

Medical careers: stories of a life

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Medical conceptions of a career are often remarkably narrow. A career is typically likened to a rocket on its launch pad, which is carefully aimed and launched, booster rockets firing at just the right time until suddenly, almost miraculously but exactly as predicted, it is in precisely the correct orbit, whence it proceeds to go round and round unchanged for 30 or more years before spectacularly burning out as it re-enters the all too solid air of the real world. Actual careers are not like that. They are rarely predictable in advance, but only make sense through the retrospectoscope. The appropriate model is literary, not physical, and follows that of Ulysses on his *Odyssey*. A simple idea (go to war, rescue beautiful heroine, come home again) gets literally and metaphorically blown off course, and most of a lifetime is spent trying once more to reach Ithaka, interrupted by adventures, upsets and disasters, and deviated by all sorts of pressing immediate needs so that perhaps it is touch and go whether any of the original goals can be met. The real world too is full of opportunities and problems that no-one can predict in advance. Only looking back can one tell a convincing story which 'makes sense' of it all – and serendipity means that it can only really make proper sense to a chaos theorist.

Medical educationists looking at medical careers have not done much better, typically cataloguing correlations (Davis *et al.* 1990). Dohn has recently emphasized the poverty of theoretical thought on the issues (Dohn 1996). He identified three phases of research into medical careers: 1950–70, looking at personality, attitudes, values and socio-economic factors; 1970–1985, looking at the effects of medical educational processes on career choice; 1985–1995, a renewed interest in personality traits, and an additional interest in socio-economic factors. Hardly gripping stuff. Dohn suggests that instead we need 'an idiographic approach (which) emphasizes choice as a conscious decision process in context leading to a decision between career alternatives'. Only then can the richness of real careers be described properly. For they are actually stories of a life, no more, no less.

Part of the problem for medical education as a discipline is that it blithely blunders on, taking no notice of the rich thinking and experience of other academics and professionals in related fields. One only has to look at the 1989 *Handbook of Career Theory* to realize how

emaciated and weak is the approach of traditional medical education for understanding careers (Arthur *et al.* 1989). Several different themes can be identified which transcend mundane obsessions with the numbers of graduates and supply and demand in various specialties.

CAREERS AS 'GAMES', EMBEDDED IN ORGANIZATIONAL CONSTRAINTS

Our word 'career' (which is first used only in 1803 in the modern sense of a professional life) comes from the French *carrière*, meaning a road or a racecourse. The implication of 'racecourse' is of something arbitrary, set up to allow individuals to compete within a particular context, with strict but often arbitrary rules, voluntarily adhered to by the participants, and written by other, usually more senior members of the society. Note that there is nothing natural here; nothing necessary, nothing essential. The sense of a 'medical career' only means anything in a particular institutional context. Most British doctors work within a very particular context – the NHS. Any organization necessarily invokes ambivalent feelings in those who participate in it; as Dalton puts it, '... we want them to be simple and benign. Organizations are neither simple nor benign; they are complex and dangerous' (Dalton 1989). The result is that our road through them is more like Pilgrim's Progress than like a simple trip along a motorway with everything under our total control. Success or failure on the racecourse of medicine depends in part on playing a complex game with only partly stated rules. And like snakes and ladders, there are many ways of sliding down as well as climbing up.

THE INTERNAL VERSUS THE EXTERNAL CAREER

It is tempting to define a career only in terms of the jobs one has held, the things one has *done*. When we look at others' careers we see only events, things done, whereas people talk about the experiences they had. It is a variant of what social psychologists call the 'fundamental error of attribution'; we explain other people's behaviour differ-

ently from the way we explain our own. Erving Goffman differentiated the internal from the external career:

‘One value of the concept of a career is its two-sidedness. One side is linked to internal matters held dearly and closely, such as an image of self or felt identity: the other side concerns official position, jural relations, and style of life, and is part of a publicly accessible institutional complex’ (Goffman 1961).

We have all felt the difference when, after reading a *curriculum vitae* and forming a clear mental picture of the person described, we interview the candidate and find our expectations and explanations completely incorrect. Career choices are more likely to be dominated by the internal than the external. However, career counselling, particularly by untrained Postgraduate Deans, is more likely to be dominated by the external. It is a very medical approach: first make a diagnosis (‘You could make a good...’), perhaps speculate on aetiology (‘Because you have done...’), then provide a prescription (‘You should do...’) and finish with a prognosis (‘You might find it difficult...’). Effective careers advice should instead be non-directive, allowing the person to understand their own thought processes and have insight and ownership of their own decisions. Rather than medicine, the appropriate model is psychotherapy, with its emphasis upon the internal life.

THE PLURALITY OF MEDICAL CAREERS AND MEDICAL PRACTITIONERS

Medical careers are changing. Even if once upon a time they could approximately be described as linear and of a limited number of types (general practitioner, consultant surgeon, etc.), now they are as diverse as there are doctors: specialties are becoming hyper-specialties; science and technology changes ever more quickly; medicine is spreading into areas of life previously ignored; and the nature of the working world is allowing diversity of practice. The problems for research into medical careers are great. It was once easy to define success and failure in a career (as most notoriously Lord Moran did when he distinguished those doctors who climbed the ladder (hospital consultants) from those who fell off it (general practitioners)). Now we have to ask questions which are internal (Does the doctor feel happy with the career?), as much as about the system’s response. The latter, of course, must not be ignored. Society needs to question who is a good doctor as opposed to a bad doctor, and pluralism will be hard pushed if more patients die as a result of it. Evidence-based medicine and specialist registration are forces working towards uniformity of practice, which could be at odds with the cafeteria approach to careers.

MEDICAL CAREERS EVOLVE

One of the growth areas of developmental psychology has been the realization that intellectual and emotional development occurs throughout the lifespan. Likewise, medical careers develop throughout the lifespan, reflecting different needs, abilities, aptitudes, and a process of growth and development. As a recent report by the Royal College of Physicians said, a consultant should not be doing the same job at the end of their career as they are at the beginning. They will change, the job will change, and both need to complement the other.

WOMEN IN MEDICINE

Since 1965 the proportion of women entering UK medical schools has risen from about 20% to nearer 55%. From a recent modelling exercise I predict it will top out at between 60 and 65%, similar to many other caring professions. This has forced discussion of areas that were long taboo or ignored. Medicine has in part changed the way it is practised, becoming more feminine, with a greater emphasis upon caring and nurturing. Some areas are still more masculine in their approach, with surgery the most stereotypically male and still having the lowest proportion of women entering it. Simple sex differences are underpinned though by psychological gender differences. As a recent example, in a study of medical applicants we used a standard measure of psychological masculinity–femininity and found, as expected, that those men who at that stage wanted to become surgeons were more masculine. More interestingly, those women who wanted to become surgeons were also more masculine than other women applicants. Of course this begs an interesting chicken and egg question: Is it being more masculine that makes one want to be a surgeon or wanting to be a surgeon that makes one more masculine? A longitudinal study (McManus & Sproston, in preparation) looking at change during the first 3 years of medical school suggests the former rather than the latter.

The entry of women into medicine (and elsewhere), and the infusion of feminist theory into academic discourse, has forced a rethinking of many areas of life – usually to the betterment of both sexes. Looking at discrimination against ethnic minorities in medical student selection has helped to develop a system which is fairer for *all* applicants, and what were once seen as the specific problems of women doctors are now seen to be very common in men as well (Allen 1988; McManus 1988). The course of feminism was not always so easy, and initially it produced a clash of cultures and an institutional backlash, as well as psychological ambivalence, particularly for what has been described as ‘a generation of women caught between the

feminine mystique of their mothers and the feminist mystique of the past thirty years' (Gallos 1989). It was well caught recently in the *Lancet's* Lifeline series (May 24 1997), where Maggie Bassendine, a successful professor of hepatology who trained in the late 1960s, said in answer to the question 'What is your unrealised ambition?' that it was 'To combine hospital medicine with having a family'. A recent more general review tried to elucidate how female career conceptions differed from those of men:

'It is easier to discuss what a woman's conception of career is not – not a lock-step, linear progression of attainments directed by a focus on 'the top'; not a job sequence aimed at upward mobility and success at all costs; not job complacency, fear of professional success, or low needs for achievement; not simply a mechanical issue of learning how to juggle marriage, children and work. But ...this list of 'nots' is deceptive...As an alternative, many women have tried to forge careers that provide opportunities for meeting personal, professional, and interpersonal goals...[T]hey have sought balance and control in their lives' (Gallos 1989).

In seeking balance and control they have also shown many men that those goals are actually their goals too.

DIFFERENT PERSPECTIVES, DIFFERENT THEORETICAL MODELS

Different academic disciplines approach the same complex phenomenon from very different positions. It has been said that psychologists claim that 'people make careers' whereas sociologists claim that 'careers make people' (Derr & Laurent 1989). A cynical medical educationist might claim that 'doctors are careers' (and there is a revealing aside by Isobel Allen in which she says 'we had not reckoned with the passion with which doctors are attached to all of their qualifications' (Allen 1988)). Below is a brief summary of how different social sciences have been said to view careers (Arthur *et al.* 1989) (Table 1).

If, as I have implied, there is a peculiarly medical perspective on careers (diagnosis, aetiology, prescription, prognosis), then it most tightly ties in with the psychological viewpoint of a career as a vocation, coupled with the sociological emphasis upon social mobility. But all of the other viewpoints have legitimate and useful things to say about medical careers. If we ignore them then we will only see a small part of the phenomenon we are hoping to understand.

Table 1 Examples of how different social sciences view careers (based on Arthur *et al.* 1989)

Social science	Perspective	Comments
Psychology: adulthood	Career as vocation	Career reflecting stability of psychological characteristics into
	Career as a vehicle for self-realisation Career as a component of the individual life structure	Humanistic perspective with emphasis upon individual growth Predictable transitions in career reflecting transitions in the life cycle
Social psychology	Career as an individually mediated response to outside role message	Careers as mediated through the psychological effects of the roles adopted
Sociology	Career as the unfolding of social roles	Overlapping with social psychology but emphasising the simultaneous contribution of the individual to the social order
	Career as social mobility	A person's title and position as indicators of social standing and position
Anthropology	Career as status passages	Careers as marked by rites of passage which signal entry into differing social positions, and maintain social organisations
Economics	Career as a response to market forces	Short-term accumulation of employment opportunities and long-term accumulation of human capital
Political science	Career as the enactment of self-interest	Individual needs for power, wealth, prestige and autonomy as sources of self-interested behaviour
History	Career as a correlate of historical outcomes	The reciprocal influence of people and the events of a period upon each other
Geography	Career as a response to geographic circumstances	Influence of local resources, human or otherwise, upon opportunities for particular working lives.

FROM MEDICAL STUDENT TO MEDICAL PRACTITIONER

A medical career lasts perhaps four and a half decades from entry to medical school to retirement, with another half decade or so at the beginning from the moment of first contemplation of medicine as a career. Of that half century, only one-tenth will be spent at medical school, and one-fifth in the conventional period of postgraduate training. What do reflections on the nature of careers say in relation to the four papers in this issue on the different phases of medical training?

PRE-MEDICINE

Carl Whitehouse has carefully reviewed many aspects of medical student selection. Most striking is how little of the effort in selection has gone into assessing the extent to which applicants have a realistic understanding of medical careers, in so far as that is possible as a 17-year-old (or even with graduate entry as a 21-year-old). Nevertheless I have a fear that even if we *could* measure career motivations better, the simple mathematical reality that we are also selecting for academic ability would mean that with only about two and a half applicants per place there is simply not sufficient room for manoeuvre (McManus & Vincent 1993; McManus 1997) to allow effective selection for career motivation. That instead puts the emphasis for intervention upon education and training.

THE UNDERGRADUATE COURSE

Adrian Eddleston and Paul Booton's paper makes some reference to career orientation, which seems principally to be driven by a perception that there is a high wastage amongst medical postgraduates. Irrespective of whether there genuinely is such high wastage (Richards *et al.* 1997), the absence of mention of formal career counselling by professionals is striking. On most undergraduate courses at present there is what 90% of the students in our recent final year survey described as only 'fair', 'poor', 'very poor', or no careers advice. If medical students are to have successful careers they need to be helped to think systematically about those careers and to approach them with an open mind, rather than the traditional medical approach of haphazard accumulation of knowledge through the random chances of apprenticeship. Doctors mostly still find out about medical careers in the same way as adolescents used to find out about sex – through the mistaken, confused ideas of their peers in the playground.

THE PRE-REGISTRATION YEAR

Fiona Moss has described how a seemingly defined and structured event – the PRHO year – has changed dramatically in recent years, mostly as a result of outside forces. As such it is a microcosm for the macrocosm of medical careers in general. Fiona also shows how many PRHOs have inappropriate expectations of what they can and should gain from the year – and here they are often in the company of the people who are training them. The use of logbooks (Paice *et al.* 1997) to guide PRHOs is a straightforward and effective way to make the experience more useful. Whether the PRHO year really does make people leave medicine, or even for that matter to change their career perceptions, is an empirical question and one for which, like Fiona, I suspect the answer is negative.

POSTGRADUATE TRAINING

I agree with Brendan Hicks' claim that the personality characteristics of would-be specialists in surgery, medicine, general practice, or whatever, are already statistically distinguishable even at the time of application to medical school (McManus *et al.* 1996). But of greater interest is how these differences interact with training of different quality in the various specialties, with opportunity, etc. Is there, indeed, any evidence that those with the personality which is 'typical' of the specialty are indeed those who are more likely to continue into it or to be more successful at it? And how much do specialties induce personalities, rather than vice versa?

CONCLUSIONS

Medical careers are rich, complex phenomena – in essence they are professional biographies. They have been studied remarkably little, and hardly at all using longitudinal prospective studies which allow one to disentangle cause and effect. Such studies are becoming ever harder, both as the diversity of careers increases and the variety of theoretical approaches to the concept of career increases. Implicit in all study of careers is that some are 'good' and others are 'bad' (although definition is extremely difficult), and that it is beneficial for patients, for doctors, and for health care in general to have more people with 'good' careers than 'bad'. Whether that is so is an empirical question that urgently needs assessing. One could probably make a career out of it.

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