rounds. And can you hear that murmur? And can you see that, you know, third nerve palsy, but no one actually says, you know, can you see that this person's extremely unwell? ... no one actually thinks to discuss that. And as such, you know you can go through the first couple of years of being a doctor and actually still be completely surprised when people die because no one said she, 'you know, this is what dying looks like.'" Participant 12 (NCHD)*

Participants described deliberately teaching RQDs about signs that could indicate that a patient was dying:

"But if I see somebody questioning, God are we sure now this person is end of life?' You know, I might just stay, 'well, look, you've given three sets of antibiotics. They worked really well ... This last antibiotic, they haven't come back to themselves. They're now not able to take anything orally. Their urine output is decreased, spending more time in bed …' Listing out what I'm used to seeing, and I know people aren't used to seeing that … That can help somebody formulate their own decision. And maybe, I suppose, believe their own decision." Participant 11 (CNS)

Providing emotional support

Many participants provided a listening ear and emotional support. They allowed RQDs to express emotion and responded to their concerns. They were alert to and picked up on a need for emotional support in a variety of situations. Some of these were more obvious where a RQD appeared upset, sometimes they were through a question they asked, and sometimes it was because of the number of contacts that a RQD was making with them.

RQDs were perceived often to be reluctant to recognise or to take on board that a patient was dying. Participants mentioned RQDs being fearful when a SPCCT member suggested that a patient might be at the EoL:

"Am some of them will actually come to you and they will, there could be a particularly emotive case at the moment and they'll say I never expected to be experiencing this as a junior doctor or, you know, I came into medicine to help make people better… And sometimes they'll come to us and they'll say, but how can we stop the treatment? How can we stop the fluids? Are we not going

to do to, you know cause dehydration or are we not going to cause them to be hungry. Yeah, there's this look of fear in their eyes when they're talking to you. Am and often they just need to talk it through and have a sounding board." Participant 3 (CNS)

Participants considered that by helping RQDs recognise dying, they might reduce concerns that they were giving up on the patient or hastening death.

EoL care was considered to be an emotionally challenging area of clinical practice. They were aware that some RQDs might have had experiences of death in their personal lives and that some were encountering death for the first time:

"I think when you're talking about death, dying, palliation, it makes people very aware of their own existence and their own mortality. And you know, they, they look at people in the beds and they can draw parallels with people in their own lives. And so it does bring to the, for a lot of them, um very emotional experiences." Participant 3 (CNS)

Many participants considered that providing emotional support for RQDs was a key part of their role and something that might not be afforded to them by other colleagues:

"they would quite often voice their, their upset, or their just again … in trying to manage somebody who's deteriorating or you know the, the younger patients in particular… you could spend a lot of time kind of standing in the corner of the ward hearing somebody out and just spending time with the person so they can kind of pull themselves on and get going." Participant 2 (CNS)

Caring for dying patients is part of the enterprise of SPC CoPs. Giving attention to managing the emotional impact of death and dying on themselves is part of their practice. In the prevailing medical culture, this type of self-care is not a usual part of the practice of most non-SPC physician teams. RQDs are often not afforded opportunities to discuss their emotions within their physician teams.

Missed opportunities

Some participants identified missed opportunities for RQD learning particularly in the areas of communication skills and development of emotional learning. One CNS considered the learning that an intern could get from being present when a patient died, which might stay with them in their career as a senior doctor:

> *"And then all of a sudden they're going to be very senior doctors. And you wonder how many of you have actually sat there when someone has had taken their last breath or, you know, so I think I think sometimes if you get them an exposure, which might be really hard for them as an intern, I think that would, I can only see that that would be beneficial going forward even in terms of their language, in terms of their presence. But I can get it's probably an opportunity that gets lost a lot." Participant 7 (CNS)*

Another discussed the merits of having RQDs present at multidisciplinary team meetings involving a variety of specialties, where complex cases were discussed. In her experience usually only senior doctors from the primary team were present. She had found these very useful for her own learning and understanding:

"… we did have an MDT every week. I thought that myself was great support

because I suppose you could tease out cases and things made maybe a bit more sense when the whole MDT was there. …. But actually now thinking of it the you know, the junior doctors weren't there actually, you know." Participant 10 (CNS)

Debriefing of RQDs by the SPCCT after difficult cases, which was not a part of current practice, was also suggested as a way of supporting learning. Several suggested the potential benefit of spending time in SPC either as a medical student or a RQD.

6.4 Discussion

6.4.1 Principal findings

SPCCT members in their brokering role, observed and interacted with multiple local physician CoPs at boundaries between their respective practices across the LoP. In doing so they had a wide range of experiences and were well placed to offer insights into RQDs roles and capabilities in EoL care. They perceived that many RQDs struggled in providing EoL care, lacked capability, found it emotionally challenging, and were often poorly supported by more senior doctors on their teams. Sometimes they identified that the knowledge of senior doctors about the use of medications at the EoL was lacking. Participants also encountered a wide range of consultants' attitudes towards palliative and EoL care. These attitudes influenced the practice of the consultants' teams: disengagement by primary teams as patients approached death was an example of this. The SPCCT members' roles and the challenges they met provided them with unique perspectives, which adds to understanding of the socio-cultural environment in which RQDs work and learn. Participants had suggestions for how RQDs might be supported to develop capability in caring for patients at the EoL.

6.4.2 Perceptions of RQDs providing EoL care

RQDs were seen to face several challenges in relation to the provision of EoL care. Participants perceived that RQDs, in particular interns, lacked legitimacy in their local physician CoPs. Many RQDs were also considered to lack capability in the provision of EoL care. They identified significant gaps in knowledge and skills, which together with their lack of legitimacy restricted the care that RQDs could offer to patients approaching and at the EoL and to their families.

Those interviewed recounted that RQDs often did not have a basic understanding of what SPC could offer and why patients were being referred for review. Several factors may have contributed to RQDs not having a clear picture of the reason for referral. Lack of clear guidance from senior doctors on their teams is likely to have contributed. Confusion about the role of acute hospital SPC teams and understanding of palliative care has been noted elsewhere, and is not limited to junior doctors (Firn, Preston and Walshe, 2016). Understanding of roles has been found to be a facilitator in referral to SPC services (McCaughan *et al.*, 2018).

RQDs were seen to encounter challenging and sad situations that they sometimes did not expect and for which, they were often poorly prepared. Participants reported that RQDs were often left unsupported to get on with providing medical aspects of EoL care as senior doctors disengaged from the care of patients who were approaching death. Other studies of RQDs have reported similar findings (Gibbins, McCoubrie and Forbes, 2011; Bowden *et al.*, 2013). Lack of support in combination with their lack of capability, left RQDs in a vulnerable position, and SPCCT members stepped in to provide educational and emotional support to RQDs. Along with recommendations on patient management, they offered advice on how to approach communication

challenges, and information on how to recognise the symptoms and signs of dying. Many were alert to signs of emotional distress and provided a listening ear and guidance. Several considered the provision of emotional support to RQDs as part of their role. Other studies have identified SPC professionals in acute hospitals as an important source of learning (Price and Schofield, 2015; Kawaguchi *et al.*, 2017) and support (Gibbins, McCoubrie and Forbes, 2011) for RQDs in relation to EoL care.

Participants considered that RQDs ability to participate in EoL care was hindered at times by lack of appropriate and clear documentation of ceilings of care decisions that participants knew had been made by the primary team. Documentation of these could have supported RQDs to take certain approaches to patient care when on call. Instead they ended up in situations where they were required to be more aggressive in pursuing investigation and management than might have been the intention of the primary team.

RQD capability in and the emotional impact of providing EoL care will be further explored in the Discussion Chapter.

6.4.3 The brokering role of the SPCCT

The position of broker is a challenging one. Boundaries are places where misunderstandings can easily occur (Wenger, 1998) and brokers require a range of skills and attributes to introduce knowledge and practices across workplace boundaries (Bornbaum *et al.*, 2015; Kubiak *et al.*, 2015; Kislov, Wilson and Boaden, 2017). In their brokering role between the SPC CoP and multiple local physician CoPs, the SPCCT members encountered a wide variety of attitudes of senior doctors towards a palliative care approach and what it could offer to patient care. Other studies have

also reported a variety of attitudes towards palliative care (Jackson, Wilde and Williams, 2003; Ewing, Farquhar and Booth, 2009; Price and Schofield, 2015). Some consultants were inclusive and welcomed input, while others were undermining and dismissive. The attitudes of these senior doctors, whose preferred approach to care determined the practice of their team, were considered to be a powerful influence on RQD learning. Results from other studies suggest that generalist services use SPC services and trust increases when there is expression of respect and appreciation of roles and contribution to patient care (Firn, Preston and Walshe, 2016)

Participants described their efforts to gain the trust of local physician CoPs. These included being available, approachable, responsive, supportive, as well as explaining the rationale behind their recommendations, sometimes to multiple members of the local physician CoP. Visibility, accessibility and timeliness of responses have been identified as important for referrers to SPC services (Ewing, Farquhar and Booth, 2009).

The intention of SPCCTs is not to deskill primary teams (National Advisory Committee on Palliative Care, 2001). Several participants mentioned their wish to enhance the skills of primary teams to enable them to care for patients where the dying process was not complicated and who were not in need of specialist services. Some raised concerns that they might be inadvertently deskilling primary teams by unintentionally facilitating a reduction in their involvement in EoL care. These concerns about deskilling have been raised in other studies (Jack, Oldham and Williams, 2002; Gott *et al.*, 2012). However, a systematic review by Firn et al. (2016) reported that primary teams who worked collaboratively with SPCCTs in providing an integrated approach to care, were better able to provide generalist palliative care than infrequent referrers.

The potential of the SPCCT to support RQD learning and development of capability in EoL care will be considered in Chapter 7 (Discussion).

Several participants noted a tendency towards disengagement by many primary physician teams as patients approached death. They frequently described their efforts to establish clear boundaries around their role as a consult service. Despite these attempts, participants frequently encountered primary teams virtually handing care over to them once death was considered inevitable. Ewing et al. (2009) found that referrers frequently left basic aspects of psychological care of patients and families to the SPCCT and also assumed they would deal with the complex needs of patients, that were well often beyond the scope of the SPCCT members. RQDs in Price & Schofield's (2015) study perceived that once a referral had been made, further decision-making was commonly left to the SPCCT. The phenomenon of doctors avoiding dying patients has been identified by RQDs and other healthcare professionals (Gibbins, McCoubrie and Forbes, 2011; Gott *et al.*, 2012; Bharmal *et al.*, 2019) and may be part of a wider medical culture that tries to evade dealing with death and dying (Reid *et al.*, 2015).

6.5 Conclusions

This study highlights SPCCT members' views on RQD capability in EoL care and their experiences of brokering in the LoP in which RQDs work and train. Many RQDs were perceived to lack the knowledge and skills needed to provide EoL care and their supervision by senior doctors was often inadequate. Consultants had a wide range of attitudes towards palliative and EoL care and these influenced the RQDs on their teams. Participants considered that RQDs often did not have an understanding of palliative care and found EoL care difficult. SPCCT members considered RQD

education as part of their role and had suggestions for ways in which RQD learning could be further supported.

Chapter 7

Discussion

7.1 Introduction

In my thesis I focus on recently qualified doctors' (RQDs) experiences of and learning about end of life (EoL) care in the cultural context of the acute hospital setting. This is where most RQDs spend their initial working years and is the setting in which approximately half of all deaths occur in Ireland (McKeown et al., 2010). In the developed world, socioeconomic and healthcare changes have resulted in increased life expectancy and excessive use of interventions and healthcare resources at the EoL (Sallnow et al., 2022). Associated with these transformations, there is a wider cultural reluctance to accept the inevitability of death (Gawande, 2014). These factors interweave to influence culture in the healthcare workplace.

There is an abundance of research on palliative and EoL care in medical education. This research predominantly focuses on knowledge, preparedness for practice, and experiences of medical students and RQDs. Many of these studies identify the need for the inclusion of more content in both formal and informal curricula (Hesselink *et al.*, 2010; Mason and Ellershaw, 2010; Bowden *et al.*, 2013; Chiu *et al.*, 2015; Bharmal *et al.*, 2019; Pieters *et al.*, 2019). Bleakley (2010) has highlighted the affordances of social learning theories in the complex area of medical education. As learning about EoL care had been less well explored from a socio-cultural perspective, I considered this to be a relevant area that warranted further attention.

I aimed, through the use of theory to gain insights into how socio-cultural contexts impact on RQDs' learning, experiences and perspectives in caring for patients at the EoL. In considering this issue from a variety of perspectives (RQD, consultant, and specialist palliative care consult team member) I was aiming to gain a richer understanding of the challenges and opportunities in learning to deliver EoL care. I hoped through the use of these insights, to provide suggestions that could inform interventions to improve EoL care experiences for RQDs, patients, and families.

7.2 Summary of thesis

In Chapter 1, I presented a case for exploring how socio-cultural contexts impact on learning, experiences, and perspectives of RQDs in caring for patients at the EoL. Difficulties encountered by RQDs in providing EoL care have previously been identified but have not been well explored from a cultural perspective. In addition, little attention has been given to the views and experiences of consultants and members of acute hospital specialist palliative care consult teams (SPCCTs) of supporting learning in this area.

My research questions were:

1. What and how do recently qualified doctors learn within their physician teams about EoL care?

2. How do recently qualified doctors navigate the wider landscape of practice when caring for patients at the EoL?
3. How do consultants support RQD and medical student informal learning about end of life care?

4. How do SPCCT members perceive RQDs capability and involvement in the provision of EoL care?
5. How can acute SPCCT members support RQDs to develop capability in EoL care?

In Chapter 2 (Conceptual Orientation and Methodology), I outlined the context and rationale for my approach to this work and justified my theoretical choices of Communities of Practice (CoP), Landscapes of Practice (LoP) and a realist theory of workplace learning in postgraduate medical education. I described my paradigmatic stance and explained my methods of data collection and analysis. I also identified and reflected on my position in relation to my research.

I followed this with four data chapters, each describing a separate qualitative study. All four studies were interview studies, and I used a similar methodology in each. For initial analysis I inductively applied Braun and Clarke's method of reflexive thematic analysis (Braun and Clarke, 2006, 2019) and at a later stage applied one or more of the educational theories as a lens to address my research questions. There was a focus throughout all these chapters on socio-cultural aspects of learning.

In Chapter 3, I addressed research question 1 and used CoP theory to explore RQD learning about EoL care within their physician team. RQDs encountered many challenges and found this area of work emotionally impactful. Undergraduate medical education had often failed to prepare them to deliver EoL care. In their physician teams, they frequently experienced practices that viewed patients as either living or dying, with consequent implementation of abrupt changes in the focus of care. Those interviewed perceived that dying was sometimes diagnosed late, and this could lead to moral distress when they had to inflict burdensome investigations and treatments

on patients who they thought would not benefit from these. EoL care was not seen as part of the core business of many physician teams. When patients were identified as dying, what was perceived to be active care was withdrawn and RQDs were often left to deliver the medical aspects of EoL care. Participants justified this disengagement of seniors from EoL care even though it left them to attend to dying patients' medical needs.

In Chapter 4, I examined RQD learning about EoL care as they moved between physician teams in a variety of specialties on their training journey, encountering many other specialties, professions, and systems along the way. In this study I used LoP theory. Each physician team had its own practice around death and dying, which was based on the consultant's preferences and there was wide variation in these. RQDs had to adjust to the local practice and doing this involved the emotional work of ongoing identity renegotiation. On-call work presented extra challenges as RQDs were required to provide care to patients under the care of other physician teams, each with their own practice. The SPCCT was an important source of support for many RQDs.

In Chapter 5, consultants support of RQDs' and medical students' learning about decision-making and communication at the EoL was explored. A realist theory of workplace learning in postgraduate medical education and CoP theory were employed to explore this area. Opportunities for supported learning were predominantly reserved for senior trainees above the level of RQDs. The findings in respect of entrustment decisions were reflective of consultants considering these to be critical and difficult areas of practice. Participants frequently seemed unaware of the value learning to RQDs and medical students. In order to protect patients and families, they often

excluded these learners from consultations where there was communication of bad news. This gap in supported learning may have led to unintentional learning.

In Chapter 6, I focused on how members of acute hospital SPCCTs perceive RQDs capability in EoL care and how they might support learning in the workplace. This study highlighted SPCCT members' experiences of brokering between the specialist palliative care and the physician teams in which RQDs work and learn. Consultants' attitudes towards palliative and EoL care were variable, and these were considered to influence the attitudes of RQDs on their teams. The participants considered that RQDs often lacked the knowledge and skills needed to provide EoL care and frequently were not adequately supported by senior doctors on their teams. SPCCT members identified that support and education of RQDs was part of their role and had suggestions for ways in which RQD learning could be additionally supported

In the current chapter, I will synthesise key findings from the four interview studies and draw the findings together to provide new insights. I will discuss implications for practice, suggest areas for future research, offer observations on CoP and LoP theories and identify strengths and limitations of my research.

7.3 Principal findings

7.3.1. End of life care in the landscape of practice

Encountering the deaths of patients is an inevitability for doctors. The majority of deaths in acute hospitals can be anticipated and these patients have an identifiable dying period prior to death (McKeown *et al.*, 2010; Gómez-Batiste *et al.*, 2014; Sallnow *et al.*, 2022). Supporting patients to die as well as possible is the responsibility of all doctors and is not limited to a minority engaged in specific specialties (General Medical

Council, 2010; Ryan *et al.*, 2014; Sallnow *et al.*, 2022). A common theme running across all four studies is the place of EoL care in the medical landscape of practice. At times, the perspectives of participants in the various studies align with and complement each other, and sometimes there are contradictions and tensions. I will highlight both aspects in this discussion.

EoL care is not core business

The findings of both the RQD (Chapters 3&4) and SPCCT (Chapter 6) studies point towards EoL care not being part of the core business of many physician teams. When patients were actively dying, participants in these studies commonly identified a disengagement by senior doctors. This has also been reported in other studies and was identified in the systematic review performed by Bharmal et al. (2019). RQD participants in my research reported being left unsupported to get on with the provision of medical care. SPCCT participants described having to consciously emphasise their advisory role and push back against being considered to have taken over patient care. In the first RQD study (Chapter 3), participants described that there was often a reductionist view taken in relation to EoL care. Patients were seen as either dying or not dying, which had direct consequences for the approach taken to their care. Patients who were identified as dying were *"made palliative",* which signified a cessation of disease managing treatments and a perception that nothing more could be done. Patients who were not identified as dying were given what was perceived as active care, which continued up to the point where a senior doctor, usually the consultant made the call that the patient was now dying. The perception of palliative and EoL care as a passive form of care, has for many years been strongly refuted by those involved in the delivery of SPC:

> Patients with incurable illness must no longer be viewed as medical failures for whom nothing more can be done. They need palliative care, which does not mean a hand-holding, second-rate, soft option, but treatment that most people will need at some point in their lives, and many from the time of diagnosis, demanding as much skill and commitment as is normally brought into preventing, investigating and curing illness. (Kearney, 1991, p. 170)

The findings detailed in Chapter 3 raise the question of how much, if at all, attitudes have changed over the intervening thirty or so years.

Variation in approaches to EoL care

In Ireland, doctors move frequently between physician teams in the early years after qualification. In doing so they experience different ways of approaching patient care. In addition, in on-call situations they encounter and have to negotiate the practices of many other physician teams of which they are not members. My research uncovered significant challenges that RQDs face in relation to EoL care on this journey through the LoP (Chapter 4). In the various physician teams they rotated through, RQDs participated in a wide array of practices, which were strongly influenced by consultants' individual preferences. Some specialties were perceived to be more likely to diagnose dying earlier or later than others. These practices could not be simply explained by the enterprise of specific specialties and reflected individual consultant's attitudes. These differences in approaches to practice were challenging. RQDs had to figure out how things were done within the team they joined. This could range from proactive identification of dying with thoughtful care planning and communication, to disengagement once dying was diagnosed, or to a reluctance to acknowledge a patient's impending death with the resultant continuation of futile and burdensome

treatments. Along their training journey, RQDs had to adjust what they did to fit into the prevailing practice.

Differences between specialties in the management of EoL has been identified in other studies (Olmsted *et al.*, 2014; Price and Schofield, 2015; Rodriguez *et al.*, 2015; Redman *et al.*, 2017; Lee *et al.*, 2019; Chapman *et al.*, 2021). The impact of differences between individual consultants' approaches to practice on trainees has been highlighted in surgical training (Apramian *et al.*, 2015) but to my knowledge it has not previously been identified in the context of EoL care.

SPCCT participants also reported a broad range of consultants' attitudes towards their practice. Some consultants were open and welcomed their involvement in patient care, while others were dismissive, and some were openly hostile. In keeping with RQD accounts, they perceived that a consultant's attitudes influenced the practice of the team and RQD learning. They identified tensions between their enterprise and that of many local physician CoPs. The practice of the SPCCT included putting substantial effort into gaining trust and legitimacy with these local physician CoPs. These are common challenges of brokering (Kubiak *et al.*, 2015; Kislov, Wilson and Boaden, 2017).

On initial consideration, there is an apparent contradiction in the finding that while SPCCT members had to work hard to be considered legitimate contributors to patient care, they were often left to take over patient care at the EoL. A conflation of palliative and EoL care and the binary conceptualisation of dying offers a possible explanation for this. When the SPCCT made recommendations for patient care earlier in a disease trajectory (before a patient was considered to be dying), they were encountering a boundary between the practice of two CoPs. Such boundaries are acknowledged as

challenging places where the competences of the SPCCT may not be recognised or valued (Fenton-O'Creevy, Dimitriadis and Scobie, 2015; Kubiak *et al.*, 2015). Whereas, when a patient was diagnosed as dying the objective of patient care changed to one that was not core to many local physician CoPs. The effect of this was that consultants disengaged and hence the boundary disappeared.

Deficits in care planning

Additional evidence of the non-inclusion of EoL care in the enterprise of many physician teams is provided by the lack of attention to proactive care planning and careful documentation of this when patients with serious illnesses were approaching EoL. This issue was raised by all three participant groups. RQDs described their struggles on-call when a patient deteriorated and there was an absence of documentation of intentions for care. Some consultants pointed to a reluctance by their colleagues to engage in identification of those approaching EoL This meant there was a lack of forward planning and deficiencies in communication with patients and families, and documentation of plans for care. RQDs find well implemented goals of care initiatives helpful to guide patient care in out-of-hours situations (Dahill *et al.*, 2013). SPCCT participants noted that even when decisions were made about ceilings of care, they were often poorly documented and not readily accessible to support RQDs in on-call situations. Advance care planning is complex and this can lead to doctors avoiding engaging in this practice (Cummings *et al.*, 2017; Walzl *et al.*, 2019). It could be expected that if EoL care was considered a core part of the business of physician teams, a repertoire of practice would have developed that supported these decisions when made, to be communicated to those providing patient care out-of-hours.

EoL care and entrustment decisions

In apparent contradiction to the findings of the RQD study where participants reported being left to figure out EoL care, the consultants interviewed appeared to consider EoL care a critical area of practice. The participants in this study had set the bar very high for entrustment in the form of either observation or participation in communication with patients and their families about EoL decisions or care. Many of those interviewed appeared to be unaware of the level of involvement RQDs had in EoL care, particularly in communication with patients and their families. Hence consultants may have underestimated the value to RQDs of learning about EoL, and as a result didn't consider this in entrustment decisions. Another potential factor is that consultants who were willing to participate in my research were individuals who held particular attitudes towards EoL care. They may have taken more personal responsibility for patient care at EoL and have been more hands on in their EoL care practice than those who were invited and chose not to participate. It is possible that others who were invited and chose not to participate, might not have engaged as much and entrusted more without providing adequate supervision and support of learning.

Culture and learning

RQDs learn and form their identities in the workplace from the practices they engage in and align with (Wenger-Trayner et al., 2015; Wenger, 1998). They learn from what is done, what is not done, what is valued and what is not valued by senior doctors. Much of this learning is tacit. The political nature of the LoP has been pointed out by Wenger-Trayner & Wenger-Trayner 2015, (p16): *"A landscape consists of competing voices and competing claims to knowledge, including voices that are silenced by the claim to knowledge of others. This creates knowledge hierarchies amongst practices."*

According to the theory, competence recognised within a particular CoP may not be recognised within others in the LoP. My studies highlight widely varying attitudes towards the practice of the SPCCT, the importance of early identification of those patients who may be approaching death, and active engagement with patient care at the EoL. The finding that RQDs often excused lack of knowledge about EoL care and disengagement by senior doctors when patients were dying, suggests that there was culturally mediated learning about EoL care and its place in the LoP. At a local CoP level, identifying with the practice of the physician team was a possible explanation for this. Viewing this through a LoP lens may provide another explanation. There is increasing respect for and acceptance of super-specialisation and the development of expertise in ever narrowing areas. This has happened at the expense of regard for generalist competences (Campbell and Dave, 2018; Srivastava, 2020). From both a CoP and LoP perspective, evidence from my studies suggest that EoL care is often subverted in favour of approaches that are seen to prolong life even when this is not realistically achievable.

7.3.2 Recently qualified doctors capability in end of life care

Deficits in supported participation in practice

According to Dornan *et al.* (2018), capability is an ever evolving individual integration of intellectual, practical and affective capabilities; the development of which requires supported participation in real world practice. In Chapter 3, RQDs described lacking the knowledge and skills needed to deliver EoL care when they started work as interns. Their undergraduate education had not prepared them for this work, and they were frequently left to figure it out without guidance from seniors. Hence, they were often not supported to develop capability in EoL care by the senior doctors in their teams.

In the absence of clinical supervision by senior doctors, some described looking to SPCCT members for advice and support. These findings are consistent with previous research (Gibbins et al., 2011; Kawaguchi et al., 2017; Price & Schofield, 2015).

The findings reported in Chapter 6 of SPCCT member interviews provide another perspective on RQD capability. SPCCT participants had frequent interactions with RQDs in the provision of EoL care, both written and verbal. Through these interactions they formed opinions about RQDs capability. They perceived that RQDs often lacked communication skills and knowledge about what palliative care could offer and medication management at the EoL. They also frequently observed that RQDs were not supported by those more senior on their physician teams. In addition, they identified that this was an area of practice that had a significant emotional impact on RQDs, especially those most junior.

Participants in the consultant study (Chapter 5) described how they intentionally supported their trainees to learn about EoL decision-making and communication of bad news, however most of their efforts were focussed on trainees above the level of RQDs. Many participants seemed unaware of the level of communication skills that RQDs needed in their work, particularly when on-call and therefore overlooked the value of this learning to RQDs. In an area that had a high threshold for entrustment, they made decisions that did not support RQDs to develop capability in EoL care.

The lack of support of senior doctors for RQDs in the delivery of EoL care has been noted in other studies. In the systematic review conducted by Bharmal et al. (2019), this lack of support along with RQD deficiencies in knowledge and skills, in conjunction with out-of-hours challenges were highlighted under the theme: *"thrown in at the deep end".* Some of the studies reviewed by Bharmal et al. (2019), found that senior doctors

also actively encouraged disengagement of juniors from patients at the EoL, but we did not identify evidence of this. Our observation that consultants potentially underestimate the value to RQDs of learning about communication of bad news and at the EoL is a new insight and has implications for practice.

Prescribing at EoL

Prescribing at the EoL requires tailored selection of medications, doses and routes to individual patients' circumstances (National Institute for Health and Care Excellence (NICE), 2020). SPCCT participants identified that doctors sometimes looked for and adopted quick fixes to prescribing at EoL. As a result, there were concerns about potentially inappropriate prescribing of palliative medications by both senior and junior doctors, which were sometimes based on recommendations made for previous patients. This simplistic approach was considered to be related to lack of knowledge. It provides evidence of a lack of capability of RQDs and some more senior doctors in this area. Other researchers have found that prescribing errors, while more commonly made by inexperienced doctors, are made by doctors of all grades (Dornan *et al.*, 2009). Their in-depth study reported that errors often resulted from a complex array of factors and were not accounted for by lack of knowledge and skills in a simple linear manner. Contextual factors such as work pressures, lack of senior support, and following senior doctors' orders without question, resulted in adaptations that contributed to prescribing errors. This suggests that seeking a formula for prescribing at EoL may not be solely an issue of lack of knowledge, and that providing more education and guidelines to RQDs on prescribing at EoL may not be enough to address potentially inappropriate prescribing. The effectiveness of any initiatives introduced to improve prescribing at EoL should be evaluated.

Specialist palliative care support of participation

SPCCT participants (Chapter 6) outlined their conscious efforts to support RQDs to develop knowledge and skills. Several of those interviewed also described providing them with emotional support. Other studies have identified SPC professionals in acute hospitals as an important source of learning and support for RQDs in relation to EoL care. Informal discussions with SPC healthcare professionals about approaches to management, the rationale for selection of particular medications, and observation of SPC members' consultations with patients and families have been identified by RQDs as particularly helpful for their learning (Gibbins, McCoubrie and Forbes, 2011; Price and Schofield, 2015; Kawaguchi *et al.*, 2017). The benefits in terms of support and feedback of having a SPC member participate with a RQD in a breaking bad news conversation with patient or family have also been highlighted (Gibbins, McCoubrie and Forbes, 2011; Kawaguchi *et al.*, 2017). Studies have also found observation of SPCCT consultations to be a valuable source of learning and skill acquisition by generalist staff (Salomon *et al.*, 2001; Jack, Oldham and Williams, 2002, 2003; Kawaguchi *et al.*, 2017). A small number of participants in our SPCCT study described providing opportunities for RQDs to observe or jointly participate in a conversation between them and a patient. These did not appear to have been common occurrences. Where they did occur, participants perceived that they were very useful learning opportunities. Additional opportunities for RQD learning were identified, including working for a period in a SPC job, sitting with a dying patient and their family, attending multidisciplinary meetings (e.g., in the context of cancer care), and attending facilitated debriefs after difficult cases. The potential for SPCCT members to support RQDs to develop capability in EoL care will be considered further under implications for practice.

7.3.3 Recently qualified doctors, end of life care and emotions

Emotion is a broad concept that can be viewed from a wide range of perspectives and defies simple definition (McNaughton, 2013; Tyng *et al.*, 2017). McNaughton (2013) and Ajjawi et al. (2022) have identified a range of discourses and theoretical positions in relation to emotion in medical education. These include emotion as a physiological response, a competence, reflective practice, and a socio-cultural mediator. They posit that the first two position emotion as problematic to be ignored or regulated. They call for the role of emotion in learning to be recognised, and argue that emotion conceptualised in terms of reflective practice and socio-cultural perspectives can be harnessed to improve medical education.

In relation to death and EoL care, emotion is omnipresent but often not acknowledged. Contact with death and dying is inescapable for RQDs. Studies have found that doctors experience powerful emotions as a response to the initial deaths they encounter and often describe remembering them long afterwards (Lloyd-Williams, 2002; Brennan *et al.*, 2010; Crawford and Zambrano, 2015; Linane *et al.*, 2019). RQDs work in a medical culture that frequently views the expression of emotions by doctors as unprofessional (Shapiro, 2011; Bolier *et al.*, 2018; Childers and Arnold, 2019; Wang, Swinton and You, 2019), and death as a failure (Wear, 2002; Jackson *et al.*, 2008; Sallnow *et al.*, 2022). In addition, doctors have to cope with powerful emotional reactions of patients and their families in the face of approaching death.

It is recognised that emotion plays an important role in modulating learning (McConnell and Eva, 2012; Tyng *et al.*, 2017; Dornan *et al.*, 2018). It has been argued that emotion is ever present in doctors' work but its role in medical education has traditionally been under recognised and under represented in medical education research (Shapiro,

2011; McNaughton, 2013; Dornan *et al.*, 2014). The importance of recognising and explicitly addressing emotion in medical training at undergraduate and postgraduate level has been highlighted (McNaughton, 2013; Dornan *et al.*, 2015; Lundin *et al.*, 2018; Mills *et al.*, 2021; Ribeiro *et al.*, 2021). According to Dornan et al. (2018) emotions are integrally associated with mood, motivation, and the development of self-confidence and identity. The importance of positive role modelling and support for medical students and RQDs when they encounter dying patients has been highlighted (Ratanawongsa, Teherani and Hauer, 2005; Tait and Hodges, 2013). Conversely, lack of support for medical students who are involved in the care of seriously ill patients has been linked to emotional distress and negative emotional responses (Wang, Swinton and You, 2019).

If negative emotions provoked by patients' deaths are not recognised and addressed, they may impact negatively on an individual doctor's health and wellbeing, and on the quality of patient care they offer (Meier et al., 2001; Whitehead, 2014). Feelings such as sadness, guilt, anger, fear, and failure can lead to avoidance of the patient and their family (Meier et al., 2001; Sansone & Sansone, 2012). Other potential consequences include poor communication with patients and other healthcare professionals, omissions in care, emotional distress and ultimately burnout (ibid)

Emotional response to observing practice

There are several instances where emotion and its impact on learning is evident in my findings. The emotional impact on RQDs of participating in EoL care was identified in Chapters 3 and 4 (RQD studies) and Chapter 6 (SPCCT study). However, it received little attention in the consultant study with a few notable exceptions. RQDs experienced both positive and negative emotions in relation to observing and

participating in care of patients at the EoL. When they observed what they perceived to be good practice and were supported to learn, they experienced positive emotions such as gratitude, admiration and reassurance which could provide motivation to learn, develop skills and prompt reflection. However, more commonly they described experiencing negative emotions when they were unsupported, lacked knowledge and skills, or were exposed to situations where they suffered moral distress in the face of aggressive management of dying patients. Negative emotions were a trigger for reflection and learning. Some participants described learning how not to do things from witnessing consultants displaying poor attitudes and behaviours.

Emotion is considered to play an important role in doctors' identity development (Dornan *et al.*, 2015, 2018; Ribeiro *et al.*, 2021). Dornan et al. (2015) using Figured Worlds theory, reported that positive emotions were expressed by medical students when they were enabled to participate in patient care. Participants witnessing what they considered to be good practice could result in them identifying with doctors and expressing positive emotions. Witnessing what they considered to be doctors' unethical or uncompassionate practice prevented them from identifying with those doctors and resulted in negative emotions. The same scenario could lead to both positive and challenging emotions such as admiration and concern.

Experiences of moral distress

Moral distress is a circumstance in which an individual is required to act and be complicit in an action or actions that conflicts with their moral code (Berger, 2014). Aggressive treatment of patients who are perceived to be dying can cause moral distress for doctors in training (Berger, 2014; Sajjadi *et al.*, 2017; Rosenwohl-Mack *et al.*, 2021; St Ledger *et al.*, 2021). In Chapter 3, I reported on participants' (RQDs)

experiences of moral distress, when as a result of their lack of legitimacy and power in their physician CoPs, they were compelled to inflict burdensome and futile investigations and treatments on patients they considered to be dying. Hierarchical structures in medicine with trainees feeling unable to speak out against aggressive treatment of dying patients has also been highlighted as a cause of moral distress in other studies (Rosenwohl-Mack *et al.*, 2021; St Ledger *et al.*, 2021). Our participants described their frustration and distress in these situations and their learning to hint or say nothing.

Responses of trainees to moral distress have not been extensively studied. An exploration of medical students' emotional response to moral dilemmas and how these influence professional development was performed by Ribeiro et al. (2021). They found that moral dilemmas resulted in complex and intense emotional responses that were remembered long afterwards and influenced professional identity development. Initial responses included detachment and upset, longer term negative responses included avoidance and detachment. Researchers studying moral distress in medical trainees have identified responses that include frustration, avoidance, and increased apathy (Liu *et al.*, 2022). Sajjadi et al., (2017) reported depersonalisation, emotional exhaustion, and an association with burnout. The phenomenon of moral residue has been identified (Epstein and Hamric, 2009; Liu *et al.*, 2022). This is as a consequence of previous experience of moral distress and leads to a sensitisation to future moral distress.

Emotions in the landscape of practice

RQDs described how they had to adjust in relation to the practices of the individual local physician CoP. The wide array of approaches to EoL care described by RQDs

and SPCCT members suggests that RQDs did considerable emotional work in ongoing modulation of identity as they moved between physician CoPs on their training journey (Fenton-O'Creevy *et al.*, 2015). Added to this was the uncertainty and increased responsibility they experienced while on-call.

SPCCT members readily acknowledged that this was an emotionally difficult area of practice for RQDs who were lacking in knowledge and skills and might have had their own personal experiences of death or have never encountered death before. They were alert to RQDs expressions of uncertainty, anxiety, and distress. They described responding to these through the provision of guidance and emotional support. Many SPCCT participants considered support of RQDs learning and emotional wellbeing as part of their role. They gave support through offering explanations of their clinical recommendations to help RQDs bridge knowledge gaps, offering advice on approaches to communication, and allowing RQDs to express concerns or upset. In contrast to the wider practice in medicine of suppressing emotions in the face of death and viewing them as problematic (Wagner *et al.*, 1997; Sullivan, Lakoma and Block, 2003; Rhodes-Kropf *et al.*, 2005; Childers and Arnold, 2019), specialist palliative care CoPs incorporate self-care and acknowledgement of emotion into their practice (Mills, Wand and Fraser, 2018) and identify these as a core part of professional competence (Ryan *et al.*, 2014).

In the consultant study, reports of concern for the emotional impact of this work on RQDs were largely absent. Only a small number of participants, apart from the two palliative medicine consultants, expressed concerns about the potential emotional impact of death and EoL care on RQDs or medical students. Consultants frequently considered patients' and families' potential emotional responses and were aware that

breaking bad news could be emotionally challenging for the doctor doing it. However, most did not explicitly refer to RQD emotions or the need to support them in this area. This aligns with the reports of RQDs in my research and that of others (Crawford and Zambrano, 2015).

Emotion as a socio-cultural mediator

From a socio-cultural perspective, emotion can be viewed as a set of practices mediated in a social, political and cultural context and is *"a medium of exchange at the interface between the individual and his or her social context"* (McNaughton, 2013, p. 76). Hence in taking a socio-cultural stance, it is important to consider how expression of emotion is socialised. This determines what and how emotions can or cannot be expressed by RQDs in their local physician CoPs and the wider world of medical practice (Fenton-O'Creevy, Dimitriadis and Scobie, 2015) . If the relative absence of reference to RQD emotion in the consultant study is reflective of their practices, then a culture in their teams that does not legitimise the expression, acknowledgement or discussion of emotions might be expected. This has been a finding in other studies, which have identified that expression of emotions by medical students and RQDs is discouraged by senior doctors (Tait and Hodges, 2013; Bolier *et al.*, 2018; Wang, Swinton and You, 2019).

The socio-cultural dimension of emotion can also be seen where RQDs, lacking in legitimacy and power experienced moral distress as described above. These situations illustrate the complexity of medical practice for RQDs and their negotiation of identity. Not being able to advocate for a patient brings tension between the identity of being a caring doctor and being a member of the community who understands the enterprise and the practice.

7.3.4 Legitimate peripheral versus marginal participation in EoL care

In applying CoP theory to medical education, medical students and junior doctors are often considered to be legitimate peripheral participants in a wider medical CoP (Cruess, Cruess and Steinert, 2018; Hodson, 2020). The theory proposes that newcomers to a CoP can bring new elements of practice into the community. In order to do this, the newcomer requires a certain degree of legitimacy (Wenger, 1998). In relation to practices around EoL care, RQDs perceived that they had little or no legitimacy to influence how EoL care was practiced on their physician teams. RQD 15 had tried unsuccessfully to get earlier referrals to specialist palliative care for patients she thought would benefit (Chapter 3). RQD 7 had learned about EoL care while working in the hospice but was not going to draw attention to this learning when he moved to cardiology (Chapter 4). RQD 14, who had a few years post qualification experience, had been asked his opinion by consultants on various aspects of patient management, but never asked if he thought a patient might be dying (Chapter 3). Several others mentioned hinting and other indirect attempts to draw consultants' attention to patients' deterioration and possible impending death (Chapter 3). The struggles that participants encountered and the lack of success in having their opinions considered in relation to EoL care decision-making raises the question of whether RQDs can be considered legitimate peripheral participants (LPPs). In relation to EoL, the participation described by participants was often problematic and appeared to be more marginal. Handley et al. (2006) contends that participating in the sense of situated learning relates only to those who move from peripheral to full participation, and hence many who might otherwise be considered LPPs are actually marginal participants.

Other researchers have also found that junior doctors did not contribute to decision-making and were unable to speak out against what they considered to be aggressive and burdensome approaches to medical care when patients were dying (Gott *et al.*, 2011; Rosenwohl-Mack *et al.*, 2021; St Ledger *et al.*, 2021). While it is recommended that decisions about directions of care at EoL are the responsibility of consultants (Neuberger, 2013), the General Medical Council (2010, p. 22) has identified that best practice in EoL decision-making should involve speaking to other team members such as RQDs:

> When considering options for treatment and care, and reviewing the patient's progress, you should consult other members of the team who may have information about the patient or relevant knowledge and experience that may help in managing or treating the patient's condition.

A marginal position in a CoP is problematic. For peripheral participants who are only allowed marginal access, their participation is constrained and they are disempowered (Handley et al., 2006; Molesworth, 2017). On the other hand, for a LPP, non-participation is actually enabling as it is viewed as an opportunity for learning (Wenger, 1998). Gill (2013 p. 127) argues that marginality related to being a junior doctor in a temporary post that does not align with their personal trajectory, does not motivate either the junior or the consultant *"to work on membership and belonging and may be counter-productive at this stage of [identity] formation".* For participants in my study, marginality led to lack of power to influence the direction of patient care, and this had an emotional cost.

I believe the lack of provision of opportunities by consultants for RQDs to learn about communication and EoL decision-making is consistent with them being marginal

participants, at least in relation to these areas of practice. The findings of the SPCCT members study where RQDs were seen to lack legitimacy on their teams adds support for this assertion.

7.4 Implications for practice and future research

In exploring implications for practice, it is important that I consider the complexity of the socio-cultural milieu around dying, death, and EoL care. The prevailing medical culture has not evolved in a vacuum but rather in a wider societal context. The *Report of the Lancet Commission on the Value of Death* has identified complex death systems that are mediated in social, cultural, political, religious, and economic contexts and are:

> … the means by which death and dying are understood, regulated, and managed. These systems implicitly or explicitly determine where people die, how people dying and their families should behave… what death means for that culture or community. (Sallnow et al., 2022, p.10).

Moreover, adding to this complexity, it has been argued that anxiety of death is far reaching and is the primary mediator of culture and human behaviour (Becker, 1973). In complex systems the effect of change is unpredictable (Bleakley, 2010) and sometimes a small change can have a major impact.

My research has identified several implications for practice that if addressed could support RQDs to develop capability in EoL care and improve the experiences of patients, families and RQDs. Some would require the introduction of wider system level changes at multiple levels and others are more specific.

Changing EoL care

The recently published report of the Lancet Commission (Sallnow *et al.*, 2022) identified a need for changes in how EoL care is approached. Multiple desirable changes in political, economic, societal, cultural, and healthcare factors were highlighted. My research has highlighted changes that would support RQDs to develop capability in EoL care.

In Chapter 1, I presented a case supported by Irish government policy for EoL care being the responsibility of all doctors and other healthcare professionals, regardless of their area of work or specialisation (National Advisory Committee on Palliative Care, 2001). In the UK, the General Medical Council considers that all doctors have a duty of care to patients at the end of life (General Medical Council, 2010, n.d.).

Timely identification of a potential impending death is important. Late identification that a patient might be approaching death or actively dying has far reaching consequences. My research found that it led to RQDs suffering moral distress. It also leads to unnecessary patient suffering and poor preparation of families (Leadership Alliance for the Care of Dying People, 2014; Redman *et al.*, 2017). There are lost opportunities for patients and their loved ones to spend time together, have important conversations and to attend to legal and financial matters. While not all impending deaths are predictable, it has been estimated that around 75% of the deaths in Ireland that occur in acute hospitals are expected (McKeown *et al.*, 2010). Evidence from other studies suggest that dying in acute hospitals is often diagnosed late (Gibbins *et al.*, 2009). Even when prognosis is considered to be poor, unnecessary investigations and treatments are continued until close to death. Futile treatments contribute to the exponential rise in healthcare costs in the last month of life in developed countries

(Sallnow *et al.*, 2022). These treatments are often burdensome and delay the provision of comfort measures. Therefore, making EoL care experiences better for patients who have an identifiable dying period and reducing RQD exposure to moral distress, requires both implementation of some and de-implementation of other interventions.

Changing practices in healthcare is notoriously challenging and implementation science has developed to address this (Bauer *et al.*, 2015). Implementation science informed approaches have been suggested for addressing complexity in medical education (McGaghie, 2011). Implementation science requires the use of theory to gain understanding of what works, in what context and why it works. Models and frameworks can then be developed to facilitate implementation and evaluation (Damschroder, 2020).

Implementation science can include both introduction of new practices and interventions as well as discontinuation of others (Bauer *et al.*, 2015; Norton and Chambers, 2020). Both are relevant in relation to EoL care where there is often a need to introduce new elements of care including symptom control, enhanced communication and increased psychosocial support of patients and their family along with discontinuing low value burdensome approaches to care (Ryan *et al.*, 2014; Sallnow *et al.*, 2022). Both implementation and de-implementation in this sense are complex interventions that require considerations to be given to the perspectives of patients, families, healthcare professionals and organisations (Bauer *et al.*, 2015; Norton and Chambers, 2020; Ingvarsson *et al.*, 2022). Implementation and de-implementation of practices and interventions have several strategies in common such as involving stakeholders and getting support from leaders. There are also features that appear to be unique to each (Ingvarsson *et al.*, 2022). One example of particular

relevance in the current context is the need for sensitive communication with patients and families when there is de-implementation of an intervention. Future research should explore how implementation science might address changes to practice at EoL.

Successfully changing practices in EoL care resulting in discontinuation of burdensome low value care and improving comfort is likely to be particularly challenging for clinicians. It would require acknowledgement by doctors that just because the diagnosis of dying is inexact, does not mean that it should not be considered until there is absolute certainty. It would also require doctors to confront the challenge of communicating honestly about uncertainty with patients and families (Neuberger, 2013).

Changing practices in EoL care would necessitate changes at multiple levels by many stakeholders in the healthcare system. Approaches such as those employed to introduce and sustain the Irish National Early Warning System (Department of Health, 2020) where the aim is to ensure "*a whole system response is in place to anticipate, recognise, escalate, respond and evaluate the clinically deteriorating adult patient"* could inform such change. This would require very significant buy in from policy makers and funders. It is important that any such initiative would integrate learning from the problems that arose with the use of the Liverpool Care Pathway (Neuberger, 2013).

Supporting RQDs to develop capability in EoL care

It is evident from our research that RQDs were participating in difficult conversations with patients and families, and many lacked the knowledge, skills, and confidence to do this. Many of the consultants interviewed had not considered this aspect of the

RQD role, perhaps because these conversations often happen out-of-hours, and the RQDs involved may not be members of their own team. Postgraduate training priorities and viewing BBN as an isolated event may also be factors. This is a new insight gained through this research and further research exploring the underlying reasons behind it might offer potential ways of addressing the issue of lack senior support for RQDs engaging in these conversations.

Consideration of trainees' learning needs has been identified as a factor that influences entrustment decisions (Ten Cate *et al.*, 2016). Improving consultants' awareness of RQDs' learning needs and the difficulties they can face, might prompt consultants to provide more opportunities for RQDs to observe and even participate in conversations where bad news is being broken. Increasing the attention given by postgraduate training bodies to supporting the development trainees' communication skills could also offer possibilities. A caveat in providing RQDs with opportunities to observe practice is that they also need to be supported to reflect and make judgements on the quality of the communication they witness. This may require facilitation by someone outside their physician team.

Supporting doctors at all levels to recognise BBN as a process, rather than an isolated intervention offers potential to change practices. The ongoing nature of BBN was exemplified by RQD participants' experiences of being called on to have follow up conversations and to explain plans of care with patients and families. Recognising this and the role that RQDs play after consultants have broken bad news might alter consultants' perspectives on RQDs' communication learning needs and influence their entrustment decisions. Another potential benefit of improving consultants' awareness of the difficulties faced by RQDs could be increased attention given to clear

documentation of ceiling of care decisions that could guide decision-making when patients deteriorate out-of-hours. The effectiveness of any such initiatives should be assessed.

One way to provide further opportunities for supported learning through observation, is to encourage supervisors to move away from making presumptions about what patients want and need. Consultants could be more active in seeking patients' and families' consent for RQDs and medical students to be present for BBN conversations. There is evidence that patients approaching the end of life are often well disposed to being involved in medical education and can find it personally beneficial (Finlay, Maughan and Williams, 2005; Arolker *et al.*, 2010; Hayes, 2012; Harris *et al.*, 2015). The views of family members, and where possible patients close to the end of life should be further researched.

Consultants have a key role in workplace learning. Deficits in consultants' capability and practices in EoL care were highlighted by both RQD and SPCCT participants. This is consistent with the perceptions of newly qualified doctors in the UK who were interviewed by Gibbins et al. (2011). In addition, some consultants had problematic attitudes towards palliative care that had the potential to impact negatively on RQD learning. Improvements in consultants' attitudes to palliative care, knowledge of patient management and communication skills at EoL are important for RQDs workplace learning. Evidence supporting early integration of specialist palliative care (SPC) in the care of oncology patients has informed recommendations and practice guidelines for oncologists (Ferrell *et al.*, 2017; Jordan *et al.*, 2018). Initiatives that support the adoption of such guidelines and encourage the inclusion and integration of SPC healthcare professionals earlier in disease trajectories are important. Such

initiatives along with improving patient care, offer potential for learning across practice boundaries.

Opportunities for SPC support of RQD learning

SPCCT members work at the interface between the palliative care CoP and several local physician CoPs. As brokers they have knowledge of practices across boundaries and because they frequently engage with RQDs they have opportunities to support learning about EoL care. In their interviews, they described supporting RQDs learning in a variety of areas of EoL care, including knowledge, skills, and emotions. Those interviewed identified a range of ways they could further support learning. One such way was through providing opportunities for RQDs to observe or jointly participate in a consultation between them and a patient. These were uncommon occurrences. When they did happen, participants perceived that they were very valuable opportunities for RQDs to learn about good communication skills (such as eliciting patients' perceptions, the value of giving the patient time, and providing bad news). The potential benefits of these types of joint consultations have been recognised by RQDs in other studies (Gibbins, McCoubrie and Forbes, 2011; Kawaguchi *et al.*, 2017), and such opportunities should be encouraged.

Another way that SPCCT members suggested that they could support learning was through facilitating debriefs of difficult cases. This was not something that routinely happened, but SPCCT members could be well placed to do this as it is a practice they engage in both formally and informally in their own CoP as a means of self-care (Mills et al., 2018). I have outlined ways in which SPCCT members could support the use of emotion for reflective learning. There would be resource implications if SPCCT members were to engage in such initiatives with RQDs.

The affordances of palliative care for interprofessional learning both formal (Wee *et al.*, 2001; Sweeney, O'Sullivan and McCarthy, 2015) and informal (Varpio *et al.*, 2014) has been identified. As SPCCTs are composed mainly of clinical nurse specialists (Jack, Oldham and Williams, 2003; Connolly *et al.*, 2021), an additional potential benefit of involving SPCCT members in the education of RQDs is the potential for informal interprofessional workplace learning. The importance of interprofessional collaboration in creating sustainable healthcare into the future and the role of interprofessional education in supporting this has been highlighted (World Health Organisation, 2010; Institute of Medicine, 2015). Stalmeijer & Varpio (2021) argue in favour of the integration of interprofessional and intraprofessional education in workplace based learning in medical education. The role of SPC nurse specialists in supporting RQD informal workplace learning in EoL care in acute hospitals merits additional attention and would provide an opportunity to research nurses' roles in informal aspects of medical education. Dornan et al. (2021) have recently described a formative initiative that used healthcare professionals including pharmacists, nurses, and doctors, along with patient advocates, to facilitate reflective conversations in the context of safe prescribing of insulin. Approaches such as this, which acknowledge complexity and focus on benefitting both patients and clinicians, also offer possibilities for changing practice in other areas.

Providing emotional support

Approaches that have potential to address some of the issues raised in relation to emotion should also be considered. Social initiatives such as Balint Groups (*The Balint Society*, n.d.) to support learning about communication and emotions in medical practice have been proposed (Bar-Sela, Lulav-Grinwald and Mitnik, 2012; Dornan *et*

al., 2015; Bharmal *et al.*, 2019; Wang, Swinton and You, 2019). The introduction of Schwartz Center Rounds (*The Schwartz Center*, n.d.) is another initiative that has been proposed for supporting and legitimising more open discussion of emotions for healthcare professionals including doctors (Granek *et al.*, 2016; National Clinical Programme for Palliative Care, 2019). A recent large-scale realist evaluation in the UK provides evidence that when well implemented and integrated into practice, Schwartz Center Rounds can over time lead to better communication, teamwork, patient care and culture change in healthcare (Maben *et al.*, 2021).

7.5 Implications for theory

The findings of my research demonstrate that the use of Communities of Practice (Wenger, 1998) and Landscapes of Practice (Wenger-Trayner *et al.*, 2015) theory and the realist theory of supervised workplace learning (Wiese, Kilty and Bennett, 2018) offered nuanced insights into RQDs learning about, and experiences of, and perspectives on caring for patients approaching and at the EoL. There are also areas where limitations were uncovered in CoP and LoP theory.

The use of CoP and LoP theory allowed me to uncover cultural influences on practice and learning. In the RQD studies, conceptualising the most relevant workplace CoP as the physician team on which RQDs worked afforded an opportunity to analyse issues of RQD legitimacy and EoL care practices within these teams. While the relatively short time spent by most RQDs on a specific physician team could call into question the use of CoP theory (Roberts, 2006), the use of LoP theory facilitated the exploration of RQDs' learning on their training journey across the healthcare landscape (Hodson, 2020). The use of LoP theory uncovered the challenges posed to RQDs in negotiating local physician teams' varying approaches to EoL care, and the

additional difficulties posed by on-call situations. LoP theory allowed for the complexity of learning in the real world of practice to be conceptualised and explored, and this work adds to the body of knowledge supporting the use of the theory in medical education.

My use of the realist theory of supervised workplace based learning (Wiese, Kilty and Bennett, 2018) provided a framework to analyse how consultants did or didn't support learning about EoL care. This has allowed identification of potential ways in which RQD learning could be better supported by senior doctors through entrustment, modelling and meaning making. Used in combination with CoP theory, it allowed potential unintentional learning to be identified.

There have been critiques of CoP theory in relation to the attention given to power and hierarchical relationships within communities (Roberts, 2006; Sarid and Levanon, 2022), and Wenger has agreed that the theory is not concerned with social structures of power (Farnsworth, Kleanthous and Wenger-Trayner, 2016). In the world of medicine, the hierarchical structure, and the power of the consultant to influence the practice of the local physician CoP can't be ignored. This limitation of CoP theory was apparent in my research in relation to RQDs' place in their teams. Despite this limitation, the theory did allow the problematic nature of RQDs' lack of legitimacy and marginal position in relation to EoL care to be exposed. Power differentials related to politics in the landscape are recognised in LoP theory. This allows knowledge hierarchies amongst CoPs to be uncovered: *"a landscape consists of competing voices and competing claims to knowledge, including voices that are silenced by the claim to knowledge of others"* (Wenger-Trayner & Wenger-Trayner, 2015, p.16*).* This

was seen in the SPCCT study where participants sometimes described negative attitudes of others towards their practice.

The role of emotion in learning in medicine is increasingly receiving attention and recognition. In the context of EoL care, the part played by emotion in learning is particularly relevant and was prominent in my research findings. I found the lack of explicit consideration of emotion in learning in CoP theory to be a significant limitation of the theory. Turnbull (2000) highlights the absence of emotion in CoP theory and has argued that Wenger's account of his ethnographic work with claims processors is rich with examples of emotion, to which he gives scant recognition. This failure to explicitly address emotion in Wenger's work is somewhat akin to the "*ever-present absence*" of emotion highlighted by McNaughton (2013). In some of the essays by authors other than Wenger-Trayner in *Learning in Landscapes of Practice*, emotion and its relationship with learning is explicitly acknowledged (Fenton-O'Creevy *et al.*, 2015; Fenton-O'Creevy, Dimitriadis and Scobie, 2015). In these writings, emotion is considered in the context of individuals moving through the LoP and doing identity work as they encounter the various practices of several CoPs through boundary crossing and boundary encounters. This resonated with RQDs' descriptions of their experiences. Socio-cultural constraints on expression of emotion are also discussed in terms of what can be expressed and in what way. This has particular relevance in medicine where expression of emotion is often curtailed by culture (Shapiro, 2011; McNaughton, 2013).

7.6 Strengths and limitations

The research studies in this thesis had a number of strengths. My paradigmatic stance aligns with the research questions, methodology and methods I employed, thus

addressing a key quality indicator (Carter and Little, 2007). The decisions I made, and my application of reflexive thematic analysis have been clearly outlined in order to support the trustworthiness of my research (Kiger & Varpio, 2020; Nowell et al., 2017).

The use of the socio-cultural theories of Communities of Practice and Landscapes of Practice to explore the cultural aspects of the phenomena I researched are another strength. These theories informed the research design from an early stage. This body of work explored the viewpoints of three stakeholder groups, representing several CoPs, which allows for a broader and more holistic exploration of the topic.

My supervisors, a qualitative health professions education researcher (DB) and a palliative care consultant and clinical educator (TO'B) brought their unique perspectives and vast experience to their supervisory roles. Through engagement in personal reflective practice and reflexivity supported by my supervisors, I sought to extend my interpretations of data and to look at alternative meanings and constructions.

As with all research, mine also had limitations. As my research is underpinned by an interpretivist paradigm, I acknowledge that the findings are related to a local context and do not represent a generalisable truth. I have endeavoured to support their transferability by providing details of context and my positionality.

The use of CoP and LoP theory was a limitation as well as being a strength. The theories lack affordances for considering hierarchical and power relationships in physician teams. The use of a theory that aligns with critical discourse analysis would have provided more affordances to explore power relationships on physician teams (Van Dijk, 1993; Jorgensen and Phillips, 2002). Limitations to the theories are also

apparent in relation to exploring the role of emotions and affective learning in the emotive area of EoL care. These limitations have received further attention in the earlier section on *Implications for theory.*

The RQD participants were primarily graduates of one medical school, the consultants interviewed worked in hospitals affiliated to the same medical school and the specialist palliative care team members were affiliated with one specialist palliative care service. My position as a member of the medical school faculty and my association with the local hospice was potentially known by several participants in each study. This along with other factors such as social desirability bias may have influenced some participants' accounts and responses.

Death and dying are emotive issues; respect for the dead and dying is a norm in our society (Preus, 1984) and to be seen as a good doctor means upholding this respect. This may have influenced how participants portrayed their practices. Moreover, participants in the RQD and consultant studies may have been individuals who were more positively disposed towards end of life care than some of their counterparts. In particular, consultants who participated in this research may have had more interest in this aspect of patient care. Hence the data collected from consultants may not represent the wider landscape of practice that RQDs and medical students journey through.

7.7 Conclusion

Through the use of socio-cultural theory, I have explored a range of viewpoints on recently qualified doctors' experiences, perspectives and learning about end of life care. My findings present a complex picture and highlight the importance of

considering the influences of medical culture in this area of practice. Addressing these cultural aspects, is central to improving RQDs capability in the delivery of EoL care and the experiences of patients and their families.

Final Reflection

In addition to detailing accounts of my reflexivity earlier in this thesis, I now present a reflexive piece following completion of this work. Interpretive research is a process of co-construction involving participants and the researcher, where meaning is *"brought into being in the process of social exchange"* (King, Horrocks and Brooks, 2019, p. 24) Hence my position in this research is of significance and I have provided details of this in Chapter 2.

Death and dying are emotive issues. Given the subject matter of this research, I felt that collection of data required a particularly careful and sensitive approach. Some RQD participants expressed distress during or after interviews and a few became tearful. In these situations I offered to turn off the recorder if it was on, and allowed time and space and the option to discontinue the interview. At these times, I sometimes felt tension between my role as a researcher and my roles as educator and former clinician, and wondered how other researchers might have handled the situation. I think that years of clinical experience of interactions with patients, families and other healthcare professionals in the context of providing end of life care, provided preparation for dealing with participants' upset. However, I was challenged to think about my role and responses in these situations. I felt a responsibility to the RQDs who shared accounts of their thoughts, experiences and emotional responses and was conscious of striking a balance between causing unnecessary upset and attempting to elicit nuanced and insightful descriptions of their perceived realities. The consultant study raised my awareness of the multiple challenges that consultants face in balancing their roles as doctors and educators and responsibilities to patients, trainees and their profession. The study of specialist palliative care consult team

members gave me an appreciation of the careful path they thread in their brokering role.

The onset of the Covid-19 pandemic was a significant challenge. Prior to that as a relatively novice qualitative researcher, I would not have considered conducting interviews in a sensitive area using video technology. I consider that I was lucky to have had experience of doing several in-person interviews in the earlier stages. Ultimately the delay I experienced in getting ethical approval to change my interview methods provided time for both participants and me to become more familiar and comfortable with the use of video conferencing. I cannot say how the final report would have differed had there not been a pandemic.

I felt a sense of responsibility to each participant that carried through to the analysis of each interview and the synthesis of the final report. I often wanted to present too much data and had difficulty letting go and distilling down to what appeared in the final report. My supervisors who were not as close to the data as I was, had clearer perspectives and challenged me, sometimes to let go and at other times to consider alternative views. Ultimately decisions were mine to make and an ongoing process of keeping a reflexive journal helped with this.

The use of the theoretical lenses also provided much assistance in deciding where to focus and how to interpret phenomena. However, I was conscious that the theories also imposed limitations. My decision to include emotions in the final report to the extent that I have, was the result of stepping away from the theory in an attempt to capture what I considered to be a crucial aspect of participants' accounts. As an educator, completing this research has caused me to reconsider the role of classroom based education in the areas of end of life and palliative care. Given the impact of

learning that happens (often tacitly) in the clinical environment, and its power to subvert what has been taught in the classroom, I have spent much time thinking about the implications. From a landscape of practice perspective, as an educator I act as a broker seeking to introduce new practices. It helps somewhat when I grapple with the big question of how to change culture, to recognise that brokering is a challenging position. One change I will make to my teaching as a result of this work, is to discuss explicitly with students the gap between the classroom and the world of practice.

While completing this research, I obtained funding to create an open access resource for teaching and learning of communication skills. My findings from this work influenced the development of scenarios within the resource, for example a request from a family member for non-disclosure of a serious diagnosis. The deeper understanding I have gained of common challenges encountered by RQDs will inform me as I continue to explore how to improve education in this area.

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Appendices

Appendix A: Interview Guide Studies 1 and 2

Interview Schedule

Begin the interview by obtaining professional background information e.g. qualifications, type of undergraduate medical programme, years in practice, current role.

Define what is meant by an imminently dying patient

Questions:

Can you tell me about a time that you cared for a dying patient?

At what stage did you realise they were dying?

What were you expecting?

What were you feeling at the time?

What sorts of things were going through your head?

What if anything would have helped you at the time?

Can you tell me about a time when you had a patient die unexpectedly?

What do you hope to achieve when you are caring for a patient who is imminently dying?

How have your thoughts on this aspect of patient care (knowledge, skills and or attitudes) evolved in this area since you qualified?

Ask about experience of interactions with the clinical nurse specialist in palliative care and how these interactions occur and how advice from the clinical nurse specialist is followed.

learning from the “interaction” with the clinical nurse specialist

When you were a medical student on clinical placement did you ever see patients who were imminently dying? tell me more etc

What, if anything could assist in preparing you for providing care to patients who are imminently dying?

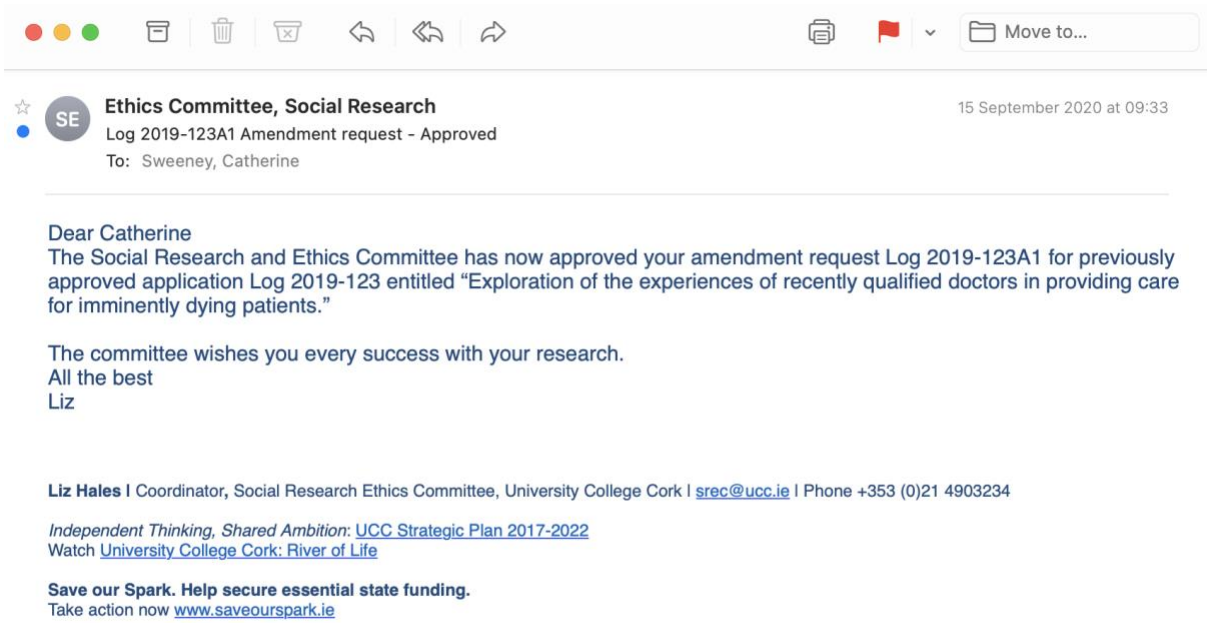
Has anything surprised you about this aspect of the work of a recently qualified doctor?

What do you find the most challenging aspect of this work?

Closing:

Participants will be thanked for their participation and debriefed

Appendix B: Ethical Approval Studies 1 and 2



Move to...

SE **Ethics Committee, Social Research** 15 September 2020 at 09:33
Log 2019-123A1 Amendment request - Approved
To: Sweeney, Catherine

Dear Catherine
The Social Research and Ethics Committee has now approved your amendment request Log 2019-123A1 for previously approved application Log 2019-123 entitled "Exploration of the experiences of recently qualified doctors in providing care for imminently dying patients."

The committee wishes you every success with your research.
All the best
Liz

Liz Hales I Coordinator, Social Research Ethics Committee, University College Cork I srec@ucc.ie I Phone +353 (0)21 4903234

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Appendix C: Participant Information and Consent Form Studies 1 and 2

Information Sheet

Thank you for considering participating in this research project entitled: Exploration of the experiences of recently qualified doctors in caring for imminently dying patients.

The purpose of this document is to explain to you what the work is about and what your participation would involve, so as to enable you to make an informed choice.

The purpose of this study is to explore the experience of recently qualified doctors in caring for patients approaching the end of life**.** Should you choose to participate, you will be asked to take part in a once off one-to-one interview with Dr Catherine Sweeney from the research team. This interview may be face to face or via videocall and will be audio-recorded, and is expected to take approximately 30-40 minutes to complete.

Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions, or decide to withdraw from the interview. Once the interview has been concluded, you can choose to withdraw from the study at any time in the subsequent two weeks.

All of the information you provide will be kept confidential and anonymous, and will be available only to the research team (Dr Catherine Sweeney, Dr Deirdre Bennett, Prof. Tony O'Brien). The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Once the interview is completed, the recording will immediately be transferred to an encrypted laptop and wiped from the recording device. The interview will then be transcribed by the researcher, and all identifying information will be removed once the initial 2 week period during which consent can be revoked has elapsed. The anonymised transcriptions of interviews will be stored on the University College Cork OneDrive system and subsequently on the UCC server. The audio-recording will be stored on the School of Medicine's Schools own local secure storage system. The data will be stored for 10 years as this is a standard requirement for research data. The information you provide may contribute to research publications and/or conference presentations. The data will also contribute to a doctoral thesis.

We do not intend to cause any distress to participants. Some of the topics broached in the interview, however, could be of a sensitive nature. Should you wish to do so, you can choose not to answer questions, or to bring the interview to an end at any time. At the end of the interview, I will discuss with you how you found the experience and how you are feeling. Should you experience distress arising from the interview, you can contact me at c.sweeney@ucc.ie The contact details for your local Employee Assistance Programme are available at the link below:

http://workwell.ie/contact-list/contact-your-local-employee-assistance-programme/eap-service-south-south-west-hospital-group/

This study has obtained ethical approval from the UCC Social Research Ethics Committee.

If you would like any further information concerning this study, please do not hesitate to me Dr Catherine Sweeney c.sweeney@ucc.ie

Tel: 0876624815

Should you have any concerns about the data protection aspects of this project you can contact the data protection officer in UCC: Catriona O'Sullivan| Office of Corporate & Legal Affairs | University College Cork | T: 021 4903949 | email: catriona.osullivan@ucc.ie

You have the right to lodge a complaint with the Data Protection Commission. T: +353 578 684 800/+353 761 104 800 | 21 Fitzwilliam Square South, Dublin 2, D02 RD28

If you agree to take part in this study, please sign the consent form overleaf.

Consent Form for Interviews

Study Title: Exploration of the experiences of recently qualified doctors in caring for imminently dying patients

I……. agree to participate in Dr Catherine Sweeney's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview with Dr Catherine Sweeney to be audio-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview☐

I do not agree to quotation/publication of extracts from my interview☐

Signed: …… Date: ……..

PRINT NAME: ……

Appendix D: Participant Information and Consent Form Study 3

Participant Information

Thank you for considering participating in this research project. The purpose of this document is to explain to you what the work is about and what your participation would involve, so as to enable you to make an informed choice.

The purpose of this study is to explore the experience of consultants supervising medical students on clinical placements, in the context of imminently dying patients. Should you choose to participate, you will be asked to take part in a one-to-one interview with a member of the research team. This interview may be face-to-face or via videocall and will be audio-recorded. It is expected to take approximately 30-40 minutes to complete.

Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions, or decide to withdraw from the interview. Once the interview has been concluded, you can choose to withdraw your details at any time in the subsequent two weeks.

All of the information you provide will be kept confidential and anonymous, and will be available only to the research team (Dr Catherine Sweeney, Dr Deirdre Bennett, Prof. Tony O'Brien). The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Once the interview is completed, the recording will immediately be transferred to a secure storage folder on the UCC network and wiped from the recording device. The interview will then be transcribed by the researcher. All identifying information will be removed once the initial 2 week period during which consent can be revoked has elapsed. The data will be stored for 10 years as this is a standard requirement for research data. The information you provide may contribute to research publications and/or conference presentations. The data will also contribute to a doctoral thesis.

We do not anticipate any negative outcomes from participating in this study. At the end of the procedure, I will discuss with you how you found the experience and how you are feeling. Should you experience distress arising from the interview, the contact details for your local Employee Assistance Programme are available at the link below: support services provided below may be of assistance

http://workwell.ie/contact-list/contact-your-local-employee-assistance-programme/eap-service-south-south-west-hospital-group/

This study has obtained ethical approval from the UCC Social Research Ethics Committee.

If you would like any further information concerning this study, please do not hesitate to me Dr Catherine Sweeney c.sweeney@ucc.ie

Tel: 087 6624815

If you agree to take part in this study, please sign the consent form overleaf.

Consent Form for Interviews

Study Title: Exploration of the experiences of consultants supervising medical students on clinical placements, in the context of imminently dying patients.

I…….agree to participate in Dr Catherine Sweeney's research study.

I give permission for my interview with Dr Catherine Sweeney to be audio-recorded.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

Signed: …… Date: ……..

PRINT NAME: ……

Appendix E: Interview Guide Study 3

Opening:

The interviewer will welcome the participant and re-iterate the information provided in the information document, including the purpose of the research, how the data collected during the interviews will be stored and analysed.

The interviewer will remind participants of the terms of the consent form signed, including the possibility of withdrawal from the study.

Given the topic to be discussed we do not anticipate that it is likely that sensitive disclosures will arise. The participants will be given an opportunity to ask questions regarding the project.

Interview Schedule

Begin

Begin the interview by obtaining professional background information e.g. qualifications, years in practice, current role.

Explain

What is imminently dying – for the purpose of our discussion an imminently dying patient where death is expected within a short number of hours or days

Questions:

Could you tell me your thoughts on what medical students get out of doing a placement on your service?

How do you decide what activities a medical student participates in when they are attached to your team?

How do you run your ward round with respect to medical students on placement on your team?

Can you tell me about an occasion when you were on a ward round, and you had a medical student on placement, and you had a patient who was imminently dying?

What was your interaction if any with the student in relation to this patient?

Could you tell me about your approach to family meetings when you have a medical student on attachment? Particularly a meeting where you will be BBN or discussing a change in focus of care to a more palliative approach?

What do you think junior NCHDs learn on your service?

How do you approach the provision of care to dying patients?

What is your level of comfort in having medical student/NCHDs observing you when you are engaging in difficult or challenging conversations with patients or families around the diagnosis of EoL or EoL care?

How do you approach meetings with patients/families e.g. around changes in focus of care, BBN etc... with respect to NCHDs?

Could you tell me about who or how dying is identified on our service?

What if anything would you find helpful if you have a medical student on clinical placement and patient who is imminently dying under your care?

Closing:

Participants will be thanked for their participation and debriefed.

Appendix F: Ethical Approval Study 3



Move to...

SE **Ethics Committee, Social Research** 15 September 2020 at 09:37
Log 2019-124A1 Amendment request - Approved
To: Sweeney, Catherine

Dear Catherine
The Social Research and Ethics Committee has now approved your amendment request Log 2019-124A1 for previously approved application Log 2019-124 entitled "Exploration of the views of consultants on supervising medical students on clinical attachments in the context of patients who are dying."

The committee wishes you every success with your research.
All the best
Liz

Liz Hales I Coordinator, Social Research Ethics Committee, University College Cork I srec@ucc.ie I Phone +353 (0)21 4903234

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Appendix G: Participant Information and Consent Form Study 4

Thank you for considering participating in this research project. The purpose of this document is to explain to you what the work is about and what your participation would involve, so as to enable you to make an informed choice.

The purpose of this study is to gain insights into the experiences and perceptions of specialist palliative care healthcare professionals about their interactions with junior doctors in acute hospitals. Should you choose to participate, you will be asked to take part in a one-to-one interview with Dr Catherine Sweeney using Microsoft (MS) Teams. This interview will be video recorded and transcribed and a back-up audio recording will be made on a separate device. The interview is expected to take approximately 30-45 minutes to complete.

Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions, or decide to withdraw from the interview. Once the interview has been concluded, you can choose to withdraw your interview at any time in the subsequent two weeks.

All of the information you provide will be kept confidential and anonymous, and will be available only to the research team (Dr Catherine Sweeney, Dr Deirdre Bennett, Prof. Tony O'Brien). The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Once the interview is completed, the recording will immediately be transferred to a secure storage folder on the UCC network and wiped from the recording device. Once the audio recording is checked the video recording of the interview will be deleted. All identifying information will be removed once the initial 2-week period during which consent can be revoked has elapsed. The remaining data (audio recordings and anonymised transcripts) will be stored for 10 years as this is a standard requirement for research data. The information you provide may contribute to research publications and/or conference presentations. The data will also contribute to a doctoral thesis.

We do not anticipate any negative outcomes from participating in this study. At the end of the interview the interviewer will debrief you and answer any questions you may have.

This study has obtained ethical approval from the UCC Social Research Ethics Committee.

If you would like any further information concerning this study, please do not hesitate to me Dr Catherine Sweeney c.sweeney@ucc.ie

Tel: 087 6624815

If you agree to take part in this study, please sign the consent form overleaf.

Consent Form for Interviews

Study Title: Exploration of perceptions and experiences of Specialist Palliative care staff in acute hospitals of their interactions with recently qualified doctors and their clinical teams

I…….agree to participate in Dr Catherine Sweeney's research study.

I give permission for my interview with Dr Catherine Sweeney to be video and audio-recorded.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that anonymity will be ensured in the write-up by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

Signed: ……. Date: ……..

PRINT NAME: …….

Appendix H: Interview Guide Study 4

Opening:

Begin the interview by obtaining professional background information e.g. qualifications, years in practice, current role.

Define the terms recently qualified doctor and imminently dying patient

Questions:

Could you tell me what you regard as the purpose of the specialist palliative care consult team in your hospital?

Who do you consider your team to be, and how and when do you interact with them?

Do you feel part of any other clinical teams? Could you tell me a bit more about that?

How do requests for consults take place in your hospital?

Can you tell me about a recent consult request that you or your team received from a recently qualified doctor?

What was your interaction with the recently qualified doctor in relation to the patient?

Referrals

Handover of recommendations

Follow up

Can you remember what you were thinking at the time?

Following a consult how do you feedback recommendations to the referring team?

What if anything do you think the referring team learns from SPC consult team?

What if anything do you think RQDs learn from SPC consult team? (Explore if they see any changes in practice etc..)

Could you tell what if any you see as your role in relation to recently qualified doctors?

What do you think is the emotional impact of caring for patients at EoL on RQDs?

Do you have any interactions with medical students?

If yes, could you tell me more about those?

What's the most challenging aspect of your job on the SPC consult service?

What if anything would you find helpful in your interactions with recently qualified doctors?

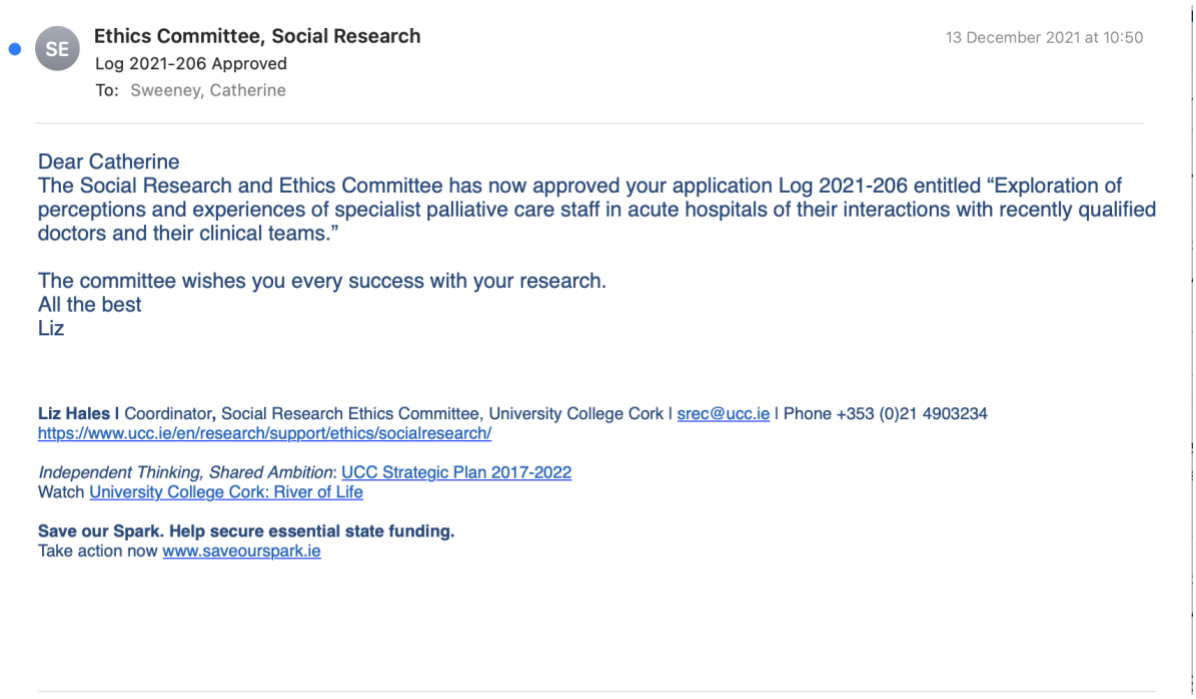
What if anything could RQDs or their teams do to improve EoL care?

Have you any questions or thoughts you would like to share?

Closing:

Participants will be thanked for their participation and debriefed.

Appendix I: Ethical Approval Study 4



SE **Ethics Committee, Social Research** 13 December 2021 at 10:50
Log 2021-206 Approved
To: Sweeney, Catherine

Dear Catherine
The Social Research and Ethics Committee has now approved your application Log 2021-206 entitled "Exploration of perceptions and experiences of specialist palliative care staff in acute hospitals of their interactions with recently qualified doctors and their clinical teams."

The committee wishes you every success with your research.
All the best
Liz

Liz Hales I Coordinator, Social Research Ethics Committee, University College Cork I srec@ucc.ie I Phone +353 (0)21 4903234
https://www.ucc.ie/en/research/support/ethics/socialresearch/

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Appendix J: Conference Presentations

1. INMED (Irish Network of Medical Educators) 2022 Annual Scientific Meeting, Limerick, Ireland.
   Short stops" and "footnotes": End-of-life care and the recently qualified doctor.
   C Sweeney, T O'Brien, D. Bennett
2. Molecules to People, University College Cork 2022
   Short stops" and "footnotes": End-of-life care and the recently qualified doctor.
   C Sweeney, T O'Brien, D. Bennett
3. European Association of Palliative Care 2023 World Congress (accepted), Glasgow, Scotland
   Short stops" and "footnotes": End-of-life care and the recently qualified doctor.
   C Sweeney, T O'Brien, D. Bennett

ASSOCIATION FOR MEDICAL EDUCATION IN EUROPE, GLASGOW 2023 (SUBMITTED FOR DOCTORAL REPORT PRESENTATION)

Recently Qualified Doctors' Learning about End of Life Care: a Socio-cultural Perspective **C Sweeney**, T O'Brien, D Bennett