

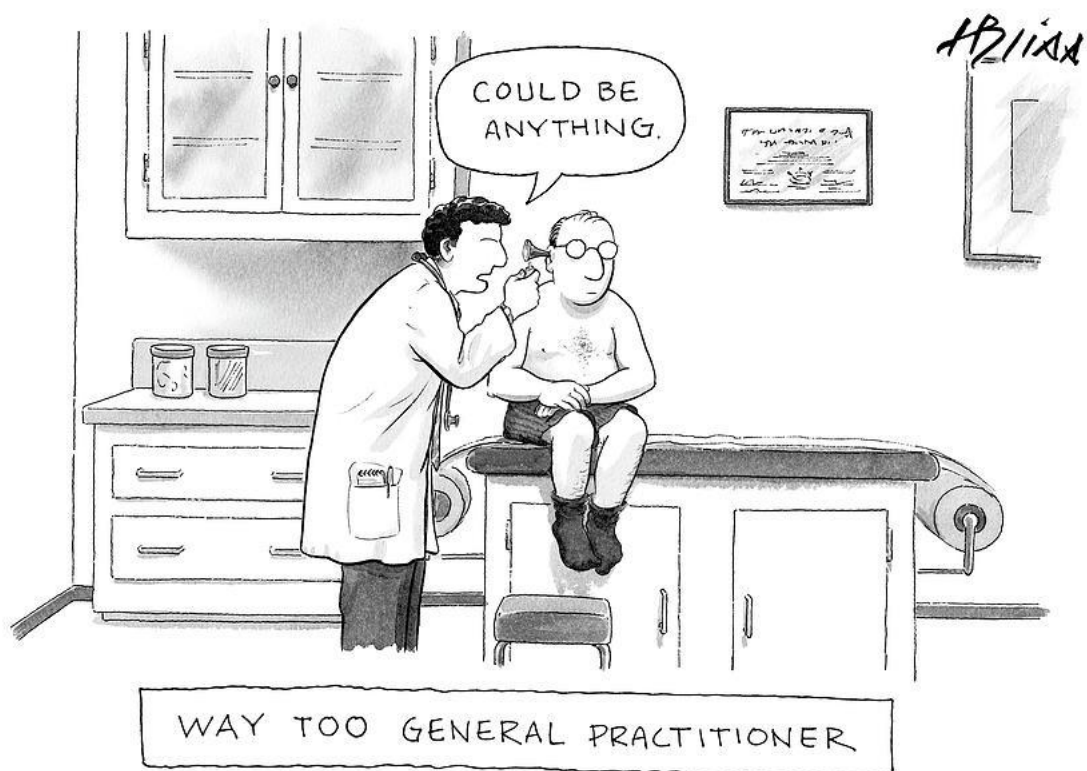
# **Faithful Physicians:**

## Discourses of Professionalism in Christian General Practitioners in New Zealand

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## **Abstract:**

In the past thirty years there has been an increasing focus on the spirituality and spiritual care of patients as they experience illness. During this peak of interest, the spiritual experiences of physicians and how it influences their practice has been largely neglected.

Discourses of Professionalism are narratives that determine what is the archetypal behaviour and performance set out for physicians to achieve. Such discourses are products of their time. This thesis inspects the intersection of discourses of professionalism, as they are negotiated with discourses of personal faith in Christianity, and the physicians' own personal identities in faith.

The findings of this thesis show that the ten Christian physicians interviewed understood their role as medical professional first and Christian second. This revealed an intentional faithfulness of these Christian physicians to respond to the reason that patients has sought them out for medical treatment, while still upholding their faith but simultaneously appreciating that they were not paid to be 'professional Christians' such as chaplains are expected to be.

The value of this thesis is that it reveals new and current contending discourses of professionalism in New Zealand's medical climate, as well as serving to be a further contribution to the emerging field of the Anthropology of Christianities.

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## **Chapter One:**

### **Introduction and Setting the Scene**

While doing a book review on 'Medical Talk and Medical Work' by Paul Atkinson in my honours year, I observed from the author's argument how the manner in which a profession is in actual fact constructed, taught and regulated is in the language that comprises the whole enterprise (1995). Although at the time, I was not familiar with Michael Foucault's concept of discourse, I was particularly interested in how language could regulate and enforce ideas within specific social contexts to the extent that to break adherence to the ways in which those ideas were portrayed is to risk being cast as an outsider.

After completing my honours dissertation looking at the negotiation of faith and medical professionalism in first year clinical medical students at the University of Otago in Dunedin, the concept of professionalism as a regulatory concept lingered with me as I went into the work force. I began to wonder how the verbal culture and ways in which we talked about professionalism actually worked in social practice and how such professional 'talk' retained its power. As I reflected on my honours dissertation, I began to realise that the first year clinical students whom I had interviewed had not (at the time I had interviewed them) received enough exposure to medical practice and professionalism to be able to articulate very deeply the ways in which their faith interacted with their profession. Consequently this led me to the idea to investigate Christian General Practitioners (who had been practicing for at least two years), in order to inquire as to how they had achieved or understood the need to host simultaneously both the requirements of identity in their faith, along with their professional identity as a medical practitioner.

The reason I chose General Practitioners was that they are often afforded a greater sense of autonomy in how they run and conduct their consultations and clinics. This in turn means they have more ability to tailor their working environment to reflect their faith. This is not to say that hospital specialists cannot also actively embody their faith within their vocational roles too, but rather that General Practitioners



often consult alone, offering a lesser response to potential peer pressure over the manner in which they navigate potential conflicts between the secular and the faith based role expectations.

Though the literature surrounding the investigations of physicians' experiences in medical anthropology is vast and has been established for some time, it is surprising there is little work inspecting the intersection of faith-filled and religious physicians as they conduct their medical practices (Franzen, 2017; Banard, 1985; Biggar, 2015; Cadge et al, 2009; Franzen, 2015; Koenig, 2011; Considine, 2007). Instead, what is more common is the investigation into the ways in which attention to patients' spirituality can aid the recovery time from sickness. Subsequently, I set out in this thesis to explore the following questions: How do discourses of professionalism influence Christian General Practitioners in their practice? How do they negotiate and identify boundaries between the professional and the unprofessional, and to what extent do notions of professionalism conflict or complement the physicians' sense of self in their Christian faith?

In setting out to research and inquire about my question of how medical professionalism discourses influence Christian General Practitioners, I came across two similar studies to my own that were valuable in different ways. Both of these studies observed Christian doctors and how they interacted with their faith while in a clinical environment. The first and most similar to this project was the article by Sarah Jensen and Christine Philips entitled: 'Bearing Witness Through Medicine: An Exploratory Study of Attitudes to Serve Among Australian Evangelical Doctors' (2013). In this article, the authors sought to explore physicians' experiences of spirituality in faith as clinical physicians. Jensen and Phillips' conducted thirteen open ended interviews of Christian physicians of whom ten were working as General Practitioners. The participants in Jensen and Phillips' study revealed that they felt the worldviews of biomedicine and their Christian faith were not in conflict but rather the two complemented one another (2013: 1182). One observation from the authors was that even though there was a strong consensus from their participants that sharing the gospel story of their faith was important, it was in practice often passed over due to the busy nature of clinical practice and an awareness of that such a conversation might have been perceived as inappropriate (Jensen and Phillips, 2013).

Instead, the participants felt they could demonstrate their faith in other ways such as declining services such as abortions “I said to her that I didn’t think from the research that I’d read and from the ethical point of view... she was a sitting duck for post abortion depression” (Jensen and Phillips, 2013: 1184). For another hospital doctor, he wrestled with what does love and compassion look like when faced with the possibility of euthanasia: “You might say when you go to church, “Oh, yeah, euthanasia is sinful.” But when you’re at the bedside of a patient who is in agony from cancer... ravaged their whole body... I’ve personally had a patient say, “Can you put me out of this misery?” ... I had to say “No.” I had to say no, but it becomes tempting. Absolutely tempting” (Jensen and Phillips, 2013: 1183). This participant cited the Bible rather than Australian law as his reason to decline. The richness of these findings is that they reveal that while there is harmony of faith and medicine in being able to care and heal, it is not without complex articulations.

Even so, the majority of the participants in this 2013 study were grateful for their work, observing their career as a Christian Physician as being a “ministry”, “privilege” and a “mission” (Jensen and Phillips, 2013: 1184). These findings of how the physicians perceived their role as being called to bless and heal in conjunction with their awareness of professionalism requiring them to be careful about when they can share their faith overtly reveal that the unification of two worldviews and discourses is an ongoing process. Jensen and Phillips’ study overall is the most significantly similar to this one in that the national medical systems, faith and participant size were all a close approximation to studying Christian General Practitioners in New Zealand.

The second most similar study to my own was a Californian study conducted by Wendy Cadge, Elaine Howard Ecklund and Nicholas Short entitled: ‘Religion and Spirituality: A Barrier and a Bridge in the Everyday Professional Work of Paediatric Physicians’ (2009). Operating from a similar research question to my own, this study investigated to what extent physicians understood spirituality and faith interactions as an aid or a hindrance towards the execution of good clinical practice. Utilising set questions with thirty paediatric specialists, the authors explored how the physicians in this study negotiate boundary work such as when to encourage and engage with faith elements in their patients’ lives during ward rounds and consultations (2009).

Within Cadge et al's study, the physicians understood questions around patients' faith to be "too personal" or described such conversational topics as "crossing the line" thus signifying a lack of confidence in engaging in those areas rather than deeming them not important. Aptly, the authors point out that such language speaks more to what the physicians already have training in, as the physician's insistence that spirituality was private was particularly surprising given that they routinely questioned patients about personal matters such as personal histories of sexual activity and substance abuse (2009).

This boundary work was defined by the participants as a dichotomy between the personal and the professional (Cadge et al., 2009). The findings of this study revealed that the physicians perceived the inclusion of religion and spirituality in consultations by patients as both a bridge and a barrier (Cadge et al., 2009). It was a barrier in that at times the faith of the patient and their families could obstruct medical treatment such as blood transfusions or a refusal to accept medicine as a primary treatment instead of prayer (Cadge et al., 2009). In such instances the physicians sometimes invoked legal measures to ensure the patient was treated with some form of clinical action (Cadge et al., 2009: 712). It was considered a bridge by the physicians as they observed that for some of the patients, their faith often gave them reassurance and care from their communities. This was particularly important in those cases when the physicians themselves did not have time to administer such care (Cadge et al., 2009). The authors drew on Thomas Gieryn noting that what is considered their role or profession is determined by what is given attention to on the ground, irrespective of formal and official conducts (Gieryn, 1983, cited in Cadge et al., 2009). This is to say that while formal establishments of professionalism exist, how much they permeate and in what ways, determines actual professional roles during the day to day activities that make up the practice of medical work.

While this study is not as close to mine as the previously cited study by Jensen and Phillips (2013), it does resemble my own in that the physicians were asked to evaluate how they understood faith interactions in the clinic and to explore the ways in which they negotiated boundary work around when to engage with such things. While this article does contribute to understanding how physicians think about faith and spirituality, it is limited to thinking of it through the proxy of the patients rather

than through the reflections and experiences of self identifying 'religious' physicians themselves.

One of the key differences of this study in comparison to those I have just discussed is that I employ Michael Foucault's concept of discourse to explain the contradictions and confluences between professional and faith based identities for doctors.

Traditionally the term discourse is used to describe dialogue, however Foucault's version entails the ways in which meaning is produced and regulated in different ways and in different societies to protect a specific knowledge (Foucault, 1972: 32). Discourse, in this sense can define, regulate and govern not just the way a concept develops prominence and authority, but also how actions flow on from that concept (Hall, 2001: 72). The significance of this concept is that unlike thought within structuralism, the concern is not where the genesis of an idea is per se, but rather how it is that the concept is made powerful through the human actions and speech cultures that propagate the concepts that become a discourse. What is of interest to me within this thesis is how discourses of professionalism are active within the lives of Christian General Practitioners who already hold a strong personal faith narrative within their own lives.

### ***Exploring the literature for Faithful Physicians***

During the process of my investigation into the literature surrounding interactions of such faith identity in physicians I have identified three major relational themes to which the texts can be ordered. The first relationship is how the physician understands their own professional identity in juxtaposition to their patients. The second is how the physician understands their own professional and faith identity within themselves in juxtaposition to their colleagues. Lastly, is how the physicians understand their sense of self and sense of professionalism in relationship with their faith in Christ and with other Christians.

#### ***1. Physicians and Patients***

Eric Cassell in his book *The Healers Art: A New Approach to the Doctor-Patient Relationship* marks a key piece of work in the literature of care as he challenges the

culture of medical practice as it began 40 years ago to turn away from treating patients as merely the hosts of diseases in towards beginning to consider them as actual people more intentionally (1976: 169-70). Cassell identifies that western medicine at the time had become concerned with propagating its own interests of research and the preservation of an elite, insular medical culture; and that in doing so, it had neglected half its duty of providing healing as well as curing (1976). Indeed, medicine only exists because of its patients and it is only because of them that such a medical culture could exist in the first place (Cassell, 1976). The author observes however that such an obsession on disease did not occur due to direct neglect of patient care but rather because in recent history, being able to treat disease was perceived as care. Part of the reason for this is because treatment is tangible and teachable whereas healing and caring is more abstract and variable. Cassell recalls a physician's saw to make this point: "What if it turns into pneumonia?" The doctor is said to have answered: "Better if it were pneumonia. That I can cure" (1976: 180). Cassell observes that for much of the brief history of modern medicine, the tendency has been to reduce the patient's problems and ailments into tangible problems that can be treated, while often skirting cosmological and spiritual issues as an aside (1976: 182).

This however begs the question; should the physician be pastoral and to what extent is it appropriate to be so? Ronald Numbers and Ronald Sawyer provide answers to this question in their chapter 'Health/Medicine and the Faith Traditions: An Inquiry into Religion and Medicine' by revealing that for much of western history, the role of physician and healer were intimately intertwined and that it is was only during the twentieth century that such roles began to see separation (1982). Significantly, the authors observe that for centuries it was the local priest's job to also double as the physician in times of need, revealing that the roles of curer and healer have long since had an intimate connection in tending for souls as well as bodies. Thus, historically the physician was pastoral before they were medical (Numbers and Sawyer, 1982).

For a more contemporary consideration of such a question, Jim Pink and colleagues in their editorial piece 'The 21st Century GP: Physician or priest?' suggest that the role of General Practitioner as pastor is becoming more overt in the United Kingdom in recent decades due to a simultaneous decline in church attendance and a rise in

affliction (2007). The authors observe that the General Practitioner, being the most accessible physician in the National Health System to the population; is found to hold the office of professional carer, as patients seek appointments for life struggles under the guise of medical ailments (Pink & Jacobson & Pritchard, 2007). The significance in the relationship between the decline in church attendance and the increase of pastoral visits to the General Practitioner reveals the family physician is perceived by the British public to be a safe and worthy person of contact and to whom one may come to for aid and advice (2007).

Part of this emphasis of healing is due to what David Barnard observes in his article entitled "The Physician as Priest, Revisited" in which he explores the role of medicine as a contemporary, unspoken secular religion (1985). Reminiscent of Foucault's exorcism of diseases, Barnard indicates that the social role of the physician has become more like that of a priest in which confession is regularly offered regardless of invitation (1985; Foucault, 1978). Indeed, Barnard observes that what is commonly expected of physicians now (yet remains unsaid) is a meaningful interaction and even the hope of physical salvation. Barnard expands this point well in citing Cassell: "...I don't believe in God anymore really; ...So the doctor's job is one that never really existed before... for me the doctor is now God" (Cassell, 1976 in Barnard, 1985: 273-4). This expectation of the physician to be able to not only treat and care for the patient but also to protect them, illuminates the growing appetite from patients for their physicians to be brokers of meaning. Barnard argues that for Christian physicians such a role of being brokers of meaning is simply a synonym for what the Christian physicians would describe as the vocation of medicine in which they serve not just professionally but as an expression of their faith (1985). In order to distinguish some form of boundary with regard to what an emphasis on care might look like, stronger definitions and tenets of professionalism are required.

Patient Centred Care proved to be the answer to this dilemma. However, it was not a problem free answer. The term quickly became popular and a wide scope of definitions of what Patient Centred Care entailed appeared. Alison Kitson and colleagues' article proves valuable here as they performed a meta-analysis of what were considered to be the key elements that defined Patient Centred Care in their article 'What are the Core Elements of Patient Centred Care? A Narrative Review and

Synthesis of the Literature from Health Policy, Medicine and Nursing: Core Elements of Patient-Centred Care' (2012).

Their study revealed three key areas that proved to be an umbrella to house the array of sub-codes (Kitson et al., 2012). First was that of patient participation and involvement, which is understood as valuing patient autonomy and individuality in a manner that seeks to inform and educate the patient of their condition so that they might conduct informed choices (Kitson et al., 2012). Second, was the appreciation of a visible relationship between health practitioner and the patient. Significantly, Kitson et al. (2012) note that what is understood as a visible and professional relationship with the patient varies not only between medical health practitioners but also internally within each physician based medical speciality. Indeed, the physician or medical practitioners' actual employed role often determines how care is constructed and executed. Thus, the visible relationship between the patient and that of a nurse in her role is likely to be more intentional in visible holistic care, compared to that of a technical surgeon.

Thirdly, Kitson et al's last key parent theme was the concept that the nature of care is heavily influenced by the physical and cultural context in which it is practiced (2012). Here the authors valuably note that hospital or clinical policies, grounded within governments have already acted as a regulator of care. Definitions of what is acceptable and affordable, both financially and emotionally, have been established to protect medical practitioners whilst still aiming to offer substantial care to patients (Kitson et al., 2012). Thus the type of care that one can offer is seen as being in direct correlation to one's professional training.

However, even with a more rigid definition of Patient Centred Care, the interpretation of what the specificities that make up patient centred care are, can be interpreted variably by the different medical staff who actually execute the care. Leslie Dubbin et al's article reveals that this interpretation process often yields a high degree of technical interpretation of care rather than spiritual (2013). This is consistent with Eric Cassell's work that showed it was more comfortable for the physicians to reduce problems to something they know and can fix rather than brave metaphysical issues with expansive and variable answers (1976). Dubbin et al (2013) point out that such a preference is in fact reflected in the variety of information the

medical staff and physicians are listening for in consultations. It can be said then, that Patient Centred Care can be pressed and moulded to what the medical practitioner acknowledges as most relevant (Dubbin et al., 2013).

Harold Koenig in recent years has proved to be a prominent scholar in the field of spirituality in patient care. In his article 'The Spiritual Care Team: Enabling the Practice of Whole Person Medicine', Koenig (2014) suggests that the way to move beyond the recognition that care (and specifically, spiritual care) is often also expected from health care professionals in addition to the hospital Chaplain, but is simultaneously often interpreted as treatment by the physician, is to create a spiritual care team as a way of implementing patient centred care. Koenig suggests that the way to do this would be to take a spiritual history, in which the physician's job would be simply to identify if the patient would like one (2014). Koenig discusses the value of spiritually attentive Patient Centred Care by citing Tracy Balboni et al's work noting that when patients have spiritual aspects of their care unmet it not only reduces the quality of life for the patient but can also triple patient health care costs (Balboni et al., 2011 in Koenig, 2014: 1164). The point that spiritual care should be considered as more than an additional nicety, because of the value of that care and manner in which spiritual patient care can effect sickness outcome and physician satisfaction (Koenig, 2014) is worth repeating. This model would enable medical personnel and health professionals to perform Patient Centred Care on a level of both technical and empathetic intentionality that could see that patient experience a very high standard of care (Koenig, 2014; Souza, 2007).

## ***2. The Importance of Colleagues***

While patient centred models offer a more harmonious integration of spiritual care and medical treatment, such holistic treatment is not always understood nor is it welcomed at medical institutions. Reflecting this commonly recognised social tension, the second biggest trend observed within the literature reviewed on the general topic of medicine and spirituality concerned how the physician understands their own professional and faith identity within themselves in juxtaposition to their colleagues (Best et al., 2016; Cadge et al., 2009; Cassell, 1991; Curlin et al., 2006; Irvine, 2015).



With similar findings to Dubbin et al (2013), Aaron Franzen (2017) in his study on 'Is This Relevant? Physician Perspectives, Clinical Relevance and Religious Content in Clinical Interactions' shows how although physicians may agree on Patient Centred Care, the expression of patient centred care may look more spiritual for some physicians than others. What makes Franzen's work different is his observation that the higher the level of religiosity and spirituality in the life of a physician; the more likely they are to engage with spiritual elements of care. Additionally, Franzen indicates that the more religious or spiritual that the physician is, the more likely they are to have reflected on how their faith conflicts with their profession, so as to work out a method of integration and harmony between the two value systems. In some ways this could be seen as consistent with the idea that physicians are only comfortable to interact with topics that they have training or experience in. Franzen (2017) notes that for the physicians in his study who both do and do not profess a specific faith, they were all fearful of having their efforts around spiritual care misinterpreted negatively.

One of the key mechanisms in which discourses of professionalism operate is through their enforcement by other people. Thus to remain outside of such enforcement is to remain above reproach in one's work around colleagues. The value of good collegiality, something that Paul Atkinson (1991) notes in his book 'Medical Work and Medical Talk', is not simply good relationship skills, but is in fact the relationship site in which medicine occurs. Atkinson states that medical work is performed through the production and reproduction of medical talk in which physician interaction with other physicians regulates how medicine is done by the manner in which the doctors converse about it (ibid 1991: 148). In order to preserve and legitimate one's standing as a physician in the social field of the medical clinic, the physician must present themselves according to the social rhythms laid out by the particular hospital and facility (Atkinson, 1991: 70).

Atkinson's argument is that the real medical work is not the execution of technical competency but rather the evidence that one knows the correct way of upholding the 'liturgy' of medical talk which in turn activates medical action (Atkinson, 1991: 70). In stating this position he proved to be a milestone in the social study of medicine by redirecting the focus from the patient – physician consultation to that of the inter-

physician dialogue. Thus while the physician may be comfortable in themselves offering spiritual care and conversation with their patients, it is the fear of what their colleagues may think of their professional competency that hinders their enthusiasm to do so. That is to say, that the inter-physician relationship is key to being able to maintain a sense of professionalism alongside that of one's colleagues.

This fear of collegial disapproval can be localised in the apprehension towards how to negotiate competing social discourses about professionalism. Such a fear is explored in Dion Forster's article entitled 'Called to Work: A Descriptive Analysis of Call 42's Research on Faith and Work in South Africa' in which he explores the survey results of an organisation that asked how South African Christians felt about being a Christian in their workplace (2014; Call42, 2013 a). The results showed that of the 1300 surveyed, 1200 respondents indicated that they believed that God had a purpose for their life which could be found in the regular workforce (Forster, 2014: 2; Call42, 2013 b). Of those respondents however, it was revealed that the two biggest reasons for the participants to not be living in the fullness of that calling or vocation was because of a misunderstanding in their calling and fear of what others would think of them (Forster, 2014: 4). Forster argues that the popular piety proven by the results is a clear divide between working professional and personal faith life (2014). He argues that what is needed instead are tools and sermons from the grass roots level that reveal how each workplace of a Christian can be their ministry without it having to be a formal ministry or affiliated to a church programme (Forster, 2014). For the anthropologist, this divide can be seen as not just the separation of concepts but of active discourses which are at play and contending for dominance in different spheres of the participants' lives.

While patient centred care helps the patient progress towards a more complete recovery, the standing with one's fellow doctors must be also upheld in such a manner that does not cause any doctor to doubt another (Franzen, 2017; Atkinson, 1995). Such social discourses can also be understood as what Clifford Geertz calls 'social scripts' in which members of a culture are actors in a performance wherein they are regulated and organised through what is expected behaviour and acceptable (Jaye et al., 2006).

### ***3. Physicians, Prayer and Practice***

While learning and upholding medical discourse can be very demanding for Christian physicians, it is also not the only discourse through which they may express their identities. For faithful and Christian physicians, they also have to uphold a discourse of faith. While this is often a taken for granted part of their identity anyway, there are times in which a differentiation can be observed between engaging in a faith activity out of love and enjoyment, and performing a faith activity to keep well with in a faith-based community's collective values and expected degrees of public immersion into faith based discourses.

When it is a natural part of the physician's faith to adhere to expectations of medicine such as generally caring for their patients, there can be found a harmony so adequate that it can be considered a form of worship. Thomas Elkins and Douglas Brown in their (1987) article 'The Meaning of Prayer: A Christian Physician's Experience' recalls the intimate and personal encounters in which Elkins contemplates the intersection of difficult medical circumstances in which he turned to God for insight. Elkins recollects the contrast he saw between delivering babies in Africa versus in the United States:

The nurse midwife finally came to us for help. She had concluded that this couple was so fixed on 'the shared experience of natural childbirth' that all the concern for the twins had been forgotten... My thoughts drifted to the pleading eyes of labouring mothers I had treated in Africa. For them, natural childbirth was an often tragic necessity rather than a desired luxury... my thoughts about prayer and care have evolved (Elkins & Brown, 1987: 288-9).

He recalls another event when working at a free clinic, his observation of dire need overwhelmed him into a state of prayer:

O my Lord, are these your children, who stand cramped or lie crumpled in the halls of 'the tub' because the entire supply of chairs and stretchers is exhausted? ... Did Jesus die for these? ...so in answering the call of physical anguish, we are freed to worship in creativity... Help me O Lord to remember the ugliness of this night (Elkins & Brown, 1987: 293).

In these moments Dr Elkins reveals that the personal way he had unified his identity in faith alongside what was required of him professionally was to pray in these moments and, in reflection, pen psalms as a form of retrospective prayer. The scenes that Dr Elkins observed throughout his career stayed with him and he was able to create a site of worship for himself in which those events could be utilised for engagement with God and the learning opportunities therein.

Robert Sevensky (1982) in his article 'The Religious Physician' states that one of the key ways the Christian and Jewish physicians can incorporate their faith into their medical practice is to be conscious of some key biblical concepts. Drawing on biblical texts, Sevensky details these tenets as vocation, neighbour, love and covenant (1982: 257-260). The author argues that while there are many professional tenets being pitched as to what medical professionalism should look like, it is important to have tenets for the religious physician which can encompass both their secular medical duty and their faith duty. Thus Sevensky's tenets of vocation and covenant speak of fulfilling the office of carer in a covenant style relationship which, unlike a contract, requires the carer to uphold their end of the agreement regardless of the other party or the patient's actions (1982). His tenets of neighbour and love echo the prayers of Dr Elkins to meet the patients where they are at, despite the overwhelming desire at times to flee from bad smells, chaotic situations and medical messes (Sevensky, 1982). Interestingly, such tenets require a demonstration of faith as upholding their medical practice well and not turning patients away, rather than any impetus to engage in forms of evangelism. Sevensky is quite clear that the physician's faith should be most appropriately demonstrated in their actions (1982).

Aiding Christian physicians in such a pursuit, Patricia Fosarelli (2002) reminds her readers that Jesus was their original healer and as such proves to be the best role model. In her article 'Fearfully Wonderfully Made: The interconnectedness of Body-Mind-Spirit', Fosarelli observes that within scripture Jesus heals as often by what He says as by what He does in action (2002). She argues then that while physicians are trained to heal and be active with their treatment, kind words can often do as much to bring about restoration to patients as treatment can (Fosarelli, 2002). Citing scripture heavily, she reveals that Christ's most common response to a request for healing was to ask: "What will you have me do?", and thus even Christ did not impose

his own will onto the vulnerable, but instead meet them where they were (Mark 10:51, Luke 18:4, in Fosarelli, 2002: 223). Subsequently, Fosarelli articulates that for the Christian physician, being faithful within the workplace does not require overt questions of salvation in patients, rather, it can be as simple as listening simultaneously to the patient and to God for His thoughts over the patient (2002).

In almost an opposite argument to Sevensky, Daniel Foster (1982) argues in his chapter 'Religion and Medicine: The Physician's Perspective' for some key tenets of professionalism for all doctors to uphold but for Christian physicians in particular to aspire to exemplify (1982). These are: trust, treating the patient as human, kindness, hope, and assisting in providing meaning to lives (Foster, 1982). Foster argues that when appropriate and initiated by the patient, the Christian physician can offer an eternal hope that is found in the presence of God. Himself a Christian physician, Foster articulates caution when expanding on one's faith with patients, but also indicates that the richness of meaning imparted and the hope that can be offered to patients is a privilege to give (1982). Whether through listening, action or active listening, the ways in which these Christian physicians seek to integrate their faith into their practice is to value the patient and God simultaneously.

In a combined article, Dion Forster and Johann Oostenbrink (2011) reveal that one of the key reasons that faith and professionalism are not seen as harmonious activities within the South African Church is because the nature of different workplaces is so variable that it proves difficult to mount a united effort to train Christians in how to deal with the conflicts and pressures of each working environment. The premise behind this thinking, the authors argue, is that often local churches preach an almost opposing dichotomy of 'the world' and 'the church' which makes it difficult to encourage believers in how to think of ways in which they can bless others in their working environment. In contrast to classical evangelical groups, the authors argue that one of the key ways that Christians can do ministry in the workplace is simply by blessing others in ways that workmates will appreciate (2011).

It should be observed that the majority of texts found for the purpose of this literature review were a few decades old. This is because the interest in spirituality in medicine more recently has intensified around patient experiences of spirituality and the ways the patient can benefit from spiritual practices towards recovery. The value

of my own project then is that it offers a unique insight into how some contemporary Christian General Practitioners experience the outworking of their faith in their practice as it interacts with discourses of professionalism.

### ***Setting the Scene:***

It seems appropriate at this point to now turn our attention to the varied contexts of the ten participants who engaged with me in the preparation of this thesis and whose lives and cultural climates are the basis of my study. I have chosen (after consultation with the participants) for all to remain anonymous in my writing and I use the simplest of pseudonyms – a set of numbers to differentiate between their varied points of view.

Due to the international scale and history of the Christian faith, I found significant variations in how the participants worshipped and what they quantified as the essential elements of being a Christian. To account for this, I have used the term ‘Christianities’ to cater for the variations of individuals’ Christian faith whilst still being true to each participant. Additionally, I will also spend some time discussing the expected and additional roles that make up the career experience of the General Practitioner in New Zealand. This is necessary in order to prepare a foundation for the comments from the participants about their interactions between discourses of faith and medical professionalism.

Understanding what kinds of churches the participants attended helps ground the Christian General Practitioners’ faith in a more local context. For example, all of the participants indicated that they were active in Protestant churches, which is indicative of New Zealand’s Christian climate and meant that they belonged to worship communities that emphasised interaction with God above tradition. This is not to say that traditions were not valued at all, as half of the participants’ belonged to more traditional styles of worship such as the Church of England and the Church of Scotland. Both of these value liturgical rhythms in their services alongside more modern elements of Christianity such as a focus on relationship with God and an emphasis on good teaching. However, even these broad brushes of denominational affiliation did not characterise the richness of diversity of Christianities as articulated by the participants themselves.

When describing their faith in Christ, the participants portrayed two key themes; the first was an intentional orientation towards God in life and the second was an emphasis on and value of scripture. Participant 9 for example, summarised these well when he said: “Well, it’s a Christian faith... the most important part of my life, trusting Jesus, and following his teaching, trusting the Word of God and allowing the Holy Spirit to guide me on a daily basis.” This can be supplemented by the comments of Participant 6 on this topic who noted: “It’s crucial to have a belief [in] who Jesus was and what He did for me.” The importance of scripture was echoed by Participant 8 when she described herself as being a “Bible-believing Christian” indicating that her faith had as much to do with her activities of reading scripture and internalising it, as it did being oriented towards God. Indeed, for some Participants, being a Bible-believing person and being a Christian were synonymous as the reverence offered towards the “Word of God” could be seen as tantamount to their reverence offered to God himself (as the scriptures are viewed as His most obvious form of interaction with humanity).

Identifying as God-oriented and Bible-believing Christians is one method of identifying what kind of Christianity the participants practice. As in many social groups, defining who the group is by what it is not, helps clarify identity boundaries of what it means to belong to a cohort. Significantly, one frequently employed method of self-description used by the participants was to define their Christian faith via antithesis by describing what their faith was not. This definition by antithesis appeared in two main forms; the first was defining how a participant’s Christianity might be different to another form of Christianity. The second was by defining their Christian faith in juxtaposition to people with other or no faith. For example:

...and I had one talk to [another] Christian GP who... said how do you know the bits in the Bible that were attributed to Jesus were said by Jesus? And I said ‘well, if that’s the level at which we’re going to have this discussion then we clearly have no common ground.’ –Participant 7

The questioning of the legitimacy of scripture is something that is traditionally considered taboo within the forms of Christianity that these participants adhered to. The significance of participants defining their Christianity against other Christianities is that it reveals the depth to which each Christian considers certain elements

paramount and non-negotiable to their faith. This is similar to how different medical specialities consider different components of personal health to be vital. Not smoking is paramount to the respiratory physician, while good diet and exercise is paramount to the cardiologist; Christians too tend to gravitate around core truths, which are favoured by different personalities.

The distancing language used by Participant 7 is indicative of the definition of antithesis mentioned earlier, as it serves to help curate a sense of common identity by establishing what is worthy of being considered an outsider's way of thinking. This clarity of self in their Christian identity also proved to cause some hindrances for the Christian General Practitioners at times in which they felt unable to minister to their patients on a personal 'insider' faith level. I now turn to a brief overview of the generally identifying elements of a General Practitioner's career. These descriptions of life as a GP are drawn from my participant observation and some general backgrounding questions that I asked of each participant.

### ***Career as General Practitioner:***

The nature of primary care entails that the General Practitioner is often the first physician the patients will see, and is the one usually to bestow the status of patient upon the individual. Participant 5 observed that the general role of the Family Physician can vary depending on what neighbourhoods one practices in:

...down in Servants [Christian free Medical Centre] where we're dealing with the folk who are living in the boarding houses, and constantly address-less 'cause they're couch surfing... living in cars; and we're always sending their records down to Milton prison, and then receiving them back when they get out again, and then down the road again and back again... So I guess you'd get different stories if you were practicing in Maori Hill, or in the Meridian [more affluent and middle class areas].

Observing the correlation between the clinic's physical location and the types of patients one treats, Participant 5 illuminates that the kinds of patients one sees influences how they develop as a physician and what kind of professionalism is expected. Three of the participants practiced quite centrally in Dunedin in the city, with two at the same clinic based out of a local mall. A further three practiced at



suburban clinics in residential areas. Three more were General Practitioners in the rural areas of Kaitaia, Balclutha and Greymouth. The remaining participant practiced at Dunedin's port township, which although it is within the large Dunedin city boundary was described as a rural-style practice by the physician.

The role of being a health educator in the participants' local communities, was identified by Participant 2 as a rewarding and more modern element of what it means to practice as a General Practitioner.

...I think every time I manage to help someone to stop smoking I find immensely satisfying. I saw a guy last week who was in danger of losing his legs... I saw him six months later... and he said "I stopped smoking the day I walked out of your surgery" [laughter]... So I think when I help people to stop smoking, when I encourage them to manage their diabetes better, when I see people who are depressed and anxious feeling better because I managed to give them a bit of hope or something; that's all satisfying.

The role of being an educator of health to the patients is one that draws on the relationships that the General Practitioners are so proficient at developing as a part of their trade. Like any medical career, the story of progressing as a General Practitioner is one that is full of rewarding moments as well as disappointments as the physicians' progress in their journey of experience and expertise. All of the participants recalled elements of their job that they found to be satisfying and rewarding which fuelled their value for practicing well and operating under a discourse of professionalism. Participant 3 delighted that the role of a primary care physician afforded him not only the satisfaction of improving patients' health, but it also aided him in interacting with people beyond his usual comfort zone.

...its more than rewarding its magic. I am always very grateful that I landed this... I almost get emotional about it because I am fairly reserved by nature... and medicine... suddenly has allowed... people that; you would have a hard time spending at a pub or a restaurant with because you have nothing in common. In that little square of a room, would open their heart to you and allow you to listen and help if you can and just be there is anothe[r]- and that's, that's magic.

This 'magic' of expanded social engagement was reflected by six of the respondents stating that they considered the most rewarding element of being a General Practitioner as being able to cultivate valuable long-term relationships with patients. Participant 1 articulated that because clinicians get to see whole generations of families being treated that they become "like a part of your family." Participant 5 echoed this value of relationships with the patients when she said:

...it's the relationship with the patients. I would think of it a bit like a TV serial, like the Coronation Street that my dad used to watch. The more you watch it, the more you want to watch it, because you want to know what happens to the characters next.

Conversely, holding a role that sees a large volume of patients over a small amount of time means that occasionally the physicians felt they let their patients down. Participant 3 recalled an instance in where he saw a patient in a rush and overlooked an important allergy factor in his treatment:

... and he developed the most severe rash and it last[ed] for weeks! ...Now, it could have very easily have been an absolute disaster... in a different context with him going to the health and disability commission... But, the plain fact that I could go; look the guy in the eye and say "I am so sorry. I've made a mistake. I'm sorry for all the discomfort you've had. I was in a rush, I didn't see." And the guy's my patient, and a very loyal patient because he knows I try my best and the fact that I've made a mess of it once doesn't mean I'll always make a mess of it, you know?

As mentioned earlier, the unique nature of primary care means that the overall interface time between physician and patient during a patient's life, is generally a lot higher than it would be with a medical specialist. Drawing on the history with the patient and the fact that he would see him again eventually, Participant 3 finds that he can engage relationally with his patient in honesty to establish mutual trust in the simple commonality that everyone makes mistakes. Being in a rural setting, this physician would also be drawing on a professional status as the town doctor which would also offer him a slight degree of protective, higher status which this physician could capitalise on also.

Another dilemma for disappointing patients that emerged was the discrepancy between the patients requesting antibiotics or pharmaceutical treatment without full knowledge of how they worked. Participant 8 recalled a recent occasion of this:

...had a really angry woman come see me on Monday because it was a big hassle for her to come into the clinic, she had two sick little kids who weren't sleeping, who had the flu. And she really, really, really wanted antibiotics and I didn't think they were indicated, and she was really unhappy with me and felt really let down by the care I provided but

PF: was it a viral illness or something?

P8: yea exactly, so there's a whole lot of situations when antibiotics don't, they probably do more harm than good, so trying to convey that in a kind and caring manner. So frequently I disappoint my patients by not meeting their expectations but I guess it could be, maybe their expectations are not that reasonable at all. I don't know, I do the best I can, its not going to make everyone happy, that's life isn't it.

Participant 7, having practiced as a General Practitioner for just under three decades, was much more relaxed in appreciating that such events of letting patients down or disappointing them was part of the career as a primary care physician:

...[laughs] that's a normal part of being a doctor, and I mean, how do you let patients down? There are just so many different ways; I mean you might not make the [correct] diagnosis... might not make the diagnosis soon enough, you might make the diagnosis but not get the referral in soon enough, you might not know the right treatment, um you might miss a phone call, you might be on leave when they need you, you might say something you don't realise hurt them and it did, um, you know every moment with every patient you might let them down, and you need to be mindful of yourself and how you come across.

What is significant here is that Participant 7, echoing Participant 8, reveals that it is the different expectations of medical professionalism from different parties in different spaces that also contribute to what is considered the discourse of medical professionalism. That is to say that disappointing patients illuminates how medical discourses of professionalism which can be multiple and conflicting at times. Despite

this, Participant 7 was quite relaxed and jovial about elements of letting others down in observing that it has as much to do with health care systems as it does for physician care. Consequently it can be observed that the discourse of medical professionalism finds actors and forms of expression through many means within the course of a General Practitioner's career and that part of doing well as a physician is knowing which discourse to adhere to and when.

Notably, all of the participants articulated that they felt they at one stage in their practice did not have enough time or strength to complete the requirements of what they would like to achieve in each consultation. Participant 9 worded this best when he recalled the stresses that the average day brings: "...there's the straight out physicality of time management, so just trying to make the day run well... and then there is the clinical pressure of thinking about the diagnosis and not making an error..." Although Participant 9 had been practicing for twenty two years he observed that the clinical pressure to prioritise medical excellence above his own fatigue was still acutely felt despite his experience.

Despite their own occasional fatigue, intentional efforts to increase the health and welfare of their patients were verbalised by seven of the participants in the form of the pursuit of social justice and caring for populations beyond their individual patients. As Participant 6 stated:

...you go to be a doctor because you feel there are needy people who you can help, and that shows there is this great need... you look after them when they're sick; but how there are hungry people; you know we're talking a lot about poverty with the election and how it affects people's health; um hunger, lack of food, lack of clothes, lack of shelter, and I guess as a GP you have a responsibility to deal with the health outcomes of all those awful things that happen to people. So maybe it pulls on the things that brings people; makes people want to be a GP.

Due to the nature of primary care often being immersed in the communities and suburbs, some of the General Practitioners revealed that they were more intimate with the physical health consequences of poverty. Participant 4 stated: "in many ways I think if a clinic should be functioning properly; should actually be much more

receptive to the community and actually trying to find out, and work with community.” In this broader sense, these physicians’ motivation of holistic care can be seen as extending to society level, in seeking to bring about health and welfare for communities as well as individuals. However, with the proliferation of technology-based feedback surveys assessing modern workplaces, the nature of what society is fostering a new climate of rights and complaints in which patients feel wholly more confident in reviewing their physician’s professionalism in a way that was unseen only a few generations before. I discuss this in more detail in the following section

### ***Modern Working Climate of Rights and Complaints:***

Standards of Medical Professionalism have in recent decades become the domain of the patients, in addition to the Medical Council, as patients are encouraged to know their rights and expect that their doctors will not make mistakes. It is important when understanding the social context of contemporary GPs work to appreciate this ‘sea change’ in the relative status and dominance of the role of physician as opposed to that of the patient. As Participant 9 observed:

...things out in the waiting room that talk about your rights as a patient... I have noticed now the person comes in and it’s like “oh yeah, there are my rights there, so the doctor [had] better measure up to that, because it’s written there” ...I would hope my professionalism would do that anyway so it’s irrelevant.

Participant 9 reveals that the modern rights based culture aids patients to be agents of medical professionalism discourse as they survey the quality of care granted them by their physician. Reflecting on this, Participant 2 expressed her frustration that this new cultural climate of rights and complaints leads to patients treating their care like any other advice:

I think that we are now just one of a number of different health providers and people will choose who they listen to. I mean I think partly it’s the internet, there’s just such a range; complementary, alternative therapies have always been around, but they kinda much more mainstream now. I mean people will come to me and say “well you’re saying that but my iridologist or reflexologist

or naturopath or homeopath says this. I will go home and weigh up what you say as opposed to what they say.” And I think it’s very different now.

This lack of traditional reverence for diagnoses was expanded on by Participant 6 when she said:

...a younger generation [of patients] I think wants more explanation, wants to engage more and [ask] why, and have more answers to questions and they question more, and if you get it wrong they want accountability more... you know the older generations often say “you just tell me” “you just do what’s best” and “yes I’ll just take that medication if you say so”, but I just wonder if there’s been a swing that’s gone the other way from now; the medical council, maybe, has been so concerned about the public’s wanting accountability and that they have sort of put all these very strict things in place to try and make us safer but I don’t know if there’s much proof [that it works].

Similar to the role of the General Practitioner as educator, Participant 6 observed that the motivation of self-care is more evident in the younger generations of patients who seek not just treatment but also a working knowledge of it. By contrast to the older generations of patients, the changing nature of primary care is evident as the General Practitioners respond to the different generational expectations of what health care visits entail, and in turn end up practicing multiple styles of medical professionalism simultaneously. This increased confidence in modern and often younger patients in being aware of their rights, expectations, and details of treatment, has also aided a shift of power by encouraging patients to be critics of their physician's professional performance. Participant 4, being the longest practicing participant of thirty four years, contextualised how the nature of his practice has changed over time:

...the rapid changes in technology and knowledge is just changing how you work... The complaints in NZ over the last 3 years have gone up 30-40%, it’s not because doctors are doing a worse job, there’s a change in the expectation and kind of complaint orientated world out there now, and that’s something new doctors are having to grapple with that I never had to grapple with. Cause you were seen to really put yourself beyond the call of duty, people gave you

the same amount of slack back, now these are the doctor's hours; what do you mean? "If anything goes wrong, I'll be complaining."

This low threshold for complaining complicates the nature of medical professionalism away from simply performing a high standard and treating the patient well, towards trying to match the patient's often unspoken expectations about who their General Practitioner should be and how they can best serve the patient. Participant 4 further expounded that

...the backlash off not working eleven / twelve tenths is that patients now see you more like a supermarket, you provide a service, if you don't provide it well we'll complain, so you could say there's a lot more um the expectations are higher, the forgiveness, because you're not nearly as integrated in their life, is much less. So if you are working in like a walk-in clinic where you don't know the people walking in, it's much more likely that they'll be upset by something you do, which is often just their expectations out of keeping with what can be delivered, they blame you for it, whereas your other, if you've been looking after three or four generations for a long time that's not likely to happen, they'll just say: "Look why did you do that?" and they'll give you a second chance.

The notion of being perceived as a supermarket form of medical care indicates a shift towards an ease of access type of clinic that has more of a business aura rather than that of a care clinic. It is interesting to note that this expectation of a supermarket type medical care is something that is attributed to the General Practitioners from the patients themselves which in turn reflects the overall shift towards review, rights and a complaints based culture of services and care. Subsequently it can be seen as the expectation of care is changing to the lay perspective of patients rather than internally from the clinic. The complexity of this new cultural climate of complaints and rights means that the physicians feel that they are treated as increasingly equal to their patients which frays the basic nature of the consultation being that of providing care and treatment options for the patients as the patients are often arriving confident to evaluate and review their physician without necessarily articulating what they want from their General Practitioner personally.

Having surveyed key terms, literature, and the local experiences of Christian General Practitioners in this study, I now turn to a brief overview of the structure of the remainder of the thesis. In Chapter Two I return in some depth to discuss the evolving concept of medical professionalism for GPs with a focus on professionalism as a series of overlapping waves of discourse. Chapter Three is concerned with more practical matters and explores the ways in which this study was constructed and how it was built. In Chapter Four I present the results and analysis of the ten ethnographic interviews and associated fieldwork observations that I made and which form the ethnographic material from which my analysis is derived. In Chapter Five I discuss my findings from Chapter Four in conjunction with the literature which I have already reviewed in Chapters One and Two. Chapter Six concludes the thesis.



## **Chapter Two:**

### **Reviewing the Recent Evolution of Medical Professionalism**

Having introduced my thesis topic and set the scene for the social context in which my participants were working as well as having discussed the matter of how to identify their varied styles of Christian faith, this chapter explores the matter touched on briefly in the preceding chapter – the growth of medical professionalism in recent years. My approach is to identify the key discursive threads to the meaning of professionalism and their overlapping waves of power and popularity in recent times.

Similar to the value of defining discourse earlier, understanding what is meant by another key term of ‘professionalism’ is a critical underlying premise of this thesis. Simply put professionalism is the manner in which one conducts and regulates oneself according to the standards set out by the profession’s governing body (Fox, 1989). However, the definition of what those standards are has not always been fixed nor stable and has in fact changed numerous times over the past century. What I will explore here specifically are the ways in which the conceptualisation of medical professionalism have changed in the past forty years. After surveying the mostly American and British literature in this area it became apparent that the evolution of medical professionalism in recent decades can be categorised into three ‘waves’ that are surges of change of focus and definition (Levinson, 2014). The first is that of disenchantment of medical professionalism in the 1970-1990s. Next is the revaluation of medical professionalism in the decades of 1990-2010. Finally, is the arrival of contending narratives and discourses of medical professionalism that occur simultaneous to existing formal definitions.

It should be observed that while it is my intention to explore the most relevant waves of medical professionalism’s recent history, this is not to imply that medical professionalism has only experienced change in the past fifty years. Indeed the American Medical Association (AMA) note that the definitions of medical

professionalism in the United States of America has changed its definition for working physicians in 1903, 1912, 1947, 1957 and again in 1980 where we begin (Fox, 1989). Subsequently medical professionalism's social tie to society in the form of a social contract, is illuminated in the changing definitions of medical professionalism as society changes its requirements of medical services. That is to say, that medicine has historically been granted the title of a profession as it is distinguished in its service to society and as an act of gratitude, has been historically left alone to be self-governed rather than by the state (Starr, 1982; Levinson, 2014).

### ***Wave 1: Disenchantment***

In order to understand the development of professionalism within biomedicine in recent times it is important to firstly understand its premise of what it means to be a profession. According to Howard Vollmer and Donald Mills in their now historic text in order to be characterized as a profession a category of employment requires a formal education, autonomous regulation from government, and academic journals supporting the profession's advancements (Vollmer and Mills, 1966). Vollmer and Mill's criteria was written in such an era when much of the workforce in American and western society was divided into manual and educated labour. Subsequently these requirements to be seen as a profession were not simply standards but rather a defence of said profession's right to exist and to exercise authority over those whom it served. For the greater half of the twentieth century, including when Vollmer and Mill's published their text, to be professional and to have a good professionalism was to adhere to the exclusive social cohort that made up the medical profession. In this sense then, professionalism was an unspoken working culture in which adherence proved one's belonging and worthiness to remain in the medical profession (Abbot, 1988).

It was off the back of such a culture that Paul Starr in his book 'The Social Transformation of American Medicine', observes the cultural change away from professionalism by medical affiliation towards professionalism via merit (1982). Coinciding with increasing health care costs and the aggressive privatisation of medical care in the United States, the American public began to question whose interest was medicine really serving and if in fact it was neglecting its service to

society then could it still be worthy of being called a profession (Starr, 1982)? Such disenchantment challenged the medical profession's privilege of self-regulation by inquiring who does medicine serve: itself or its patients? Such questions began to fray a blind trust for the 'doctors orders' as the inspection of the moral character of both physician and institution was brought into public forum (Starr, 1982).

In New Zealand, the beginning of the disenchantment of medicine away from blind trust was sparked not from the increasing inaccessibility of health care but rather from the abuse and malpractice within public health care (Coney, 1988). Sandra Coney details in her book 'The Unfortunate Experiment', the dramatic 1987 case of Dr Bill McIndoe being found out to have conducted a clinical trial of patients with cervical cancer without their consent for over two decades. Medical colleagues who opposed this trial once it became known that the physicians were intentionally not treating patients for the sake of research and publications were hushed through either avenues of hierarchy or group pressure (Coney, 1988). This is not to say that such dubious clinical trials were perceived as professional but rather, as Coney points out, it was more important to preserve the working culture and image of being leaders in research and publications (Coney, 1988). Thus, as patients died and the 'unfortunate experiment' of intentionally not treating cancer in women became known to the public, the imperative to change what was being tolerated as professionalism was a pressure stemming from both the local population as well as the New Zealand Medical Council (Coney, 1988).

### ***Wave 2: The Response of the Disenchanted: revaluation of medical professionalism***

In light of such conspicuous malpractice on unsuspecting patients coupled with the increasing American inaccessibility to health care, the disenchantment of medicine had led to doubt around whether the institution of medicine was still worthy to remain as self-governed as it had in the past. Just as the public forum was beginning to question the safety of the culture of medical praxis, it began to become apparent that structural violence was also harming physicians themselves (Sinclair, 1997). The professionalism that propagated the profession above the care of patient or physician health was fading.

Simon Sinclair in his book 'Making Doctors, an Institutional Apprenticeship' reveals that historically, the honour of being accepted into medical school would often be sufficient motivation to endure all forms of unprofessional socialisation behaviours (1997). Surveying trending research, Sinclair observed that as more research surrounding the effects of the medical institution upon young physicians was published, the correlation of mental health harm to junior doctors was becoming evident (Firth-Cozens, 1987 in Sinclair, 1997: 310). Sinclair, borrowing Pierre Bourdieu's concept of habitus, describes the working culture and sense of medical professionalism as being simply the working environment in which physicians find themselves having to conform in order to fit in within the medical field (Bourdieu, 1977 in Sinclair, 1997:302). The value of Sinclair's work is that it marks a shift in professionalism being understood historically as an apprenticeship style model in which trainees emulate their mentors, to a broader and more transparent medical system whose flaws could be identified and addressed a lot quicker.

Julia Connelly's article entitled 'The Other Side of Professionalism' furthermore reveals this notion of traditional twentieth century professionalism of medicine requiring a silent suffering from the physicians (2003). She recounts one story of an Obstetrics and Gynaecology physician who throughout her career was always offered the opportunity to finish when her shift ended according to the clock but felt compelled to stay for the remainder of each labour so that she could be seen to be a 'good doctor': "...I feel committed to the patient... hours pass, years pass. I no longer know who I am. My husband was ill recently and died. My children are grown. I am so tired, worn out" (Connelly, 2003: 179-180). For this physician, the discourse of being a 'good doctor' can be appreciated as the earlier forms of medical professionalism. However, as is revealed in her lamentation, such a professionalism came at the expense of her personal life as she sought to be one that did "everything possible" rather than their best (Connelly, 2003: 181). Thus at the end of her career, this physician observes that her perception of medical professionalism and being a 'good doctor' was no longer a noble, selfless vocation but rather was revealed as a thief to the joys of a normal life (Connelly, 2003).

Sylvia and Richard Cruess prove to be exemplars of the second wave of new medical professionalism (2009). In their chapter 'The Cognitive Base of Professionalism', the

authors note the historical trend between the role of the healer and the role of the curer (2009). The premise of the authors' model is that the medical professional should have two dual roles, that of healer and that of professional. The healer role was explained as being able to communicate clearly and generate rapport through respect. The professional role was understood as appreciating one's scope of practice and becoming aware of how medicine is just one part of the health system. The authors propose that the two roles should also unite to house the tenets of medical professionalism of competency, altruism, trustworthiness, morality and responsibility (Cruess and Cruess, 2009). Such a definition of medical professionalism via tenets of virtue characterises this second wave of professionalism as the shift away from medical culture to physician conduct was encouraged. Additionally, Cruess and Cruess' work also reveals the process of relocating the discussion of what medical professionalism might mean and whom it should serve, away from the medical faculty towards the public and academic fields such as medical anthropology.

Fredric Hafferty's solo article entitled 'Definitions of Professionalism: A Search for Meaning and Identity' details the struggle that the American Medical governing bodies had in terms of trying to identify the key tenets that would be best for defining medical professionalism (2006). The governing body of the American Board of Internal Medicine (ABIM) defined professionalism as "attitudes and behaviour that serve to maintain patient interest above physician self interest... and aspires to altruism and accountability, excellence, duty, service, honour, integrity and respect for others..." (ABIM, 1995 in Hafferty, 2006: 195). While the American Council for Graduate Medical Education (ACGME) defined professionalism as "respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self interest..." (ABIM in Hafferty 2006: 195). Within both these definitions is the expectation that professionalism entails the eclipse of self-interest and while this is quite understandable when it comes to greed or selfish gain it could also encompass the need for physician rest, a lack of which could be detrimental to both physician and patient. To add to the chorus of boards defining what medical professionalism should be, is the [American] National Board of Medical Examiners who offer sixty behaviours of professionalism with altruism in the lead (NBME, 2005 in Hafferty, 2006: 196).

As observed within the American and wider medical literature, the most common tenet proved to be altruism while in the United Kingdom it proved to be Patient Centred Medicine (Wearn et al., 2010; Hafferty, 2006). While both these notions are noble and both are focused on patient oriented medicine, it should be acknowledged that patient centred medicine does not require the sacrifice of self that American medical professionalism does. The United Kingdom and New Zealand by contrast are much more concerned with being a good doctor rather than the hero doctor. Indeed, while it was generally agreed that a virtuous form of professionalism would be beneficial, no one set of virtues was found to be sufficient across all medical regulatory bodies (Tallis, 2006). Professionalism has always required the physicians to go beyond their general duties for which they are employed, however in this second era of medical professionalism the emphasis is on service to the patient rather than to the faculty (Tallis, 2006).

Cynthia Brincat (a physician herself) represents an internal perspective of medical professionalism in her chapter 'How Medical Training Mangles Professionalism' as she calls readers' attention to the fact that much of the difficulty in defining medical professionalism with a set definition stems from too many interlocutors contending for what medical professionalism should be (2006). Indeed within this era of medical professionalism, a new fervour to protect patient rights emerged with emphasis on such things as patient autonomy, consent and involvement, all of which add new dimensions to care and competency that many physicians did not have as part of their medical training (Shirley and Padget, 2006).

Simultaneous to the slow eradication of the deity like status of being a physician has been the increased recognition that physicians work is actually done within the context of a medical team and not by the medical profession alone (Brincat, 2006). Brincat expresses concern that too much attention to the patient with a uniform view of medical work can lead to policies that are cumbersome to physicians (2006). Simultaneously, she acknowledges that on a meta level, American Medicine has been too concerned with defining professionalism that it still has neglected to actually implement tenets such as altruism into its senior staff (2006). Her solution is to return to the ontological purpose of medicine, being that of caring for the patient and

curing disease in a way that is accountable to society and transparent in order to minimise malpractice (2006).

Within New Zealand, medical professionalism is observed to have been changing in nature according to the New Zealand Medical Council and the educators of medical training (Wearn et al., 2010). Andy Wearn and colleagues observe in their work the changing nature of medical professionalism as having gone from a form of elite exclusivity to performance of highly technical and relational competencies (2010). This is important to note as much of modern medicine and medical professionalism is worded with language and assessment matrixes that are oriented around competency levels and whether one displays the approved levels and methods of good practice training (Wearn et al., 2010).

Indeed, Wearn et al note that prior to the disenchantment of medicine in the 70s, that much of what was considered as medical professional practice was defined by antithesis of what was considered unprofessional. That is to say that while there were formal attributes of medical professionalism, what was enforced and promoted was what a physician should endeavour to avoid doing least they are seen as undeserving of the exclusivity of medical professionalism (Wearn et al., 2010). During this second wave of professionalism the shift to tangible virtues was made which then in the new century became characterised by tenets which could be measured and tested. It is for this reason that New Zealand's tenets of medical professionalism included notions of different competencies (including relational) which could then be achieved and awarded, making maintenance of medical professionalism much easier for administrators (Wearn et al., 2010).

Up until this time of the early 2000s, discourses of medical professionalism existed as an expectation to go beyond normal working hours and to really serve one's patients even to the cost of family and personal life. As this was the expectation, discourses of medical professionalism as harmful could not yet exist because any harm or damage taken to the physician's family life was perceived as heroic and altruistic. However, as the discourse of medical professionalism began to change to focus more acutely on the moral and skill set of individual physicians, the narrative of the old methods of medical professionalism as serving the institution began to be disparaged.

### ***Wave 3: Current and Contending discourses***

In response to the disparage of old discourses of medical professionalism and an often hyper philosophical new medical professionalism, the most recent work in medical professional literature has been to amalgamate essential attributes of a physician along with forms of medical professionalism that actually were being practiced but not necessarily indoctrinated.

These contending discourses of modern medical professionalism are observed best in Brian Castellani and Fredrick Hafferty's chapter 'The Complexities of Medical Professionalism' as they reveal some of the most common alternative discourses to the dominant medical professionalism as altruistic (2009; 2006). The authors identified seven major alternate discourses of medical professionalism that have arisen in the past thirty years that reveal what is valuable and seen as being a good doctor to different kinds of medical personalities (Castellani and Hafferty, 2006). Having collated data from their previous studies over the past two decades, Castellani and Hafferty identify the seven main contending discourses of medical professionalism as Nostalgic, Academic, Entrepreneurial, Lifestyle, Empirical, Unreflective and Activist (2006: 9). It is beneficial to briefly survey these seven.

Nostalgic professionalism firstly is the old guard of medical professionalism that prided itself in heroic self-sacrifice of one's own time in order to serve the patient. In company to Nostalgic is Academic professionalism, which is perceived as providing an external authority to justify the work of medicine. Entrepreneurial professionalism embraced the commercial aspects of medicine in which being a good doctor was reflected in one's financial income. Unreflective professionalism was understood as being that of a civil servant, one in which the doctor performed their duties and avoided any meta discussions on social justice or major changes to the institution of medicine. This was found to be more common in American primary care. Lifestyle professionalism seeks to first do no harm to physicians by ensuring that doctors look after themselves so that they are fit to look after patients. In opposition to nostalgic professionalism, Lifestyle emphasises the importance of family life and rest rather than the sacrifice of such activities for the sake of medical heroism. Empirical professionalism is similar to academic medicine but serves as the frontier of advancements in medical progress with a heavy emphasis on research.



Finally, Activist professionalism is a discourse of professionalism that seeks to employ medicine as a vehicle to carry the banner of humanistic virtue and make social justice issues conspicuous.

These alternative discourses of medical professionalism are manifestations of different social currents in different societies. For instance Unreflective Professionalism is a common form to be found in American state primary care that seeks to practice but not engage in health politics. New Zealand's single tier government means that primary care in New Zealand is almost the opposite in which many primary care physicians seek to bring about changes in governmental health programmes and as such are closely wed to public health (Wearn et al., 2010).

Sandra Jarvis-Selinger and her colleagues in an article entitled 'Competency is Not Enough' explore that beyond measurable professionalism of skills is the nuanced definitions of professionalism which is unique not only to different medical systems but also to medical specialities (2012). Such nuances are what contribute to such contending and alternate discourses such as that of lifestyle professionalism mentioned by Castellani and Hafferty (2006; Jarvis-Selinger, 2012). While such nuances do not dominate the literature of discourses of medical professionalism they are a valuable contribution to understanding the spaces in which discourses of professionalism are active and as sites where disputes about professionalism might be made. Jarvis-Selinger suggests, when it comes to individual physician professionalism, that it is unhelpful to think of professionalism as achieved and not achieved but rather to value that just as competencies and skills grow and develop within a physician's career, so too does their degree of professionalism (2012). That is to say, that discourses of professionalism can often only be active in the physician to the extent that he or she has learned skills and tenets that can be valued as professional.

James Shirley and Stephen Padget in their chapter entitled 'An Analysis of the Discourse of Professionalism' argue that the key to understanding the new discourses of medical professionalism is not simply found in producing a set of virtues and practices alone, but rather in understanding who those practices serve (2006). For Shirley and Padget, language is the real act of professionalism as it is what supports discourses and having a mastery not simply on definitions but on social transactions

of language is what the authors argue will reveal actual professionalism as it is done (2006). Subsequently the authors argue that concepts such as altruism can be viewed as unprofessional as they require a compromisingly large emotional withdrawal from physicians that the more recent generations of physicians are not willing to pay (Shirley and Padget, 2006). Shirley and Padget argue therefore that the discourse of professionalism is something that is reshaped and remoulded over time through language rather than directly replaced (2006).

This is evident in the phases of medical professionalism revealed so far as the change has been located in both whom medicine should serve to be professional and how to identify that as such. Thus the authors argue that one of the key reasons for the increase of many different forms of contending discourses is due to a lack of consensus of shared values between whom medicine serves (the patients and society) and who medicine trains and supports (the physicians) (Shirley and Padget, 2006). As observed earlier within Brincat's work, the many voices and groups defining medical professionalism are not just problematic but are also becoming increasingly complex as the definition of who society is, is ever expanding in plurality and diversity, creating a more difficult opportunity to achieve a consensus on what good medical practice and medical professionalism should be (2006). Shirley and Padget warn that siren calls to a simpler and nostalgic version of medical professionalism should be avoided as they no longer adequately reflect the diverse populations the modern physicians now serve (2006).

In light of such complexities of medical nuances and diversity of population that contribute to the discourses of medical professionalism in any one country, it is worth observing that there was much that was held in common by the GPs who contributed to this study in the manner in which they understood professionalism in their own lives. That being said, before moving on to discuss in detail exactly how these shared understandings of many aspects of professional identity interfaced, reinforced and sometimes contradicted their particular faith identities as Christian practitioners, it is appropriate to consider how best to investigate such a complex question. Thus, I turn now to a discussion of the ethnographic methods that I used for this study – both their challenges and their undoubted benefits for engaging with

others on such intimate details of their personal and professional lives.

## **Chapter Three:**

### **Methods**

In this chapter I explore the academic theory supporting the project, as well as detailing the mechanics of methods undertaken to carry out the investigation and complete my project. To answer the research question underpinning my thesis I selected qualitative open-ended interviews as the most efficient and appropriate means of data acquisition. Due to the complex nature of investigating discourses of professionalism and the ways in which they are experienced and contested, a survey would have proved to be insufficient. This is because surveys do not allow the room to expand and pursue relevant content as it is presented by the participants. Indeed, the very nature of my research questions as to how discourses of professionalism influence Christian General Practitioners in their practice, as well as how they negotiate and identify boundaries when is something seen as unprofessional, are both questions that are open ended (Madden, 2010). Ethics category 'A' was approved for this project by the University of Otago Human Ethics Committee (Reference number 17/001) and a copy of the interview questions and prompts is included in Appendix A.

The nature of my own fieldwork is divergent to that of traditional anthropology fieldwork which is usually understood to be exotic, rural and removed from the ethnographer's world (Forsythe, 2001). Instead, like Diana Forsythe in her work 'Studying those who Study Us: An Anthropologist in the World of Artificial Intelligence' I chose to study in an urban environment with a participant group that is close enough to my own world that I can call on acquaintances to source participants. While such fieldwork grows more common and eliminates many logistical issues, a new set of issues arise pertaining to power. Within this project, I am studying those who are used to having authority and power within society because of their medical office so participating in this research seemed to be a refreshing change in daily routine as well as a bit unusual for the participants. Forsythe notes in her book that the complications of 'studying up' prove manifold as such participant groups often are likely to have influence over you in the near future (2001). For Forsythe, her participants could have proven to be her future employers, which in many ways

affects the extent to which raw data can be presented as reproducing an unflattering comment may damage future prospects (2001). I already have a General Practitioner for my own healthcare whom I did not recruit thus I avoided any future ethical obstacles in that regard. I was aware however that unlike my previous research (Franklin, 2014) that was conducted with participants who were at a similar age and life stage as myself, these physicians had a wealth of experience both clinically but also as parents and contributors to their community. As such, they were significantly important and well-known people. I now understand that part of the reason that my initial recruitment efforts did not take flight with ease was perhaps because I was perceived as unworthy and too 'lay' to inquire into such a people group without any medical training. In other words that I was not a member of the 'medical tribe' and not insider enough to appreciate the pressures and demands of their work. To counter this, I successfully (and eventually) drew on my ties from my faith and church networks to facilitate recruitment as is discussed later.

### ***Dialogical Anthropology:***

Because of my interest in discourse, in searching for a particular theoretical approach to the collection of my data I chose to undertake Dialogical Anthropology (Tedlock, 1987). I made this choice because dialogical anthropology is a form of anthropological enquiry which examines not simply the cultural content of observed actions and conversations for itself but also the mechanisms of speech and discourse that propagate, regulate and negotiate what is deemed acceptable and exception (Omohundro, 2008). This seemed a congruent choice for my methods because the topic I was investigating was delicate, and it seemed that there might be potential for participants to self-censor their views or perhaps withhold certain viewpoints because of the dominance in New Zealand of professional practice codes that are promulgated from within a secular framework.

The manner in which dialogical anthropology is conducted is one that reveals the ethnographer is sensitive to their interlocutor and their construction of discourse as it is revealed in their worldview. The process of articulating what it means to belong and identify with whatever participant group is being studied is understood within this anthropological paradigm to provide important insights into the shared meanings within the participant group. Dialogical anthropology is different to many

other styles of 'doing' anthropology, as it is not interested in content only but also in how the conversational content comes into being (Garriott and O'Neil, 2008).

This has a particular resonance with a study exploring aspects of Christian identity as Christianity has always been dialogical from its earliest life. Indeed it was largely perpetuated through correspondence between believers which was then later canonised into the New Testament. This study however engages with an even more complex subject position as it explores the simultaneous embodied experience of interlocutors who are required to be both an interlocutor for the discourses of medicine *and* the discourses of faith. The value of dialogical anthropology for this study is in exploring not how physicians are defined as worthy of becoming doctors, but rather how they protect that title of physician by perpetually moving toward medical professionalism. It is worth noting that the nature of discourse never fully grants a stable and achievable position of being professional, rather its power lies in the fact that it is always required and yet there are always ways to be more 'more professional'. That is to say, the discourse of professionalism always requires a withdrawal or an emotional distance from its subjects in order to keep them safe in their office of physician, and that in itself is its reward.

Dialogical anthropology practised both *with* and *as* a Christian adds another layer of complexity again. For example, a form of self-questioning that arose very early in the research and always remained a focus of dialogue was: "How is a Christian qualified to hold the identity of 'Christian'?" Again, what makes this topic entirely dialogical in nature is not the content of the conversations about different forms of Christianities that state what it is to be a Christian because of specific doctrines or practices, but rather how the participants in their local Christianities experienced what it means to be one. In this study, the participants identified that reading biblical scripture and being in an orientation towards God in prayer and deed were the key elements that satisfied their definition of what it meant to hold a Christian faith. It is worth noting that even this definition is a very fluid definition, as the participants never quantified how often or how intensely one might pray or read in order to suffice. Consequently it can be valued that in this statement it is the *action* that the dialogue produces, rather than an achieved, static, state of faithfulness which unifies the participants in this study.

One such example of native qualification of being 'Christian enough' is in the work of William Garriott and Kevin O'Neill as they observed that at the forefront of the minds of their participants from Guatemala is the distinction between one who is a 'believer' and one who is a 'disciple' (2008). Within their work, their participants appreciated a believer as affirming a Christian faith, and valued a disciple as individuals who sought to please God in living out the gospel through outward commitments and a more intense internal engagement (2008). This distinction thus allows both to be considered Christians but with disciples being the ones who are seen to be appreciative and subsequently more active and substantial in their faith. The value of Garriott and O'Neil's work then is that this case study of Christians reveals dialogical anthropology internally within the Christian participant group where definitions of belonging and identity are made and qualified in their activity. The participants of this project indicated that the marks of a worthy Christian was that their lives were seen to be God focused and they were intentional about learning and living out scripture. Throughout the interviews it was apparent that my own knowledge of biblical texts aided the pace and development of thoughts as the participants made references to the verses. This was exemplified in interview nine in which I encouraged the participant to continue to expand on his reference about being 'salt and light' which prompted him to recall other verses that he engaged with in his work ethic.

Appreciating who is considered Christian has become a core question in the developing field of the Anthropology of Christianity (Robbins, 2003). Joel Robbins observes that in order to sustain and foster the dawning field of the Anthropology of Christianity, the focus needs to shift from Anthropology's complicated historical relationship with Christianity to the specifically internal cultural issues that occur within Christianity itself (2003). As an example, Robbins observes Talal Assad and John Bowen's separate contribution in the anthropology of Islam as fostering an ethnographic focus on internal Islamic issues that are free from an institutional bias that the anthropology of Christianity has experienced (Assad, 1986; Bowen, 1993 in Robbins, 2003). It is my ambition in this work to similarly achieve an ethnographic focus of the quiet internal issue of the intersection of the discourses of medical professionalism and the participants' faith.

### ***Christian Anthropologist:***

The notion of Christian ethnographer was one that was, until recently, conceived of as something of a contradiction in terms. This history epitomised in the competing agendas of missionary and anthropologist in the field has historically caused those of the cloth and those of the academy to hold general animosity towards each other (Arnold, 2006). Robbins explains that the reason that an anthropology of Christianity had not arisen sooner is due to the fact that much of the discipline of anthropology and been fostered out of the enlightenment's stance against Christian concepts (2003: 194-5). In 1991, Susan Harding published an article which suggested Christian anthropologists were seen as an undeconstructed 'repugnant cultural other' by other practising anthropologists and in doing so indicated that potential Christian ethnographers had significant institutional obstacles to overcome in order to contribute to their discipline. This tension was picked up by Brian Howell who in his work, argued against such background prejudices within the discipline, and stated that ethnographers committed to a faith should be valued the same as researchers who hold an epistemological stance such as feminism in a stance he deems 'Christian Standpoint theory' (2007).

As already observed in Emerson et al., the process of ethnographic research can never be purely objective, and indeed the authors note that it is wrong to presume one has 'discovered' data as the very nature of constructing a research construct preludes a framework as to what can be discovered (1995). Rather, the very nature of the premise and founding ideas of the project afford the kind of accent which is used to narrate any findings from the project. This accent can be understood more wholly as the common ethics and religious values that I share with the participants of this study. In this regard then it could be said that I am a case of native gone anthropologist (Wolcott, 2008: 169-70). Subsequently, Howell makes note to the utility in such a situation of Lila Abu-Lughod's term 'halfie' to appreciate the complementary notions of an ethnographer who is both at once an anthropologist and a Christian (Abu-Lughod cited in Howell, 2007: 376). That is to say, one who belongs in faith but is an outsider in medicine. At the very least then, being native in Christian faith means to adhere to set principals and beliefs shared by many internationally and often supported in deeds. Similarly, when it comes to worldview, Howell observes that the notions of belief that comprise a worldview for a Christian



are comparable to some degree to worldviews held by other ethical and theoretical clusters such as feminism (1995).

Indeed, Sandra Harding observes that all attempts to knowledge and research are situated within political and cultural climates that are often unconsciously providing conditions on what might be considered as 'objective' and that in fact to assume pure objectivity possible in social science is to ignore the knowledge production process entirely (1993). The value of standpoint theory is that it is a method of research that starts on the fringes of historically overlooked parties in research such as women (Harding, 1993). Subsequently, I support Howell's notion that instead of perpetuating an uncertainty surrounding the relationship of embodied Christian and ethnographer, that it was beneficial instead to consider my work as a type of 'Christian standpoint theory' (2007). In this way, the native component of an ethnographer's personal faith in Christ becomes not a presumed contamination or bias, but a declared form of participant observation and a source of potentially rich shared meanings that aid in deepening rapport between fieldworker and participant.

This transparency affords the clarity to the participants and research group to whom the results are returned, that there is an assurance of shared respect in the handling of the data; but also additionally identifies for the academic, the theory and epistemological locale of the work (Poloma, 1982). Additionally, to avoid my own faith becoming something of a soteriological agenda within this research, I elected to do this study through anthropology rather than theology so that when I processed the results it would be done through a theoretical lens of standpoint theory. Having previously completed a minor in theology in my undergraduate degree, I had previously observed a tendency within myself to cite scripture to counter unflattering findings, but within anthropology the chance to explore the richness of open ended results was a useful corrective to this position. The value of standpoint theory is that it affords the Christian ethnographer the ability to partner with the same set of values in their faith without having to internally host the same cultural nuances or beliefs from their spiritual environment, allowing for the local differences in expression of faith to be valued whilst still hosting commonality. The remainder of the chapter will now explore the ways in which the fieldwork was undertaken.

## ***Mechanics of Methods:***

### ***Recruitment***

Unlike my previous fieldwork that was conducted with participants of my own age group in 2014, this project proved more challenging to recruit participants. A successful snowballing recruitment method requires a first few initial participants to gain momentum. However I struggled to attract willing participants after dropping posters and emails into local clinics. One of the major reasons for this was disclosed to me by Participant 5 who stated that seeing the terms ‘discourse of professionalism’ in an email represented to her the opposite of what she had striven to create in her medical career. She expanded that she perceived her role as translating medical jargon into lay for the patient and consequently ‘discourses of professionalism’ represented to her the overtly formal and quite recent changes to medicine that was still greatly unfamiliar. Thus having a young student, who was not medically trained inquire about medical professionalism was received with mixed emotions of apathy and indifference. To counter this, and to secure participants, I subsequently drew on networks of friends and family to contact the physicians directly using a snowballing sampling method over ten weeks (Blaikie, 2000).

Once a potential participant had been identified, contact via email and Facebook Messenger was conducted to further explain my project and test how willing the participant might be. It became apparent after the first interview that the easiest way to communicate what the interview would involve, and what was being investigated, was to send the interview questions themselves to the participants for them to have a quick inspection. Of the ten participants, Participants 2, 6 and 9 had thought about their answers prior to the interview while the remainder used the questions as a gauge for what the interview would entail.

From the fieldwork it was revealed that eight out of ten participants attended a church in the Dunedin area, while the other two were locals to the provincial towns of Greymouth on the West Coast and Kaitia in Northland. Out of the ten respondents, two were from Baptist churches, which holds a strong theological tradition and has proven to be very intellectually stimulating and was recognized as commonly being a very popular with local Christian physicians. A further two participants identified

with Pentecostal churches which are a form of Christianity renowned for freedom of expression in musical and sung worship. Five participants indicated affiliation with more traditional forms of Christianity - two of those being Presbyterian and three of the ten being Anglican. Both of these denominations place a high value on unity and tradition. The final respondent belonged to an international church, which was organised more around a home language and a diasporic community more than a theological faith tradition. Surprisingly, only two of the participants shared the same church as a local place of worship and thus it can be observed that there were nine different communities of worship and Christianity which influenced, helped create, and informed the participants' perspectives on faith and those essential components that constitute one's faith.

Participants 1 and 7, being General Practitioners in Kaitia and Greymouth respectively, were both recruited as they were visiting Dunedin for other reasons. Participant 1 was unique in that he had agreed to do an interview with me after having seen me preach the day before while visiting his daughter's church in Dunedin where I too attend. Having first seen me in a very native Christian setting the interview proved to be a high yield as the basis of a deep faith foundation was observed rather than assumed. Unfortunately, as he did not know any other suitable participants in the Dunedin area it proved for a slow start in gaining momentum in snowball recruitment. Participant 7 I met while being a volunteer patient for a sonography training course, during which he made polite conversation to me as the acting patient and subsequently became captivated by my project to the point that we agreed to conduct an interview after his training session was over for the day.

It is worth noting that Participants 1, 3 and 7 were all expatriates of the South African Republic who had undertaken Medical School there and then had settled in New Zealand more than a decade ago. This cultural and national background is worth noting as each of these participants noted the difference between New Zealand and South Africa in the cultural and religious climate. New Zealand was understood to be more hostile to a Christian faith which was a stark contrast to South Africa. For example, Participant 3 identified: "...when I grew up: until I left South Africa, the religion was almost the country. You know? ...Um so, coming to New Zealand where, it's totally voluntary and it's a minority group, so it's really, you have to stand up for

yourself...” Additionally, Participants 1 and 7 spoke of their faith in Christ with a confidence that was more relaxed than their New Zealand counterparts that I interviewed who in turn displayed a greater sensitivity to cultural and medical professional discourses of religious pluralism. This is not to say that the South African participants did not show a sensitivity to such discourses but rather they were clearer and less hesitant when it came to a discourse of faith.

### ***Interviewing and Coding:***

Originally, my questions proved to be too specific and so were modified a total of six times reflecting emerging themes. One example of this was the centrality of peer review in informing the participant’s understanding of discourses of medical professionalism and mental health. Being sensitive to how the participants were actually describing how they conceptualised medical professionalism and navigated it in orientation to their faith afforded a greater depth of results as my interviews progressed.

However, the nature of the majority of my participants was such that their generous and eager nature meant that I did not realise that some of my questions could be perceived as closed questions until I was doing my final few interviews. Thus I continued to refine and enhance my techniques for engaging in open ended interviewing throughout the entire project.

Before recording began, I briefed the participants with a synopsis of what would be covered but also explained that I was not seeking formally ‘correct’ or ‘incorrect’ answers. Doing this afforded a freedom to explore new, relevant topics of interest that presented themselves rather than ensuring we completed all of the questions. Throughout the data collection period, I began to learn which questions elicited particularly rich lines of conversation and ensured that I attempted to prioritise these with the other questions as supplementary. The interview questions were also divided into two major parts, with the former focusing on questions surrounding elements of faith in the clinic and the latter focusing on discourse and experiences of medical professionalism (See Appendix A for interview questions used). While there was a total of two pages of questions, I was sensitive during each interview to ask

only the questions that I believed would be of the highest yield for that interview. Consequently, no participant answered every question listed.



**Figure 1:** External pictures of 4 of the clinics where 5 of the participants practiced. Top Left: Mornington Health Centre. Top Right: Caversham Medical Centre. Bottom Left: Meridian Medical Centre, based within the Dunedin town mall. Bottom Right: North Dunedin Medical Centre.

After the completion of the interviews, the anonymised audio files were saved to Dropbox as an external and online storage system as well as locally on software. Transcription was performed by myself and my wife Gina. Gina herself was working as a final medical student at the time and found the content easy to process. None of the participants were previously known to myself or Gina and the majority elected to remain anonymous. Robert Emerson and colleagues note in their book 'Writing Ethnographic Fieldnotes' that the process of data collection is never purely an objective task as the initial research question and research itself informs and grows expectations of what one is expecting to find, and in turn influences what the

researcher looks for (1995). This was definitely the case for my own experience as I have just explained.

Coding of the interviews began initially by hand on printed copies of the transcripts that afforded me an opportunity to think laterally and to annotate the printed copies with potential codes. A menu of codes was maintained by myself to maintain an awareness of the similarity of emerging codes and this in turn assisted me to label different phenomena under different concepts and at times, amalgamate the concepts if there was considerable overlap (Strauss and Corbin, 1990).



**Figure 2.** A sample of Dunedin Churches attended by the Participants. Top Left: Opoho Presbyterian. Top Right: Dunedin City Baptist Church. Bottom Left: Saint John's Anglican. Bottom Right: Elim Pentecostal.

These codes were then categorised under parent codes which held a unifying title for a collection of concepts. Having done this type of coding before, I found myself too eager to anticipate parent codes and subsequently had to demote some codes such as 'social justice' into a larger code of the role of the General Practitioner. I realise now that by being so intrigued over different comments that the participants were

passionate about that I had then assumed that such a passion for such items would be common. NVivo 11 was employed as the software platform upon which I turned codes into nodes that the system would be able to identify the concepts that I had collated and identified.

This rearranging and relabelling of codes and categories is part of the evolving nature of qualitative research that emerges as the researcher seeks to listen more intently to what the data and participants have actually said together and not simply what the researcher was anticipating to hear. As Hammersley and Atkinson note in their chapter “The Process of Analysis”, ethnographic research often holds such a richness and multiplicity of stories that it is unclear what the final story is until the project is collated and overarching trends are spotted (1983). Having all my codes in hand, I listened and looked for the story that the participants had told rather than what I had anticipated them to tell. I commenced writing of my first draft of my results with a strong setting of the scene section which was later relocated to the introduction. The results then proved to show a clear dual theme of discourses of faith and discourses of medical professionalism.

### ***Inclusion criteria:***

As with any study that requires participants to hold a certain worldview or faith in order to participate, the interpretation of what it means to meet the criteria of being a Christian is ultimately left to the description of willing volunteers (Koenig, 2011). In order to create a sense of harmony in this ethnographic research I did specify an inclusion criteria that featured in my ethics form as a “frequent proximity to God defined as a self-identified relationship with God, supported by both regular church attendance and internalisation of Christian faith as the core aspect of their personal identity.” My appreciation of proximity to God was understood as the Christian General Practitioner would value their faith above their profession both in word and in deed. While this was certainly true of most of the participants, many of them perceived their faith and their profession as subjects of their lives that were equally demanding and thus had not thought of them as explicitly distinct or unified, but rather as different requirements of the day that drew on different identities. Thus when it came to speaking of discourses, the medical profession proved to be the lead



identifier for the participants as I was often seeing them in offices that visually spoke of a medical environment.

To understand the distinctions made in my inclusion and subsequent exclusion criteria, I drew on the work of Aaron Franzen in his typologies of four common forms of spiritual and religious expression which help illuminate the emphasises of different elements of faith and how each proves themselves relevant in daily life in different forms (Franzen, 2017). Franzen details the four main type of religiosity as: Religious and Spiritual (RAS), Spiritual but not Religious (SBNR), Religious but not Spiritual (RBNS) and Not Religious or Spiritual (NROS) (Franzen, 2017: 5-6). Within these four, Religious is understood as the forms and outward activities of religion such as the traditions and church attendance and as an outward expression of belief. Spiritual is understood as the internal components of belief and supernatural connectivity through meaning in a phenomenological way.

It was my ideal for participants to consider themselves as both religious and spiritual (RAS) so as to draw a depth of dialogue within the interviews. While I did expect there to be a sufficient variation of expression of Christianity enough to warrant using the term 'Christianities' I was, in the end, surprised at just how much variation did occur. This is not to say that the different forms of Christian expression were so different as to compromise ethnographic integrity, rather it was that the variation manifested more in the outward expression of faith in religiosity rather than the spiritual phenomenological encounters in their faith which is where I had originally suspected the variation to be located. This then served well within the dialogical framework for the project as it displayed that it was the intentions and momentum of the participants towards God and faithfulness in both medicine *and* faith as being the true focus and location of identity.

The dialogical anthropological work of being attentive to what the participant understood of their world and where the discourses interacted was important so as to not force in my own understanding and expectations from what I had learnt in the literature. In my fieldnotes for example, I recorded the previously mentioned interaction with Participant 5 in which she had disclosed after the interview that she had received my recruitment email, but had thought initially that she would avoid my



project as 'discourses of professionalism' was a title too laden with modern conceptions of medical formalities, something which she felt was alienating the heart of patient care. This notion of being deterred by the initial title of this project proved to be common to a few of the other participants, all of whom had been practicing for over two decades. As noted by Participants 6 and 8 within the discussion of the results, they felt that the discourses of professionalism were too burdensome and hindering to the actual execution of primary care and subsequently were unsure if the nature of this project was to be just another enforcing arm of the bureaucratic implementation of professionalism.

Subsequent to these illuminations of concern from the participants as to what kind of agenda my project might initially hold, was the self-realisation that not only was I fleetingly perceived as potentially an extension of the execution of biopower, but also that I was interacting with a participant group who was also very accustomed to holding authority as a normality. I recalled again Diana Forsythe's work where she identifies that some of the complications that arise with modern urban fieldwork is the potential overlap of the participant as respondent and the participant as being potential future physician or holding a role of some degree of influence over the researcher themselves (2000).

I was very aware that for some of the participants that they were not used to being the interviewee rather than the interviewer. The participants' confidence in their professional office was more pronounced in the General Practitioners who practiced rurally suggesting that the discourse of professionalism that they operate in is active beyond their roles in the clinic but is more present in the community. All of the participants were very kind in nature and attentive to the questions that I asked during the interview, which in part reveals their character as family physicians.

To conclude this chapter, in summary, I have engaged with a dialogical style of anthropology and Christian standpoint theory in order to afford this research the ability to advance the dawning field of the anthropology of Christianity. Dialogical anthropology affords the space for the differences within expressions of Christianity to be valued and coherently represented alongside other expressions of the faith in the common dialogical unity of moving God-ward in their lives and intentions as they practice. Dialogical anthropology also gives a fertile bed for contending discourses of

professionalism to emerge as occurred within the results of this project.

Subsequently, while the participants in this study did not look exactly like the RAS profile that I had originally hoped to sample, their difference proved to add a welcome depth of data to this ethnography that I had not initially anticipated. I turn now to the results analysis which emerged from these most interesting conversations.

## **Chapter Four:**

### **Results and Analysis**

This chapter explores Christian General Practitioners' experiences of the discourses of medical professionalism and of Christian faith in their clinical practice.

The following is their account of how they understand themselves as faithful physicians in their faith and practice. Having already covered the contextualisation of the professional working environment in the own words of the participants in the introduction, this chapter explores the different layers of complexity starting with deeper observations into the discourse of faith, followed by discourses of professionalism. Both discourses are then revealed to be interacting simultaneously in the boundary work section. This chapter then concludes by inspecting briefly some fallout that may occur when such boundaries are misunderstood.

#### ***Practicing the Confluence of Faith-Based and Secular Discourses of Medical Professionalism:***

The biggest site of interest to occur from the participants in this research was how to respond with integrity in upholding both discourses of medical professionalism and a faith based discourses grounded in Christianity. Thus, it could be said that there are two journeys occurring simultaneously for the General Practitioners. These journeys included growing in their faith with its local worldview, and also that of their medical practice as they grow in their clinical competency and medical knowledge. Some of the complexities that are explored in this chapter reveal the range of responses as participants each consider different elements of their faith and of their medical practice as paramount.

As seen in the table below, the average length of time a participant had been practicing was just over two decades. Participant 10 was the anomaly as he stated "I'm still quite young in the industry." This youthfulness is not only of age but also of experience as he sought to grow in proficiency. The greater theme here however is the wealth of experience in the participant pool that leads to not only a high level of competency but also an individualised style to each participant as they have developed their practice in response to the needs of their community (See Table 1).

Thus while participants all practice primary healthcare the outworking of their practices look quite different.

<p><b>Table 1.</b> <b>General Participant Data</b></p>						
	<b>Years as Practicing GP</b>	<b>Sex</b>	<b>Location of Clinic of Practice:</b>	<b>Age of Participant</b>	<b>Rural Clinic</b>	<b>Christian Denomination</b>
Participant 1	19	M	Kaitaia	56	Yes	Pentecostal
Participant 2	26	F	Caversham, Dunedin	57		Presbyterian
Participant 3	31	M	Balclutha	59	Yes	Anglican
Participant 4	34	M	North Dunedin	62		Presbyterian
Participant 5	25	F	Mornington, Dunedin	63		Anglican
Participant 6	22	F	Port Chalmers	52	Yes*	Baptist
Participant 7	28	M	Greymouth	59	Yes	Anglican
Participant 8	10	F	Dunedin Inner City	39		Baptist
Participant 9	22	M	Roslyn, Dunedin	52		Pentecostal
Participant 10	2	M	Dunedin Inner City	29		Chinese
	Average years as GP: <b>21.9</b>	4:6 F/M		Average Age: <b>52.8</b>		
*Rural Clinic defined according to participant's description						

The type of clinic in which each participant practiced added another variable to the complex articulation of medical professional and faith discourses. While all of the participants' primary workplaces were officially secular, the Christian values of four participants who worked in rural settings were more widely known within the small communities. In rural towns, the General Practitioner is more visible and known within the community, for example their attendance to church and faith is observed by their community. As Participant 3 stated:

... where I work in Balcultha, and before that in Owaka; I think very quickly people know where you come from. So the people in Owaka know I go to church. The people in Balcultha [taps table affirming] *knew*. A lot of my

patients would be people from the church background because they select you for that reason you know.

For these rural participants, the discourses of faith were active in patients as they both knew and expected to see the conspicuous elements of their faith, including in the way they practiced. These settings and contexts of the Christian General Practitioners help provide a framework for exploring the three key areas in which the complexities of both discourses of medical professionalism and faith were outworked. These three themes are that of physicians wanting to show themselves faithful in their Christianity thus giving the values of their faith priority in their clinical practice. Second is the theme of medical professionalism in which professional values dominate their modes of care. The final key theme was that of boundary work, evident in participants' descriptions of balancing integrity in both faith and professional discourses.

### ***Theme One: Faithful Physicians:***

In this section, the key themes of how the participants sought to remain faithful in upholding both their integrity of faith and their integrity of practice through Christian motivations are explored through the words of the participants. Six of the participants could recall specific scriptural verses that they found encouraging for what it meant to be a faithful physician. Of these six recollections, two main sub-themes emerged; first, verses illustrating what it means to serve others and second, verses that indicate what it looks like to display God and elements of Christianities as a blessing to others. Serving others from the place of being a faithful Christian and physician was something that Participants 8 and 4 observed as an instruction from Jesus in his sermon on the beatitudes. While the participants did not quote the text verbatim, the relevant text is from Mathew chapter five, verses one to twelve:

And Jesus opened his mouth and taught them, saying: "Blessed are the poor in spirit, for theirs is the kingdom of heaven. "Blessed are those who mourn, for they shall be comforted. Blessed are the meek, for they shall inherit the earth. Blessed are those who hunger and thirst for righteousness, for they shall be satisfied. Blessed are the merciful, for they shall receive mercy. Blessed are the pure in heart, for they shall see God. Blessed are the peacemakers, for they shall be called sons of God. Blessed are those who are persecuted for

righteousness' sake, for theirs is the kingdom of heaven. Blessed are you when others revile you and persecute you and utter all kinds of evil against you falsely on my account. Rejoice and be glad, for your reward is great in heaven, for so they persecuted the prophets who were before you.”

In a service role such as primary health care it is not surprising to have such a text quoted because the forms of medical professionalism in existence also emphasise a duty to serve those who are often overlooked. Following this theme of an awareness of the underprivileged, Participant 6 referenced a parable which involved faithful sheep choosing to intentionally love those who are forgotten, only to have revealed later that they were loving Christ himself.

Matthew 25, and it's Jesus... He talks about when I was hungry you fed me, and when I was thirsty you gave me a drink, and when I was sick you looked after me, and when I was in prison you visited me... and he would say whenever you did it for one of the least of my people, you did it for me, that concept of just caring for people, and there are so many other themes of that in the Bible I guess, so those kinds of things really do encourage me.

This conflation of loving others as actually loving Christ achieves the goal of the participants' faith in loving Christ through the outworking of caring for others. Frequently accompanying this theme was the Good Samaritan story recalled by Participant 3 in which the message of identifying people in need is tantamount to being responsible for addressing their situation. Participant 3 noted this as his Christian duty: “...I think Christianity gives you a bit more of an obligation; ah it says: “this is expected” and “this the underpinning of what your meant to be doing” (C.F: Luke 10:25-37). Whether through obligation or charity, the Christian discourse of faith and the imperative of serving others is clearly identified by participants.

Participant 9 was pragmatic, offering a verse that helped the General Practitioner to transfer the burden of worry and anxiety over to God. “Philippians 4; [verse 8]” “Don’t worry about anything but give everything to God and his peace that surpasses understanding will help you,’ and that’s something that helps me ... a quite stressful job.” This participant was particularly distinctive out of all of the interviews as he seamlessly weaved scriptural references throughout the interview revealing that

scripture and faith strongly informed his medical practice. Furthermore Participant 9 recalled a verse that encouraged that sense of peace to be imparted to all persons that Christians interact with: “That’s a basic um Christian principle to make a difference in society, to be light and salt, so that encourages me everyday when I see somebody, that I can encourage them for good.”

Additional notions of encouragement for the Christian General Practitioners lay in referencing Christ himself, as he is understood by participants themselves.

Participants 1 and 5 mentioned Jesus as the “healer man” as a role model for them in how to tend to and treat patients in their practice. Participant 8 furthered this notion of Christ’s being a role model of a healer as referring to him as “The Great Physician.”

### ***Faith within Medical Professionalism as Interwoven:***

These elements of Christ as role model in being a healer and carer followed through to the second largest sub-theme of how the faithful physicians sought to integrate their faith into their practice. One such example was Participant 2 who received insight from prayer to be able to further one patient towards breakthrough in the consultation:

...led by Holy Spirit... just popped into my head... “ask her how her relationship with her daughter in Australia is” and I thought; “wow that’s a bit specific. I don’t know what family she’s even got, let alone where they are”... so I asked that and it was just the door that opened the thing and all her physical things were a result of being estranged from her daughter... and the next thing I knew I got... a little hamper thing with a card saying my daughter had been waiting for me to contact her and apologise... to reconcile with her for 20 years.

Married to a minister, Participant 2 felt relaxed and confident in her faith enough to be able to draw on prayer as an effective means of determining treatment and healing for her patient. When presented with questions about to what extent the participants considered their medical profession also a form of worship, eight of the participants spoke of seeing not a dichotomy of faith verses medicine but rather a form of harmony. Participant 9 stated: “I do see my [clinical] work and what I do as part of

who God has made me and that's an offering of worship." Participant 3 rejoiced of his practice:

...we are so blessed, or I am so blessed that I am in a job where I am in a serving profession. So ah, the better I serve, the better I carry Christ['s] message out... I don't have to, to *evangelise*, the plain fact that I know am a Christian; Graham Langley used a saying that "your behaviour speaks so loudly that I can't hear a word you say."

Participant 2 offered prayer at the start of her workday as she intentionally sought harmony between being faithful to God and in her clinical work:

I see them as both equally glorifying to God, um, not because I'm preaching in my practice but I hope that, um, I don't know, bringing a little bit of the kingdom of God into my work situation. And so yeah, so for me I see it all as quite integrated, and I commit my day to God at the beginning of the day and just say "Here I am, use me", and help me to glorify you and so whatever I do during the day the hope for me is a sense of worship.

Such a harmonising of faith and practice was echoed by Participant 8 who articulated: "Certainly when I felt very out of depth in things and was able to pray and ask for help and that sort of thing like I felt personally encouraged and strengthened and like I've been given the tools I need to deal with those difficult situations." Participants 3, 9 and specifically 5 mentioned that the nature of having a service-orientated role in primary health care made it easy to live out the parts of their faith from scripture that required them to love others. "...I think I... find it easier to integrate my faith into my work in a job like this that is service and healing than if I were a cleaner or an accountant you know?" Further notions of how a faithful physician negotiates when it is permissible and when it might be considered inappropriate to integrate their faith into their practice is discussed at greater length in the later discussion on boundary work.

Recollections by participants of missionary work in their faith also offered examples of physicians seeking to integrate their faith with their practice. Half of the participants recounted missionary work in foreign countries such as Senegal, Thailand and the Pacific Islands. Participant 4 spoke of some associates he knew:



“And I’ve seen some other really good models of care people going out, surgeons who have quite a Christian commitment, Iraq, Nigeria, all these places doing it for nothing and just seeing it as part of their Christian command I guess.” This awareness of other colleagues amalgamating clinical work and faith so successfully, proved to be the easiest examples that the participants could draw on as an archetype of what it looks like to weave the discourses of faith and medical professionalism together.

The elements of mission focusing on blessing others in difficult national circumstances had sibling themes for domestic settings in the stories of the participants of times where they felt they could particularly offer genuine care and hope in ways that they felt proud of. Participant 8 recalled that she had recently aided refugees who were new to Dunedin:

...there was an interpreter ... I spent quite a lot of time with the family, those consults kinda take ages anyway just working through an interpreter and I really felt I was able to deeply meet the needs of the patient, who was incredibly grateful, you know she gave me a big hug and a kiss at the end...

This example of tending to the needs of refugees could be appreciated as mission both medically and theologically in a local context. The gratitude received from the refugees too affirms the call of serving others. Another occasion where a General Practitioner recalled the satisfaction in administering care was when Participant 5 was able to sing a blessing over an unconscious patient.

...in the palliative care setting, particularly when I know the patient or family is Christian, then at times I have prayed for an unconscious patient holding their hand, and a couple of times have sung the Aaronic blessing shortly after their death, you know the one? [sings] *“The lord bless you and keep you, the lord make his face to shine upon you and be gracious unto you, the lord lift up his countenance upon you and grant your peace”*, and that’s been warmly accepted on a number of occasions, when I’ve said would you mind if I sung a blessing, and one family said where did that come from, and I said, “Oh that’s thousands of years old, originally written in Hebrew” [laughs].

Participant 6 articulated that when it came to depressed patients she aimed to care for them in a way that helped not only to provide treatment but that also stimulated

hope. "...case of quite bad depression where there's been such a loss of hope for those people... but I guess I try to find a way to ignite that hope, which could just be by being caring and encouraging and supportive..."

Being able to impart hope grounded in her faith, Participant 6 identified an obvious way for her to weave together her faith and practice. Participant 6 recalled another occasion of care where she was doing a rotation on paediatrics during her house officer years:

...she came in and we quickly checked the baby and she was fine and the mother went to sleep on a bed in the ward, and just slept the whole morning and into the afternoon... and when the mother woke up she just felt 100 times better cause... and all she needed was just a place to put her head and sleep, and in those situations I kind of acknowledge, and in those situations we can let people down. "No you're work for me and I don't want you to come into the hospital, it's work for me." And the GP thinks, "I don't want to see that baby, its extra work, we feel we've done everything we can." But here's this person with this need and we can really let them down when they just need something simple, a simple bit of support just put things right for that mother...

Realising that the mother was in need of rest as well as the baby, the participant learned that caring for others holds a broader scope than just looking after those who present themselves officially as the primary patient. This humility can be seen as the physician applied herself to be open to learning and being faithful to her practice and her faith.

### **Christian General Practitioners as Regular General Practitioners:**

One recurring theme that emerged from four of the interviews was the humility of the participants in appreciating that while it was their ambition to be faithful physicians; their faith did not automatically grant them improved clinical or professional skills compared to secular GPs. Participant 6 expressed this well:

...I acknowledge that non-Christian GPs are great GPs and give a lot to their patients, so I don't think it's as if Christian GPs have this amazing ability to be great doctors, and perhaps there are Christian GPs who are not so caring as

well, um but for me, very personally, I think my faith just encourages me to go a bit beyond if I can.

This awareness from Participant 6 illuminates the diversity of expressions of Christianities, that while the intention is to bless others in service, that in turn does not mean that the faithful physicians are the best at doing so. While some participants recollected accounts of mission trips, others felt they upheld the values associated with being a faithful physician via a more quiet and reverent form of faithfulness. Participant 3 indicated that although he did not think of his medical practice as mission or worship he did think of it as a calling.

I do think about my practice as my little piece of land that I am ploughing that I'm tilling, that I'm working on, that God gave me, so, so in that sense it is, it's an expression of it being a vocation – it's a calling to be there and I'm very grateful that, that's what came my way.

This notion of vocation and calling can be seen as helping ground the Christian General Practitioner in such a way that they feel that both their faith and their profession are acts of fidelity in their Christianity. Participants 5 and 8 expressed similar affections for being faithful to both God and their career in more general and quiet ways.

The confluence of discourse of medical professionalism and particularly of faith in Christ has been observed by the General Practitioners in a variety of overt and covert ways. Encouraged by scripture, the physicians sought to uphold their integrity of their faith as well as practice as they sought to not only care for their patients but also bless them by doing so and in turn proving themselves as good Christians.

### ***Theme Two: Medical Professionalism***

Simultaneous to the Christian General Practitioners' endeavours to be faithful to medicine and Christ was their awareness of their official medical status as primary health care physicians. When asked about what the participants thought of medical professionalism, many of them listed specific attributes that one might find to be admirable qualities in a doctor. The attribute that was mentioned most often, was maintaining good confidentiality. Participant 9 stated: "You know the way you treat people, the way you talk to them, confidentiality; that would be part of

professionalism.” The way confidentiality was frequently mentioned, implies it was something so normative and regular in understanding primary health care that it was seen as too obvious a tenet to be worthy of expansion.

Another tenet of medical professionalism mentioned was that of prioritising the patients’ interests. Participant 3 articulated this well: “Whatever I do must go back to that – ‘Is it benefitting the patient?’ and um, as long as I do, keep on; using that as a touch stone; [then] the rests falls into place.” The appearance of Patient Centred Medicine here is indicative of the goals of primary health care and medical care in New Zealand and this example can be seen as an active reflection of its prevalence as a model for medical professionalism. Distinct to the common and fleeting responses of most participants listing conceptual elements of medical professionalism such as confidentiality and respect, Participant 2 instead referred to the official attributes that are the basis of the University of Otago’s medical school official commissioning principles. She recalled that good medical professionalism for all physicians who graduate should have a “commitment to life long learning”, “a commitment to reflective practice” and a “commitment to helping a type of social conscience.” In this context, Participant 2 was able to recite a mantra of medical professionalism that represents an example of normative medical professionalism discourse in action.

Participant 6 noted that during the course of her career the pressure of having to become a fellow of the New Zealand Royal College of General Practitioners has gone from being an encouraging addition towards becoming a formal requirement:

...maybe 50 years ago there was this concept of being a ‘professional’, but now and you have to prove yourself more in your professionalism, because the college wants you to have written this plan to know you’re being professional, so you have to prove it to somebody that you are a ‘good enough professional’ because you have done x, y and z... there’s a burden of proof to keep showing to some external body that you are still being professional.

The discourse of medical professionalism here can be seen as having evolved to become more formal and has moved from being a social subtle professional pressure to a tangible and measurable standard required of all physicians including General Practitioners. Participant 3, being the second longest practicing participant of 31

years, felt that within his practice the emphasis of medical professionalism is more on a sense of duty and responsibility than it is on new formal criteria.

... I think that by the time you become a GP you've been through all their training... and you start wearing this *mantle* of I'm a GP [laughs]... and it's very seldom, very, very, very seldom that we have to 'correct' the young doctors... basically as doctors [we] are in the *field of* 'we are GPs, now how does a GP do that?' 'A GP does it this way' you've got that; like a professional soldier... So, there is this whole 'this is how it's done' kind of system and that is professionalism but we never mention it...

This suggests that for older participants, professionalism includes a tacit understanding of the way things 'should be done' in General Practice. After the interview, Participant 3 also stated that because of his practice being situated inside the rural hospital, that there is required a higher need for role performance awareness of things such as tact so as to make the clinic operate well without causing difficulty for the remainder of the clinic and the hospital. Subsequently the medical professionalism of Participant 3 can be appreciated as having a wider scope that extends beyond primary care at times. Medical professional discourse often reflects an emphasis on the environment in which it is supported such as medical school and the national cultural nuances in which that medical school is established. This is evident in newer generations of General Practitioners such as Participants 8 and 10 who have trained in New Zealand and have been General Practitioners for ten and two years respectively and both practice at a relatively new and urban clinic.

...I don't really know it's changed at all from the last decade in my perspective, like all the way through med school there was discussion around professionalism, professional integrity and professional values and those sorts of things kinda continued through my GP education and the post grad papers I've done. I don't think it's changed over that time.

This younger generation of General Practitioners had only been trained in an age of medical professionalism in which its focus and regulation has been more overt and thus these participants did not experience older service oriented discourses to the same extent. These participants then prove to be a good example of the newer and

more formal discourses of professionalism in which they have not experienced explicitly contending discourses.

***Peer Review:***

Participants identified General Practitioner peer review groups as an important forum for the discussion of medical professionalism. This was something that appeared in the first interviews and developed into a specific question in subsequent interviews. Participant 9 spoke highly of the value of peer review:

...in Australia no peer review - unbelievable. And here it's a requirement... there will be discussions about... attitudes and approaches to patients and professionalism... I've really appreciated that... it's really good to have other GPs that you can just talk things through.

Four other participants shared Participant 9's praise about the benefits and community that peer review can offer to General Practitioners, Participant 6 exclaimed that:

...my peer review group is fantastic. So I would say that out of all those things that I'm asked to do by the medical council or GP College um; that is the most valuable thing for me. So I think I gain more knowledge... more knowledge from my peers than going to a medical education meeting and listening to a lecture for an hour, or because we; and I think that's what peer review groups should be; we know each other now with time we've got to know each other quite well, we're open to other people coming in, um but we just bring cases, we talk about our families, we talk about our stressors, our tiredness, you know when we're feeling jaded, but we talk about our cases and get advice, you know, what would you do for this person, we talk about very difficult patients who can be very difficult where we feel really stuck, like what can I do for this person, and in all these things I think we encourage each other, and I just wouldn't; I just wouldn't do without my peer group.

Peer review, as described above, bears some similarities to small church based support groups in which believers gather together to encourage one another and build each other up in their faith. Peer review provides the participants assistance with troubleshooting difficult clinical scenarios but also a more basic level of

emotional support through fellowship with other physicians who understand the world of general practice and share its culture.

However, this view was not shared by all participants. Participant 5 described her peer review meetings as focusing more on “policies and procedures” and felt that these groups were “too big to talk frankly and learn to trust each other...”

Furthermore, trying to run them was like “herding cats or netting smoke.” Participant 5 felt that much of her frustration around her current peer review stemmed from an unfavourable comparison to a peer review group she belonged to previously that had contained fellow Christian General Practitioners within it and which was smaller in size, thus affording a higher degree of intimacy and productivity. She lamented: “We were far franker in that eleven year group than I’ve been able to be during 15 years in Dunedin.”

### ***Colleagues:***

While the majority of the participants enjoyed peer review, three of the participants articulated that their clinical colleagues proved to be more of a social pressure to conform to in their day-to-day practice with regard to expectations of a secular and professional General Practitioner. As Participant 7 verbalised:

...people like you to be in your box, um, like if you’re a drug addict you’re a drug addict. Whereas I would see the person God created who could be someone different.... like I’ve got a patient who is on methadone; methadone is a drug used for drug addicts ...started on it by a pain specialist ten years ago... and he’s stable with his back ache and he’s on it, he’s been working on a farm, totally productive; and these two junior doctors because its ‘*methadone*’ have been giving him the third degree about getting off it because they’re viewing him as a drug addict... he’s totally trustworthy with it. So, we’re full of bigotry, we generalise about people and we put them in boxes...

Working in a rural environment, Participant 7 found himself having to defend a long-standing arrangement of pain treatment for a patient against junior colleagues whose more contemporary medical enculturation included a low tolerance for drug overusers/abusers. This suggests that ideals and values of medical professionalism

can change in accordance with changes to trending medical curricula and changing social values and expectations. This participant also experienced complaints around his practice because of such treatments which will be explored further in the section that explores professional complaints later on.

### ***Medical Professionalism as Unhelpful:***

Contemporary regulatory discourses of medical professionalism ensure a high level of practice and a value for adequate care, yet some of its mechanisms were felt to be more of a hindrance than an aid. Participants 5, 6 and 10 lamented at the yearly self-performance and development plans that they were required to complete as a measure to ensure they were growing as good clinicians. As participant 6 expressed:

lots of GPs get fed up with having to prove themselves and having to write screeds of paper about how you've gone from this person to this person, or how you've improved from this way; because a lot of us feel you were just doing it anyway.... I can see why, I can see the reason, but when you're caught up in this group because there's a few people who never did it right and were always unsafe and you get caught up in this wave of trying to make... people safe from their doctors, um I guess it's quite frustrating when you get caught into quite onerous paperwork um when you felt you were doing a good job anyway and it hasn't made you any better by doing all of those things, it hasn't made you a better GP.

Participants 6 and 10 were relatively new in their careers as General Practitioners and as such observe that their generation of physicians experience medical professionalism as more of an investigative procedure to ensure compliance. Additionally Participant 5 found that the dense medical jargon used to implement treatment plans was what she considered as unhelpful to the patient and hindering care:

....I haven't got those sorts of words... I'm sure if I was being trained these days I would have the words and be able to trot out the professional sounding phrases, but for a long time now I've seen my job as the reverse; taking professional sounding phrases from the hospital specialists' letters and saying, "What they mean is you haven't got enough platelets."



“What are they?” [mimicking the patient responding to this explanation]

“Well they’re little floating sandbags that plug up a hole when you’ve got a hole in one of your blood vessels.” [laughs] And I really have to think, now what word am I supposed to call it? Thrombocytopenia! [laughs] I’m used to translating down, and I’m beginning to lose my skill in wording up. Makes me a bit frightened to do things like a university paper, because I’ve interpreted down for so long... but I [short pause] for me professionalism mostly boils down to love your neighbour as yourself, and do as you would be done by... I would take that far above words about respecting human life or whatever in professional documents, yeah.

Perceiving medical jargon as a hindrance to medical professionalism, as she understands it, this participant is defying contemporary mechanisms of medical professionalism by not engaging greatly in academic pursuits of medicine. However, she is also simultaneously upholding an older and still relevant discourse of medical professionalism namely that practice of treating patients well and ensuring they understand what their diagnosis and treatment entail.

A further alternative discourse of medical professionalism that came through was that of Lifestyle Professionalism in which holding a rewarding personal life in recreational time was considered to be as rewarding a part of the career as their actual medical practice itself. This notion entails then that good medical practice is not just to have and protect time for oneself but also for one’s family. This was specifically alluded to by Participants 2, 4 and 6. Participant 2 and 6 articulated that as young female physicians that being a being a good physician meant creating the space to rear children. As Participant 2 stated:

I started off doing surgical training and then met [husband] and it kinda didn’t fit, that would have been difficult and then we had three children in two years and so to be perfectly honest it was more of a lifestyle choice than a medical choice.

Participant 4, being the longest practicing physician expressed concern that newer discourses of lifestyle professionalism potentially threaten the values of older discourses with physicians prioritising vain interests over medical practice such as

hair appointments. He expressed: “That’s almost kinda gone too far where lifestyle is more important than any service and I think there’s a, you know, it’s overreached and needs to come back a wee bit. Just an interesting thing [laughs].” Having been trained in a culture of medical professionalism where extreme levels of commitment to duty and service was considered normal, Participant 4 felt that too much change had occurred.

### ***Theme Three: Boundaries***

The largest theme to emerge from the data was how participants navigated boundaries between faithfulness to Christ and medical professionalism – particularly where the values associated with faith and practice came into conflict. Understanding when the Christian General Practitioners’ faith may be seen as welcome and when it may be complicated in their practice was a dynamic situation and was defined differently by each participant as according to their different expressions of Christianity and personality. The three biggest examples of boundaries raised by the participants were that of abortion, euthanasia and mental health. For Christian physicians, these three topics are archetypal ethical issues in which faith and theological value’s interaction with secular medical issues and requirements is observed most noticeably. While issues such as abortion were not raised by the researcher, the Christian General Practitioners found these issues an obvious place to start conversing over general professional boundary work in the clinic. These negotiations of boundaries ultimately can be seen as the process by which it is possible to simultaneously hold to dual integrity of faith as well as an integrity of practice.

#### ***Abortions:***

In all ten of the interviews, terminations and issues surrounding abortions featured strongly. Participant 3’s statement was indicative of seventy percent of the participants when he said: “[it is] well know[n] in my extended practice that I don’t do abortions for example. I don’t refer people, I don’t do the basic tests for it, everybody knows it and I don’t go there.” It should be noted that Participant 3, being one of the co-founders of his clinic, found that he had relative ease in stating that he would not process terminations as he held a degree of senior authority within his

clinic. Participant 1 was also clear in articulating that the boundary should be a firm 'no' for Christian General Practitioners:

How many people will actually stand for their faith..., you say listen: "Count me out, because according to my values, as a born again Christian – I don't do this." ...they will bend under pressure, where the true guy that stands for his faith will not do that. But it might get you into trouble. So what are you going to do? So you see that's where the, where the true things actually reflect what is most important in your life. Is it your work? Or is it your relationship with God? [short pause] Especially with your colleagues because I think most, most doctors are not Christians, or they are not practicing Christians and they don't stick to the values of what the word of God says. Because that to me, are my core values. [voice wavy with emotion] I don't bend. [Long pause].

For the majority of participants, abortions were not just a boundary to be established of conscience but can also be seen as a test of their faithfulness in their Christianity. Other participants such as Participant 7, held the same theological values but defined this boundary differently in practice:

Of all the people I have referred, not one of them [h]as met the requirements of the law, I've written that on all the referrals, [and yet] every one of them has been assessed by two of my colleagues and have had abortions... And 98% of them are for mental un-wellness for the mother, so 17,000 women, 98% of them who are so severely mentally unwell [laughs] I don't see it in the community... What happens is, the abortionist will do the work in Christchurch, the women will get bleeding, will get infection, will get depression, they don't go back to the person who did it, they come back to me... I'm not going to judge you for your decision, that's your decision, you've got to live with it, but if those things happen [then] I'm happy to continue to walk with you. So they come back to me, the one who's against, and that's why I don't put the plaque up, because then they wouldn't come to me, even though it pains me every time it happens.

Participant 7's navigation of this issue is a clear example of holding to integrity in both faith and medical practice as he perceived that the law should often deny the

potential abortion cases that he submitted under its own legislation and that consequently the legal element of medicine would say no for him. Yet, when abortions are cleared regardless he identified that disassociation from the patient would be detrimental and that his faith compelled him to respond with compassion after the event.

Belonging to a Christianity that is an avid advocate of social justice issues, Participant 4 stated that over time he has found that he has conducted terminations: "...in the end I found I have... and that might be considered a conflict of faith... I guess if I was up against some hard and anti-abortionist they might tear me to shreds a bit..." Aware of abortions generally being a pro-life stance by some of the Christians that he knew, this participant articulated that although in his practice he is content in performing terminations, he felt compelled to acknowledge that this would be an unpopular stance. This is an example of the discourse of faith in action, that Participant 4 felt he had to disclaim his stance simply because of the cultural context of faith in which he was answering medical questions about his experiences. He expanded: "Hmm. Maybe I am just good at compromising my ideals [laughs]." This compromising of ideals was portrayed as a strength by participant 4 as he referenced his church fondly as a place that had capacious theology and a wide spectrum of belief to incorporate many Christianities in having "big broad boundaries; you could be a big Christian with hardly anything you doubt; it was all possible."

Participant 5 also proved to be unique in the processing of her boundary work in this issue. Recalling a story about how her medical supervisor, the chair of Society for the Protection of the Unborn Child (SPUC) was the one also conducting abortions:

...You're not leaving are you?" and I said, "Yes, aren't you?", and she looked at me fiercely with those blue, blue eyes, and she said "I most certainly will not. If I don't do this procedure *[renowned surgeon] will and he won't care*". And she let me in on the story; it was a woman in an abusive relationship to an alcoholic, who had three kids in rapid succession to him, this was before the days of the DPB. She'd finally got up the courage to leave him and was accommodated in a place on her own, and he broke the bathroom window and got in over night and raped her. And from her point of view, this child was going to meet a termination anyway from one of her colleagues, who would

just do it as a surgical procedure, and not follow up to see that her and her children's life had become right after this bad experience, and she would. And so I helped her with it...

This participant found that the ethical boundary work modelled of being anti-abortion but also being pro-patient care was formative enough that she adopted her supervisor's boundary work practices as her own. In this process she identified that performing abortions for the sake of domestic care and value of the mother's welfare is aligned with the integrity of medical professionalism in the care that she could offer. Replicating boundary work performed by one's superior was a topic expanded on by Participant 5 after the interview ceased, in which she recalled that medicine has moved away from apprenticeship and mentoring training towards a more general means of production and training of new doctors. Thus the older generation of physicians in this study who were trained in this form of mentoring, were much more intimately influenced by their superiors than Participants 10 and 8 whose own boundary work has been much more individual.

### ***Euthanasia:***

Another similar issue that occurred in three interviews without prompting was that of euthanasia. As the arena in which euthanasia is considered is a political and hypothetical one, this issue was much easier to define a boundary for, as there is not yet any overt pressure from patients for their General Practitioners to perform this procedure. In all three references, euthanasia was mentioned as an expansion to their thoughts on abortion and twice in which the physicians warned that the permitting of easy access legal abortions and euthanasia they felt was verging dangerous close to how the Nazi Germany regime began. As Participant 7 stated:

Nazis killed normal people as well, who were vulnerable, and were taken to Nuremberg trial. Here we are, not many years later, doing the same stuff. We're now talking about euthanasia, becoming mainstream...

### ***Mental Health:***

One of the most overt locations of boundary work to be identified in the clinical practice of Christian General Practitioners was the issue of mental health. Supernaturally this is a topic within Christianities that has historically been

attributed varying degrees of causation such as demonic encounters. While all participants were content in treating mental health issues using medical therapies, there were varying degrees of interpretation at how spiritual the issue might be and to which discourse they should be housed in.

Participants 1, 6 and 9 understood mental illness to be both something spiritual and physical in duality. Participant 1 articulated that such duality comes with additional boundary work:

Not all mental health, um, problems are connected to spiritual problems, but I, I think there is quite a lot that is unidentified. And if you really, you know, sit down with these people and you talk about it and you go back, you can see there is a connection that probably needs more spiritual intervention than medications. And that is where there is a problem; how do you do that?

As mentioned earlier, Participant 1's solution to this was to meet up with patients as friends outside the clinic to discuss faith based elements in more depth. Participant 1's motivation however for meeting up with patients and discussing spiritual issues can be appreciated as much more than evangelism but also as a life line. He recalled how he laments at seeing communities suffer from many suicides:

And that is the people that we see: they find them with a noose around their neck in a shed or at a tree. Because they have committed suicide. And people do not study those things and see the connections where these families; I've talked to the, to the funeral directors the other day. Three; three young boys from the same family. Few months apart hanging themselves at a specific place on the West Coast. Now you know, that is crazy that in one family, three of the sons used the same tree to commit suicide in exactly the same way. And that's tragic for people like that, and it is unacceptable. I feel that, you know, if you have the answer or you know more about these things; we need to step in and actually help those people. But *someone* has to do it, someone has to step out. Because there is a saying: "evil things will prosper [chokes up] when, when good men do nothing" [long pause].

For Participant 1 then, actively reaching out and risking boundaries of professionalism being misunderstood or breached was a matter of eternal value of

life and death. The magnitude of this situation helped clearly define the spiritual components of mental health issues for Participant 1. Valuing mental health as both physical and spiritual as well, Participant 6 articulated:

...I think there are spiritual elements for perhaps all illnesses and I don't know with say depression or bipolar or psychoses, we can have the feeling there's this huge spiritual element in that, but I think there's also just disease and that's something has gone wrong in their brains.

This notion of dual medical and spiritual factors causing mental health issues helped Participants 7 and 9 treat mental health as almost a seamless problem. As Participant 7 stated:

If someone has a mental illness, they're depressed, they're anxious, they've got somatisation, they've got schizophrenia, that's not different from them having diabetes or high blood pressure or rheumatoid arthritis, that's their brokenness in this broken world, that's their exit from Eden penalty, that's their consequence of being human, through no fault of their own generally, they may have done stuff in coping that added a burden to that. So all my patients have a need for faith.

Acknowledging the failings to humanity that creates a broken world, Participant 7 was capacious in thought when he indicated that the need for faith will bring a wider form of healing and wholeness to humanity. This theme was expressed in a slightly different way by Participant 9 when he said:

I think um I do treat psychiatric issues which is mainly depression and anxiety as I would blood pressure or asthma or dermatitis and my faith helps me with all of those consults. So I don't see the psychiatric condition as sort of more spiritual, like clearly there's something, an oppression going on here, like God doesn't want you to be depressed, well He doesn't want you to have asthma either.

In this way, these two Participants considered their practice as a form of missionary work in which they sought to overturn sickness and illness in the world towards restoration which as Participant 9 articulated is God's will and is consistent with most Christianities. Insightfully, Participant 10 also mentioned that holding a faith

such as a Christianity did not make one immune to experiencing mental illness oneself.

Unlike other participants, Participant 3 perceived mental health as a purely medical illness. In his own words:

...[short pause] to be quite honest; I don't often regard psychiatry; your major psychiatric problems like depression and bipolar disease and so as a spiritual problem at all... it's a disease like heart failure yeah, yeah.

Content to treat mental health as a regular form of medical illness, Participant 3 easily defined the professional boundary as inherently a medical one with no need for any element of his own faith to be incorporated into the consolation. Three of the participants proved wary of even articulating their own faith in the presence of mentally unwell patients as they noted that many psychiatric patients tended to have their own spiritual rhetoric which these participants were not willing to engage with during a consultation. Participant 8 worded this best when she stated:

I worked in a mental health in-patient unit for three or four months as a junior doctor and if anything, because a lot of the patients have religious delusions - I would be probably more hesitant to even discuss those sorts of things with those patients. And as a GP, I don't think so, yeah.

For Participants 4,5 and 8 then, the boundary work for mental health was perceived as a mine field for Christian General Practitioners as it held the potential to be easily misinterpreted by more seriously unstable mental health patients. Thus the key elements within boundary work within mental health were characterised by whether it was primarily perceived as a medical problem or a spiritual problem in each instance. This in turn defines what kind of boundary work is required in establishing care for the patient or protection for the physician.

For some of the Christian General Practitioners then, mental health issues were seen as a potential mission field of outreach and support from their faith while for others it was seen as a haphazard land. The difference between the two can be characterised by what the participants' experience of mental health issues has been in their clinics throughout their career. Subsequently the boundary work in mental health was found to be often more clear than not, but with varying lines drawn to protect different



parties such as the physicians themselves from miscommunication or protecting the patients from worsening outcomes at the risk of being seen as unprofessional to help save lives.

### ***General boundary work: A welcome faith?***

As this study investigated how the Christian General Practitioners include their faith into their practice and in what ways, medical professionalism in itself can be appreciated as the base line to be expected in all scenarios from which faith is added. The general boundary work issues conducted by the participants then were ones that sought to flesh out what level of integration of the participants' faith was beneficial and permissible into their practice. Thus the variable is the degrees in which faith is incorporated into practice, rather than the converse of boundary work about what medical professionalism would look like in the participants' native context at church. Participant 10 recalled that because of the nature of belonging to a small Chinese church locally, that he did in fact have to establish boundaries between the church and the clinic.

...I do find a lot of Chinese patients naturally wanting to come and see me and sometimes you find people you know in the community cause Dunedin's pretty small. Sometimes it cannot be helped because that's the only language they speak, it does become harder for me to have a boundary as a friend and a doctor. So I'm trying to work towards separating that. But it is hard. Cause then when you see them in church they may informally ask you for a consult which can be tricky. And you tend to know more of their personal stuff, being on a friend basis.

Participant 1, being perhaps the most zealous participant in wanting to share his faith, proved to be also very cautious understanding stating that "some people have had real bad experiences with religious people." In which case he proclaimed that if he sensed that the participant only wanted direct medical treatment and no additional form of more spiritual care then he would "...just back off and use a straight medicine approach... and leave it be." For Participant 1 then, he was aware that it was not only he who defined and regulated professional boundaries but also that his colleagues and the medical council might take issue with his approach if they

felt he was not defining his medical professional boundaries strong enough. As he stated:

So you, I know, you have to be so careful if um, you go or you, you start to initiate things in that, you know, that perspective, you, you are on shaky ground usually. If people are... positive about it... and they give you permission then, I usually tend to say to them: "Listen, I will meet you outside, the professional boundaries of a practice... I'll meet you as a friend at a place where we can have a coffee and stuff," –so I don't see them as their doctor, I see them as a friend.

To counter the threat of 'shaky ground' and the risk of permeating professional boundaries, Participant 1 indicated that it was better to change the environment in which he approached matters of faith in more depth and consequently avoid having to do laborious boundary work at the clinic by changing the premise and environment upon which he engaged in conversation about faith based topics. By changing the location of the faith discourse to protect both himself and the patient from misunderstandings about intention, the patient's status is changed from patient to friend by manner of catching up outside of the consult.

Participants 2, 7, 8 and 9 empathised with this notion of giving additional level of care to patients through their faith discourse. Something which, if both parties of patient and physician were fluent in a faith discourse could afford a greater depth of treatment for the patient. As Participant 2 stated:

...always felt a little bit of frustration or limitation of what I can offer when I feel like all I can offer is kinda second best without that next step of well you know if you committed your life to Jesus and following him a lot of this stuff would just resolve, but that's a bridge too far, I can't do that, so I find that frustrating.

Referring to treatment as 'second best' for patients who do not hold a shared faith, can be interpreted as an incomplete desire for the Christian General Practitioners to operate in the language and concepts of spiritual health that are native to their Christianity, as a mechanism of additional care. However, through the participant's caution towards initiating a faith discourse with patients, the same participant was

identifying that in doing so. it would be a “bridge too far.” Such a metaphor is explicitly a form of boundary definition in which she identifies that although her desire is to administer to patients more fully from her faith, her medical professional boundaries in fact would not permit her to do so. While there was no mention of the medical council or peers, this participant held this boundary as her own, which is consistent with formal medical professional boundaries. A similar notion was shared by Participant 9 who stated:

... I don't openly preach or openly go “You know, Jesus is the answer to that pain you've got in your tummy.” You know I wouldn't do that right, it's a boundary. And I actually think Jesus is the answer to a lot of people's problems, like of course! You know, He's the healer in every aspect of our lives, but my job as a doctor is to practice medicine.

This statement by Participant 9 reflects his earlier comments stating that while he does not believe that God wants people to be ill with mental health issues, it is no different to wanting people to be free of physical ailments. However, what was different about Participant 9's response here was that although he did believe that the patient's overall health would benefit from faith in Christ he recognised that this was not the reason they had come to see him. Similarly, Participant 2 observed that the formality of roles that professionalism allows to be developed also helps define the boundaries.

I don't know if you knew Mike Wright, but... at his funeral some of the people from the polytech talked about “Holy Mike” and because of his role as a chaplain everyone knew he was a Christian and that was kinda his role, and he had license to say stuff and ah, because he was almost the ‘professional Christian,’ if you like. Whereas for me it's just an aspect of who I am, that I can't or don't promote... so I think that it's easier if you have an official role, whereas for us it's not an official role, it's who we are.

What can be deduced here is the distinction between having the ability to operate within the participant's faith and the actual permission or invitation to do so. Patients present to the clinic seeking biomedical aid and as such Participants 2 and 9 identified that this has to be honoured as the starting boundary as a Christian General

Practitioner. What Participant 2 introduces here however is the concept of a discourse of professional faith in which Christians and chaplains are not just allowed to move freely with faith activities but are also obliged to do so as part of their occupational identity.

Participants 4 and 5 articulated that even if the patient initiated conversation over Christian articles of faith or suggested prayer that they still declared such a conversation to be in the wrong setting and too unprofessional. Participant 5 captured this best:

...Um, I would, in the [clinic] setting, I would wait for them to say to me, "Well do you have a faith yourself?", um, to which I would say, "I certainly do, but that is probably not the setting to discuss it..."

More sensitive to medical professional boundaries, Participants 4 and 5 conducted a more wholesale form of boundary work where in general they felt that while faith discourses could be included in medical practice that it was not for them to be champions of this integration. Instead, Participants 4 and 5 sought to patrol the boundary of medical professionalism more clearly so as to not confuse the two bands of discourses.

### ***Professional Complaints:***

Confusion of the integration of the discourses of medical professionalism and faith often were manifest in the flash point of professional complaints. This other side of boundary work was when the patients themselves take on the role of cartographers of boundaries and define the boundaries themselves. Participant 10 contextualised this when he said:

Usually GPs get the most complaints over their work life, because the amount of patients we see is huge: about 100 patients per week. So I think maintaining professionalism is important for me, just to avoid getting complaints or going up to the HDC...

With a large patient load comes more potential candidates to lodge complaints and less time with each patient which in turn also can foster negative feelings in patients if they feel their needs were not met in that time. Half of the respondents raised the

issue of professional complaints, with all of those five recalling an instance in which they had had a complaint lodged against themselves. For some like Participant 10, it was a simple matter in which the patient felt like he was not listening well:

...in hindsight I thought I was doing a good job but not in the patient's perspective... the patient complained I wasn't listening to her, but I thought I was, [short pause] I may have misunderstood her.

While a specific boundary pertaining to faith discourse was not indicated as the reason for this complaint, what can be deduced is that both the patient and the physician in this example had separate definitions about what good listening entailed which were both assumed under medical professional discourse but not articulated until the patient felt her definition was not met. Participant 1 had a more archetypal complaint which demonstrated when the discourses of medical professionalism and of faith clashed rather than complemented. An example of disagreement of boundaries:

Yeah; so she complained. Or, her mother complained... said, "It's not my place. To, to talk to the young people like that. I am there to give them treatment for STIs: [fights tears/ compassionate pain and anger in face] sexually transmitted diseases, to give them contraceptive pills. To do you know, talk to them about things, not about, where you gonna go once you die." *Fair enough*... And so we, we had a meeting and the outcome of the meeting was; they said um, you not allowed to talk about Jesus, you not allowed to talk about Christianity, um, there is no place for that. And I said, "I, I beg to differ. [fights tears/ wavy voice with emotion] if I get prompted to say something like that to help people then I'll will do that." Because that, that person's eternal life depends on that... this how these lies get told from one group to another... "is actually not that bad" if you commit suicide, "at least you go to heaven." It, it takes the [short pause] tragedy out of that whole situation really because you supposed to be in a better place but it might not be. So for me it's important to put the truth out there. You know, um, because that can make the difference between ending up in the wrong place for eternity.

After being challenged on his actions as being not in accordance with medical professionalism, Participant 1 illuminated that he felt the importance of the tenets of his faith required him to go beyond the boundaries of medical professionalism for the eternal sake of his patients' souls. He expanded:

Because the way that you conduct yourself and the way that you speak to people they need to know that there is a Christian doctor, [wavy voice]... if they say, "Well. We are going to take away your licence away and you won't be able to practice," then I'll say, "Well then you need to take it bro. That's it, then I'm out." That it. Because it's the same as when the people put a gun against your head and they say, "Okay, you need to renounce Jesus man or we'll shoot your family, you know are you going to do it or are you gonna stand for what you believe in?... that's how these guys; martyrs man. [wavy voice with emotion] that's how it is; that's how you need to do it. You need to stand your stand...I get really tearful when I talk about these things eh.

Reflecting on this later in the interview, Participant 1 went on to further assert that although he enjoyed being a doctor, that he was more concerned for people's eternal health rather than their immediate physical health alone. Although the boundaries are conscious in Participant 1 and other participants' minds, they can also be contested at times and redrawn for occasions if they feel stirred to prioritise their faith above the values of medical professionalism.

Overall, the most common themes articulated by the participants was navigating the confluence of faith and medical professional discourses and also tending to the ways they did not integrate in a way that still sought to uphold integrity for both discourses. The different forms of complexity revealed in negotiating personal conviction on topics, alongside time available, and patient receptivity, illuminated that understanding how the discourses of faith and medical professionalism affect the participants hinges on a series of variables. These variables, such as how long the participant has been practicing for and how easily they perceive the confluence of the two discourses, determines the form in which the expression of each discourse is made manifest in the participants' lives. The extent to which these discourses reflected documented discourses of professionalism will be explored in more depth in the discussion chapter.

## **Chapter Five**

### **Discussion**

Having surveyed the appropriate literature and heard from the ten participants from this study about their own experiences, this chapter will now explore the key themes of negotiating boundaries and discourses of medical professionalism in juxtaposition to the participants' own faith. It is worth observing that when posed with the question of the intersection of faith and medical professionalism, many writers have been quick to think of bioethics as the obvious point of connection. While this is not a bioethics study but rather one of medical anthropology that investigates the ethnographic accounts of Christian General Practitioners, the literature for this project was sourced from two main fields. The first is that of the ethnographic experiences of religious and Christian physicians, sourced mostly from the *Journal of Religion and Health*. The second is that of various contributions towards the evolution of medical professionalism as seen in chapter two. This is something that has developed over recent decades and has been expanded upon in those disciplines with an interest in the area such as biomedicine. Subsequently the focus of this project which explores both discourse and boundary work in Christian physicians, has proven to be an original and site of rich complexity for investigation.

Michael Foucault's (1972) concept of discourse is a key component of this thesis in understanding how Christian General Practitioners view medical professionalism. The focus of this concept, as mentioned in the introduction, is not the origin of an idea, but rather how an idea executes power and influence over a population or specific people within a group. The changing nature of discourses of medical professionalism as observed in chapter two, reveal that while the discourse imperative to be 'professional' remains, the ways in which it is defined varies over time and location. This is was reflected within the results of this project where a few of the participants mentioned that there was 'a way things are done' without explicit mention of local practice culture or medical professionalism. Such a reference represents well an example of a normative discourse in which the participant is aware of the discourse in action but classically also reveals the illusory nature of

attempts to pin down the associated normative knowledge to a discrete and unitary source.

Indeed, when I initially asked for examples of ever having witnessed a colleague to 'be more professional' this question proved too direct and a difficult method to secure examples of discourses of medical professionalism. To counter this I asked questions around the culture and experiences of the participants' work places to obtain examples of discourse in action. In conversations before interviews, it became apparent that the participants had anticipated that medical professionalism's intersection with Christian faith was likely to be a site of conflict. However, after I briefed them stating that there were no 'right' answers that I was particularly looking for, they relaxed visibly and could answer more naturally.

Having made known that I was not looking to defame Christian General Practitioners, the participants quickly revealed that it was their heart and intention to bless their colleagues and patients through their faith. In light of this, one of the most common findings in my results was that the Christian General Practitioners viewed their medical practice as an extension of their faith in being able to love others through medical care, social justice, and providing a listening ear. Participant 9 said this best when he said: "I do see my [clinical] work and what I do as part of who God has made me and that's an offering of worship." Participant 5 spoke for all the participants when he said "...I think I...find it easier to integrate my faith into my work in a job like this that is service and healing than if I were a cleaner or an accountant you know?"

This notion of caring for one's patients is not new, but for the Christian General Practitioner it has a particular imperative to it that is a biblical command, being that of loving your neighbour (Matthew 22:39). This was consistent with the findings of David Barnard (1985) whose work explored the role of the Christian physician acting not only as carer and curer, but at times as a spiritual guide or priest, imparting words of hope and encouragement to patients when the opportunity presented itself. As observed in the results, Participant 2 provided an example of this when she recollected an occasion where she felt a prompting in prayer to ask about her patient's estranged daughter in Australia, despite not knowing if her patient even had any family there.



Such an instance of being led in prayer in a consultation is similar to Barnard's work in that Christian physicians prove to not only care but also act as a broker of meaning to often hope-hungry patients (1985). Part of the motivation for being attuned in prayer during a consultation can be attributed to a verse that two of the participants cited in Matthew 25 in which the sum theme was that when a Christian takes time for the lowly, undesirable and socially difficult, that they are in that moment loving Christ Himself through proxy of that person. Such a reference to this verse was also a common theme within the literature surrounding Christian physicians suggesting that it may even be taught by fellow Christian physicians (Fosareli, 2002; Irvine, 2015; Sevensky, 1982; Wills, 2014). However, this is not to say that Christian General Practitioners have a monopoly on care. Rather, a few of the participants acknowledged that non-Christian General Practitioners are often very noble and compassionate in how much they offer their patients.

Such a humility was common throughout the participants as they expressed their respect for their colleagues around them. Participant 3 addressed the Christian discourse of evangelism that was pregnant in the interviews but was not explicitly my aim. This discourse implies that to be Christian is to also share one's faith whenever there is a chance. Rather than the General Practitioners engaging with patients in this manner and imparting something to them, Participant 3 and 9 both emphasised that they hoped that their professionalism and high standards combined with good care reflected their faith.

The participants in this study were overall shy in engaging with their faith with patients or colleagues. This was not because their faith was not important to them or because they lacked a desire to be able to bless or discuss faith and spiritual matters, but rather because of the national cultural environment they find themselves working in. In the most recent published census of 2013, New Zealand identified as 47.65% Christian (New Zealand Statistics, 2016). While this statistic may seem large, it reflects the lack of majority of Christians in New Zealand which in turn, creates a working environment which is largely secular. By comparison, in South Africa where 85.6% of its citizens identified themselves as Christian in 2014, the dominant working culture proved to be secular still (Statistics South Africa, 2014; Forster and Oosterbrink, 2015). Forster and Oosterbrink attribute this to the apprehension of

believers' to incorporate their faith into the workplace due to a combination of not knowing how, and fear that it would not be received well (Forster and Oosterbrink, 2015). This was telling of the participants in this study too, who although their heartfelt wish was to bless others they were often apprehensive to mention their faith at work due to a suspicion that it would be misinterpreted as aggressive evangelism rather than as blessing.

Alistair Appleby and colleagues observe in their recent meta-analysis of current literature surrounding religious physicians, that creating space for physicians' faith to be valued is not a simple process (2018). The authors articulate a key component to the discourse of faith which is that cultural contexts determine what that discourse looks like and how welcome it is within a social or working environment (Appleby et al., 2018). Thus while discourses of faith are cultivated within local churches and faith settings, the extent to which they are welcome in the workforce is determined by the contesting discourses of professionalism which often include a tenets of respectful pluralism (Shirley and Padgett, 2006).

For the participants of this study, the confluence of their faith in respect to medical professionalism was understood at the site of vocation. This notion of vocation and of calling is something that was highlighted within the work of Robert Sevensky (1982) as he emphasised vocation as one of four key tenets of medical professionalism for Christian physicians. Sevensky urged them to understand that they are called to fulfil a role of service to people for God just as Moses led the Israelites and as Jesus led his disciples. The difference between vocation and occupation for Sevensky is that an occupation is general employment but a vocation is a task done in prayer and response to prayer (1982).

This finding of perceiving one's work as vocation is not surprising in light of Arron Franzen's work (2017) where his survey of 1,144 American physicians revealed a high correlation of the likelihood of spiritual care being offered to the patient and the physician's own self-identified spirituality and religiosity. Franzen allows for a definition of religious or spiritual that lets the participants identify themselves according to their own sense of spirituality in addition to identifying with established religions (2015; 2017). Franzen notes that this correlation is because the religious physicians were more likely to have contemplated the areas in which their faith

conflicted with their medical practice and to have invested their own time in seeking out a resolution.

***Medical Professionalism:***

The theme of medical professionalism has been a core component of this project from its inception and in this section, I elaborate further. Behind the discourses of medical professionalism is the idea of what it means to be ‘professional’ medically.

Understanding how this idea is constructed, and altered over time helps identify how the currents of social pressure as capitalised by discourse are used to enforce conformity towards upholding a discourse of professionalism.

Indeed a few of the participants noted in frustration that over the course of their career the Medical Council of New Zealand has become much more prying in its investigation of professionalism to the extent that Participant 6 felt she could never satisfy their inquiries sufficiently, and that in turn, all doctors were now treated with constant professional suspicion by the Council. She recalled elsewhere that she became a General Practitioner for a job, but that now one has to at least be a member of the Royal New Zealand College of General Practitioners before even considering General Practice as a career. Eighty percent of the participants in this study had been practicing for over two decades and as such were trained in a generation in which their formative discourse of professionalism was the use of the title ‘doctor’, granted as a bi-product of identity by virtue of being trained as a physician.

It should be briefly recollected that the main triggers for such a change in discourse of medical professionalism were due to the increased alienation of patients from health care in the United States as costs rose, and in New Zealand due to the public scandal of malpractice in the National Womens’ Hospital in 1987 (Starr, 1982; Coney, 1988). Such a conspicuous shift in compliance to measuring up to standards of professionalism were not solely remittance for the mistakes of some bad doctors. Instead, they were about creating and ensuing that the new generations of physicians were reliable and accountable to the regulatory bodies that are the New Zealand Medical Council, and the Royal New Zealand College of General Practitioners (Sainsbury, 2015). As time goes on, what it means to be medically ‘professional’ is still changing as new medical and social issues begin to affect the ways in which

General Practitioners can practice. During what I described as the ‘second wave’ of medical professionalism in my second chapter, the New Zealand Government passed The Health Practitioners Competence Assurance Act in 2003 which then proved a further shift away from medicine as a self-regulated entity towards a legally accountable and state sponsored institution, ensuring that the Government set standards of medical professionalism were met (Sainsbury, 2015). While there had been similar acts passed in 1968 and 1995, the 2003 act was intentional in specifically identifying additional medical specialities and ensuring they were under legal accountability (Sainsbury, 2015). In the 2016 ‘Good Medical Practice’ booklet created by the Medical Council of New Zealand, medical professionalism is defined as ‘good doctoring’:

...Good doctors make the care of patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy and act ethically (MCNZ, 2011: 2).

Such a definition is consistent with other Commonwealth definitions which value patient centred care as their core component (Hafferty, 2006). In light of the second and third waves of the changing nature of medical professionalism, the American Board of Internal Medicine (ABIM) states on their home page the difficulties of defining a stable definition of Medical Professionalism, saying:

Today’s definition of medical professionalism is evolving – from autonomy to accountability, from expert opinion to evidence-based medicine, from self-interest to teamwork and shared responsibility. For many, medical professionalism is the “heart and soul of medicine.” More than the adherence to a set of medical ethics, it is what originally attracted them to the field of medicine.

Many physicians today experience profound obstacles to fulfilling the ideals of medical professionalism in practice. These obstacles range from struggles faced on an individual level to issues that exist throughout the system. (ABIM, 2018).

Although the ABIM does have a more intentional effort in describing medical professionalism under 'The Physician Charter', it is telling of the changing nature and contesting discourses of medical professionalism that the most obvious information when searching for their definition is instead a disclaimer to the complexities of defining medical professionalism and potential threats to it. Endorsed by the American Academy of Family Physicians (ABIM, 2017) 'The Physician Charter', formally known as 'Medical Professionalism in the New Millennium: A Physician Charter', was published by the ABIM, the ACP Foundation and the European Federation of Internal Medicine as a formal definition of medical professionalism (2005). In contrast to the mantra style of the Medical Council of New Zealand's appraisal of what it means to be a good doctor (that has expansions elsewhere), the Physician Charter details that good professionalism is summed up by patient welfare, autonomy, and social justice (2005: 1-2). These three key themes are then supplemented by ten commitments expected of physicians which take the form of virtuous tenets such as honesty and confidentiality (2005: 1-2).

Unsurprisingly, both the Medical Council of New Zealand and the ABIM's statements of medical professionalism consist of tenets of virtues in which a moral state of being is required as well as competencies that prioritise patient care. Astutely, Haffery observes that within the American definitions, notions of altruism and heroic sacrifice for patients trend higher than the British Commonwealth definitions of patient centred and 'good' medical care (2006). However, Cynthia Brincat points out in her work (2006) that even when statements of medical professionalism are set, they can be variable in the subjectivity of their interpretation. Indeed, she notes that many older physicians who have been practicing medicine alongside the arrival of the newer emphasis on medical professionalism and Patient Centered Care, prove to display enough empathy in their patient encounters to be seen as professional, but not to the same extent as those who are trained with it as part of their curriculum. This has led to what is known internationally as the 'hidden curriculum', in which there is a discrepancy between how medical professional practice is modelled, and how it is taught (Jaye et al., 2006).

To be clear, this is not to say that the participants of this study are opposed to professionalism. Rather the discourse around professionalism has changed so

substantially for older practitioners through their medical career that for the majority of the participants that they are not particularly willing to engage with newer narratives of medical professionalism. In part, this could be because doing so would require admitting a novice status on the contemporary thought and concepts of medical professionalism which is in overt contrast to their personal medical competence that they have developed over the course of their career. Participant 5 recollected this when she said “....I haven’t got those sorts of words... the professional sounding phrases, because I’ve interpreted down for so long.” Her apprehension in engaging with contemporary discourses of medical professionalism directly, such as keeping up with modern terms, was also a product of her having found satisfaction and joy in being able to care for individual patients genuinely, as well as provide treatment, and in turn identifying such care as professionalism.

Valuing the lives of others, and being patient in translating medical jargon is one way in which General Practitioners can differentiate themselves from other medical specialties by addressing the social needs of the patients as part of the treatment. It is because of such attitudes as kindness towards patients, as seen with Participant 5, that Jim Pink and colleagues in the United Kingdom report an increasing trend of pastoral visits to the General Practitioner (2007). The authors observed that simultaneous to the decline in church attendance is the increase of pastoral visits to the General Practitioner for issues such as bullying, relationship advice, and counselling (Pink et al., 2007). This type of patient behaviour is what Eric Cassell was advocating for in his book that called the attention of medical practitioners back to the human elements of their patients (1976).

However, the volume of patients that a General Practitioner can expect to see within a week now has dramatically increased as two of the participants attested to having a patient load of over one hundred per week. Observing that the General Practitioners themselves need support, the Medical Council of New Zealand has made peer review compulsory as a part of the larger scheme by the regular practice review (MCNZ, 2016). Peer review is a weekly meeting with other physicians of one’s own speciality, which provides an environment in which the physicians can discuss difficult patients and alternative solutions to different cases. Half of the participants in total intentionally spoke of their delight in peer review and the support it afforded them. It

can be observed, that for these Christian General Practitioners in this study, peer review settings are familiar as they strongly resemble discipleship groups that most Protestant churches encourage their members to attend on a weekly basis. Indeed, Participant 5 lamented that she missed her old peer review group in Auckland that was located in a Christian clinic and as such, the peer review group almost doubled as a discipleship group with fellow Christians.

Having time for extra activities such as discipleship groups and especially time for family, was a common theme throughout the conversations with the participants. Borrowing the title of 'lifestyle professionalism' from Brain Castellani and Fredric Hafferty's typologies of alternative discourses of medical professionalism, many of the participants displayed favour towards such a notion of medical professionalism as it allowed time for important personal activities and commitments (2006: 9). Participant 2 stated that it was because of the stable hours that General Practice offered that she elected to become a family physician so that she could raise her own children.

While only specifically mentioned by Participants 2, 4 and 6 in this project, lifestyle professionalism has been at the fore of public media in New Zealand in the last year. The Safer Hours campaign, driven by the Resident Doctors' Association (RDA) has been contending for a more humane roster for medical registrars (New Zealand Herald, 2017). What the RDA has been fighting for is not just for the restructuring of registrar programs and shifts to be safer for patients by allowing more sleep for their trainees, but also to give their registrars more time with their families (Sasha, 2016). Such lifestyle professionalism is becoming more popular in research surrounding physician self-care as it is one mechanism to help prevent burnout in medical professionals (Meldrum, 2010). Indeed, in 2017 the medical oath that is taken for the commission of junior doctors was amended to include a statement that articulates that caring for one's self will empower the caring for patients (Radio New Zealand News, 2017).

While volunteering as a radiography patient for Emergency Department and Rural Specialists training up on sonography in Dunedin, I conversed with an English registrar who recounted a recent case in the National Health Service of the United Kingdom where a series of unfortunate and preventable events had led to a highly

trained paediatrician having a fatality. Such unfortunate events included software failure, understaffing, epidemic shortage of resources and physician fatigue (BBC, 2018). Observing the current chaotic state of the NHS, he indicated that this young paediatrician served as a scapegoat for the many problems of institutional failure that the NHS is experiencing (BBC, 2018). He mused: “At some point in your career, you realise that no one is going to look after you; so [you] have to look out for number one (yourself).”

In this sense then, lifestyle professionalism is not occurring out of the wish for more free time but rather as a response to redefining previous discourses of medical professionalism as harmful. Jamie Shirley and Stephen Padgett observe in their chapter that the history of the medical profession has depended on the lives of often unseen female roles (2006). The authors argue that due to the length, intensity and tradition of medical training, physicians have been historically normalised as superior in the discourse of professionalism, even though to perform the office of medical doctor, one depends upon nurses and other paramedical professions (2006). The authors aptly point out that the discourse of altruistic medical professionalism was not so noble after all, as it was only possible because of the unseen family roles of domestic spouses, who served as relentless support for the physicians by tending to their needs, and caring for their children. However, with the waning influence of such gendered roles, the ability to propagate and implement such forms of medical professionalism are no longer feasible as the new domestic normality is for dual career couples.

Participant 4 represented a similar traditional view of medical professionalism, which Castellani and Hafferty’s labelled ‘nostalgic professionalism’ (2006: 9). Having practiced for almost three decades, Participant 4’s active discourse of medical professionalism was one that echoed of such twentieth century virtues: “That’s almost kinda gone too far where lifestyle is more important than any service and I think there’s a, you know, it’s overreached and needs to come back a wee bit. Just an interesting thing [laughs].” Participant 4 feared that as lifestyle professionalism contended for dominance as a form of medical professionalism, it could come at the expense of patient care and priority in favour of personal pursuits. While there was not any evidence in this study to support this, Participant 4 does make an excellent



point about the changing nature of how General Practitioner clinics are treated as supermarkets, with often-unarticulated expectations on behalf of the customer.

The notion of being perceived as a medical supermarket is indicative of the increasing complaints culture as mentioned in the setting the scene in the introduction. Online forums such as 'RateMDs.com' now exist to leave starred reviews for physicians as though they were a restaurant (2018). Brincat (a physician herself) addresses this issue, stating that modern definitions of medical professionalism have strayed dangerously far from those who understand and are actually trained in medicine, and instead lay groups are wielding an unbalanced and uniformed level of influence (2006). As mentioned in wave one of disenchantment in Chapter Two, the modern and recent evolution of discourses of professionalism have arisen in response to the lack of trust in the medical institution's ability to serve patients. Consequently, the newer generations of medical practitioners fight for lifestyle professionalism can be viewed as partially due to a decline in work satisfaction where family physicians are treated as one option among many. This point was articulated well by Participant 2:

... we are now just one of a number of different health providers and people will choose who they listen to... I think partly it's the internet, there's just such a range. Complementary, alternative therapies have always been around but they're kinda much more mainstream now. I mean people will come to me and say, "Well you're saying that but my iridologist or reflexologist or naturopath or homeopath says this. I will go home and weigh up what you say as opposed to what they say". And I think it's very different now.

As Brincat feared, medical professionalism is tested not simply by the Medical Council of New Zealand but now also by the patients. Thus the patients themselves are now key agents in engaging with discourses of professionalism with the Christian General Practitioners in this study. Participant 9 observed in kind that his patients had become more confident in comparing his professionalism with a poster of their rights in the waiting room. In this regard the medical professionalism of the General Practitioners in this study is challenged not just by empowered patients who are evaluating their professionalism, but also by patients who challenge their very medical authority itself, the very thing they have come to seek. This adds an

additional layer of complexity to the study of the discourse of medical professionalism, as it challenges the very notion that medicine should be considered a profession. The value of medical professionalism then lies in its ability to display the profession's worth in accordance with what is expected of it (Starr, 1982).

***Boundaries:***

Negotiating what is expected of General Practitioners as medical professionals, and what is expected of Christians, finds a unique overlap in the participants of this thesis. Indeed, while I did not address the issue of abortion directly in the interviews, it proved to be an archetypal intersection of discourses of Christian faith and that of medical professionalism. For many Christians, the correct answer, to preserve community and stay in accord with their discourses of faith, is to be opposed to what? This stands in contrast to the more abortion friendly working environment that New Zealand primary care offers, in which it is considered that the General Practitioner's scope of practice is to be able to refer for abortions. While all of the participants in this study mentioned abortions at some point, their thoughts on the matter varied. Participant 1 and 3, were quite clear that they were against being affiliated with the procedure, and Participant 1 viewed it as a test of his faith tantamount to how martyrs are tested. It is worth noting that both Participants 1 and 3 practiced in rural clinics, the latter establishing his own clinic. Subsequently, being able to stay true to their faith and belief systems in this way, it could be said that they were helped by the fact that their long service in a small town helped earn them a reputation as a Christian General Practitioner, which they could comfortably operate through that simultaneous identity.

The transparency of the lives of prominent individuals in small towns such as where these General Practitioners lived, set them apart to be rather high profile in their township to the point that locals observed their faith. Similar to the way that Participant 9 mentioned his patients coming in after reading their rights before seeing him, so too is the discourse of faith active and supported by the locals in the small townships. In these environments, they simultaneously expect and call the Christian General Practitioners into faithfulness, and into faith discourse as they assign an identity marker to the physicians – they are Christians and physicians. Participant 7 held a unique balance in the way he proved authentic to his faith, as

well as to his profession, by seeing a third option beyond a binary situation, by appealing to the legal clause that qualifies a patient to gain an abortion and intentionally identifying to the referral physicians if said patient did not match the legal requirements.

In appealing to the criteria of the law, Participant 7 lets the legal work be his own boundary work by identifying when the patient does not meet the mental health criteria required as a premise for the abortion procedure. Yet by not stating a blanket refusal policy, Participant 7 is able to still tend to and care for women post abortion if they return with complications. In this way, Participant 7 sees his role as care above that of judge, which in turn allows him to stay true to his faith's position on the issue, by invoking the definition of medical professionalism when it comes to abortions. Such an utilisation of medical professionalism, to stay true to one's faith and still maintain care for the patient, is observed in Sarah Jensen and Christine Philips' study, which is similar to my own, where one of their participants stated:

I said to her that I didn't think from the research that I'd read and from the ethical point of view... I don't think it's the best thing for her. And she actually had some depression in the past and so she was a sitting duck for post abortion depression (Jensen and Philips, 2013: 1184).

This type of statement is indicative of the majority of the participants in this study who mentioned at some stage in their interview their desire for the confluence of their faith and their medical professionalism even in the complex moments. This was a notion that was supported in the work of Kenneth Olive (1995) whose study on American physicians revealed that for particularly Protestant physicians, there was a strong desire to reconcile their faith with their practice. Subsequently Olive found that said physicians spent more time looking for ways to instigate a confluence of medical professionalism and personal faith (1995).

Participants 4 and 5 both revealed that when it came to abortion, that they upheld the common discourse of medical professionalism, which is to process referrals for the procedure as regular General Practitioners would. Participant 4 stated that he was comfortable doing this because he belonged to a church that was capacious in thought and theology. Although Participant 4 also admitted that he might receive

some disdain if he voiced this attitude too loudly. Participant 5 was unique also in that she replicated the boundary work performed by her superior, who was in fact both the chair of Society for the Protection of the Unborn Child (SPUC), and was simultaneously willing to perform abortions. For Participant 5, the issue was more than just the termination procedure, but rather the social justice, and life of the mother behind the case. Referencing biblical scripture, Participant 5 observes that Jesus came to help alleviate all forms of oppression, which at times got him in trouble with the religious leaders, as even Jesus broke with the current faith discourse at the time. Participant 5, did not mind upsetting the current discourse of faith if it meant caring for the patient in her life context.

A similar such instance of reconsideration of a traditionally taboo bioethics dilemma was from another of Jensen and Philips' participants about euthanasia:

You might say when you go to church, "Oh, yeah, euthanasia is sinful." But when you're at the bedside of a patient who is in agony from cancer... ravaged their whole body... I've personally had a patient say, "Can you put me out of this misery?"... I had to say "No." I had to say no, but it becomes tempting. Absolutely tempting. (Jensen and Philips, 2013: 1183).

This participant's quote is particularly salient as it demonstrates the contending discourses of faith and of medical professionalism that overlap at the site of care. His recollection that he 'had to say no' is indicative of his faith discourse, and his faith based identity dominating in this instance. Being based in Australia, where euthanasia is illegal (Murphy, 2016), it is also partially the discourse of legal medical professionalism coming into play, however the care element is consciously strong. In the past year in New Zealand, the assisted suicide bill has been considered in Parliament, which presents physicians the possibility of potentially having to legally provide such procedures (New Zealand Parliament, 2018). Participant 7 feared that such a bill would encourage a culture of killing off citizens who can't protect themselves, something which he believed would be reminiscent of the genesis that led towards Nazi genocide.

While Participant 7 has already demonstrated his ability to provide care in complex situations such as with post abortions, his greater concern was that a new discourse

of killing undesirables would emerge over time. It was in the context of the similar emotional distress of complex and confusing moments that Thomas Elkins and Douglas Brown (1987) wrote their book on Elkins' accounts of retrospective prayer within tough clinical situations. Elkins laments that lay discourses of natural medical procedures risked the lives of unborn twins, where he had to labour with much energy to convince the parents that the medical procedures were there to serve this deteriorating delivery (Elkins & Brown, 1987: 288-9). In such a moment, Elkins was able to transform the chaos of this situation into an invitation of prayer in which he could draw strength by processing what he was seeing through his faith.

Another such instance of complexity mentioned by the participants of this study was the overlap between the participants' faith and that of their sense of medical professionalism in the topic of mental health. Supernaturally, this is a topic that has historically been assigned the realm of the demonic, or that of the enemy of Christian spirituality. As the peculiar nature of mental health has been understood as spiritual as well as physical. Identifying when a case of mental health is a spiritual issue or not, is an important process for the Christian General Practitioners, as how each one responds, draws on different elements of their identity and training. Within Christian discourses, it is understood that dark supernatural powers generally have some involvement in causing mental health issues at some stage. The medical means available to the Christian General Practitioners are usually pharmaceutical and/or counselling. Like the participants' responses to abortion, the reactions to mental health issues with their patients were varied. Some participants understood mental health problems to be both spiritual and medical. Participant 7 articulated this best when he said: "If someone has a mental illness..., that's not different from them having diabetes or high blood pressure or rheumatoid arthritis... that's their 'exit from Eden' penalty"

In this way, Participant 7 perceived some health issues as being the somatisation of the unaddressed spiritual problems of bad life choices such as broken relationships, and unresolved conflicts, all of which he traces back to the fallen-ness of this world which is affected by the alienation that is sin. This is consistent with Horacio Fabrega Jr's work in which he observes that somatisation is indeed an under-reported problem, but that due to its nature of presenting symptoms without sickness, it

remains difficult to identify as somatisation (1990). As New Zealand is a predominantly secular country, the notion of having a spiritual illness (which mental health could be considered to be) can prove alarming due to the lack of public spiritual engagement (Pratt, 2016). Subsequently mental health issues within the New Zealand setting often come with a stigma attached, and although the eradication of this has been the focus of various agencies for some time, the preferred treatment is often pharmaceutical so that it falls within the discourse of physical sickness that requires physical treatment (Barney et al., 2006). Some participants were quite content in seeing mental health as at least a partially physical notion and saw their ability to prescribe as part of being able to bless their patients. Participant 9 said this best:

I don't see the psychiatric condition as sort of more spiritual, like clearly there's something, an oppression going on here, like God doesn't want you to be depressed, well He doesn't want you to have asthma either.

For other participants, such as Participant 1 and 6, their careers had held experiences in which they felt they could easily identify an instance of spiritual warfare manifesting as mental health issues. To combat this, Participant 1 sought to meet up with patients outside of clinical hours so as to aid them with their struggles in any way that he could. He tearfully lamented a story of three young brothers who all hung themselves on the same tree, and stated that his role as Christian at this point superseded his role as a physician: "But *someone* has to do it, someone has to step out. Because there is a saying, "Evil things will prosper [chokes up] when, when good men do nothing" [long pause]." Participant 1 was not alone in feeling the desire to respond to the spiritual needs of patients. Mark Ellis and colleagues observe in their work of both secular and religious General Practitioners, that while their participants were positive about engaging in spiritual matters, there was not much formal training for it for those doctors who were trained before the changing discourses of professionalism in recent decades (2002).

In such instances of repetitive suicides, Participant 1 viewed the discourse of medical professionalism as inferior to the greater eternal issues that were at stake. By Participant 1 meeting up with patients, "As a friend," after consultation hours, he enabled the discourse at play to change from that of medical professional to social

and relational. Thus one alternative to current discourses of medical professionalism is to opt out of it by changing the nature of the relationship by relocating away from the site that requires boundary work, and thereby setting a social expectation. I myself met up for coffee with Participant 1 after the interview, and it was very apparent that his delight was in caring for those whom he could, even if it meant just having a pastoral conversation with a patient at a sausage sizzle outside The Warehouse.

This notion was reflected by some of the other participants who expressed that while they were content to offer spiritual care, they observed that their discourse of professionalism was for medicine rather than for professional pastoral care, and that as such, they were cautious about delving too deeply into theological, spiritual and personal matters. This is consistent with the findings of Scott Murray and colleagues (2003) who found that while many secular General Practitioners in the United Kingdom considered addressing spiritual elements as part of their role, it did not usually come from the physician's initiative. The authors observed that it was rare for the General Practitioners to engage deeply in spiritual matters with non-palliative care patients, and that palliative care patients themselves were often hungry for hope rather than any particular religion (Murray et al., 2003).

The desire to impart hope for the participants in this study, was understood more specifically as a desire to impart hope in Christ. Participant 2 observed however, that the patients had visited her for medical remedy first, and as such, she did not feel she had the license to offer hope in Christ as explicitly as the way a professional Christian would, such as a chaplain. In this distinction between being expected to operate in the discourse of faith professionally, and in medical professionalism, Participant 2 identifies that the boundary for her is medical items first, and then faith ones if they come up, but not self-initiated.

Alison Kitson and colleagues, in their meta analysis of key concepts that comprise the construction of Patient Centered Care, found that one of the key elements that determines how this concept is executed is that valuing of the local, cultural working environment in which Patient Centered Care is interpreted and delivered (2012). This is reminiscent of Pierre Bourdieu's concept of habitus in which the 'field' determines the how an idea is regulated and performed within a people group

(Bourdieu, 1992). Indeed, as Participant 2 states, the expected role and the expected field for her to operate from with patients, was that of the medical professional discourse rather than faith. This is to not say that faith discussion with patients cannot happen within the consultation, but rather the patients are not expecting it and occasionally do not even know which General Practitioners are Christian and which are not. Such anonymity of faith was supported by Participants 4, 5 who indicated that even if the patients raised the topic of Christian faith, they felt it was safer to steer away from such conversations for professional safety. More sensitive to medical professional boundaries, these two participants conducted a more wholesale form of boundary work where in general they felt that while faith discourse could be included in medical practice, it was not for them to be champions of this integration.

Participant 9 spoke for the majority of the participants when he articulated that he viewed his faith to be interchangeable with his work, but that he was employed to practice medicine, and that as such, he instigated a boundary that differentiated his theology and his training. In doing this, Participant 9 could uphold both discourses of faith and medical professionalism by affirming that he believed that Christ was the Great Physician, in addition to realising that he himself was the General Practitioner who was there to practice medicine.

Part of the reason for this caution and this conservative attitude toward the General Practitioner's revealing their faith in the clinic, is because of the increasing number of complaints that General Practitioners receive in the new rights and consumer based culture outlined by the participants in the introduction. Sandra Jarvis-Selinger and her colleagues work in exploring issues of competency in medical professionalism, find that although certain skills are measured and tested to accredit professionalism of physicians, it is worth inspecting individual physicians to observe what smaller and nuanced skills they have developed over their career (2012). In doing this, the authors argue that a more holistic sense of professionalism can be observed, as often the patients are testing physicians on uncommunicated expectations (2012). Such nuanced skills can be appreciated as what distinguishes General Practitioners from other medical specialties as their primary role is to listen and interpret lay descriptions and expectations into possible treatments and care (Pink et al., 2007).



In contrast to Participant 4 and 5, and the work of Harold Koenig (2014), which all illuminate caution when speaking of faith topics in medical professional environments, Participant 1 felt that eternal life is of greater value than holding a medical license. Participant 1 went on to say that if he was pressed hard to see if he would ease on zeal in discussing his faith at times, that it would be tantamount to being a test of martyrdom in which he would be willing to lose his medical licence rather than his life. Participant 1's answer is what I had initially anticipated to find more of when I began drafting this research. His faith is clearly visible as the dominant element in his life. Part of the reason that I believe that this finding was not as common was because Participant 1 was near the end of his career, and as such felt that the loss of his medical career in favour for doing outreach and Christian pastoral care would not be such a bad thing as he was well established in life now.

The most zealous participants in this study trained in Medical Schools in South Africa, where discourses of faith were more permissible in work environments. However, the exception to this is Participant 3 who also trained in South Africa and was satisfied with the distinction between work and faith discourses. This distinction of professional discourse at the clinic and faith outside of the clinic was shared by the majority of the participants. While I had hoped for more common and conspicuous overlap of the two discourses for the sake of stimulating results, the ways in which the Christian General Practitioners often preferred to err on the side of medical professionalism, was stimulating in a different way.

In this respect then, my research question of how much did the participants' faith conflict or complement their practice, proved to be answered in part by a third option that emerged, that of holding to the cautious intentionality to generally not have the two discourses meet within a professional clinic environment. Indeed, after debriefing with the participants immediately after the interview, many of them professed they had never really considered the overlap of their faith and their work in such a concentrated way. This speaks of the separation being not a refusal of overlap due to fear of being understood as unprofessional, but because they simply were never placed in a situation regularly enough to see them overlapped. In some regards this can be understood by the New Zealand working climate, in which it is expected in general employment discourse, that one does not enter into

conversations about their faith, as the outcome can be unpredictable and potentially emotional. For the participants in this study then, who have a degree of authority granted to them by their medical standing, engaging in such topics can be seen as complicated.

Shirley and Padgett observe that one of the underlying difficulties with the evolution of the discourse of medical professionalism lies in who medicine serves (2006). They argue that as modern western societies grow more pluralistic, new measures have to be included to factor in additional cultural fluency and respect. Part of the reason then that the Medical Council of New Zealand's definition of a good doctor is simpler and more articulate than the American Physician Charter, can be attributed to the fact that our population is smaller than of a single major city in the United States. Nigel Biggar in his work argues that due to such a diversity of belief and variation in what is considered ethical and professional, that the institution of medicine should acknowledge that medicine can never be a truly secular space (2015).

While this is already observed in New Zealand, Biggar notes that valuing religious physicians such as Christian doctors, should be done in such a way that celebrates their personal values and commitment as well as what is considered professional (2015). In doing this, the value of physicians' religion and spirituality can be seen as an active benefit to their medical practice. This also affords the celebration of religious physicians from other faiths. This is not to say that Biggar is welcoming open evangelisation within clinical settings, but rather it is a helpful acknowledgment of the potential value of being able to celebrate the rich intersection of discourse of faith and discourses of medicine as seen by the participants in this thesis.

Located in this intersection of the participants' faith, and the discourse of medical professionalism, it can be observed by the participants' motivation, that they are honouring of both narratives. In this sense a new discourse of medical professionalism can be appreciated which is that of 'faithful professionalism', which proves unique to religious physicians, in whom there is the constant outworking of their faith. The religious physicians seek to uphold their own faith, as well as that of medical professionalism. Such a discourse proves a useful identification of the nuanced ways in which the Christian or religious physician experiences a new layer of the complexity of medical professionalism.

In conclusion, this discourse in medical anthropology seeks to sum up the lived ethnographic experiences of the participants in this study as they seek to value both their professional and personal identity, and the expectation patients have of them, in addition to the expectations they have of themselves as Christian physicians.

## **Chapter Six:**

### **Conclusion**

This thesis set out to investigate how discourses of professionalism influence Christian General Practitioners in their practice and to what extent do notions of professionalism conflict or complement the physicians' sense of self in their Christian faith. The results revealed that far from a simple binary of conflict or complementarity of the juxtaposition of the physicians faith and their sense of professionalism, more careful and complex negotiations in in order to express the outworking of resolutions beyond dualisms.

This was best personified in the issue of abortion. While I did not have any specific interview questions over the topic of termination it proved to serve as an archetypal overlap site of faith and professional discourse both in conception and in practice. Such an issue arose because of the dialogical nature that I undertook to conduct my open ended interviews in which I was careful to pursue what the participants wanted to talk about within the confines of my topic rather than offer questions that were primed with an expected answer. For the majority of participants in this study they were not willing to perform abortions. Participant 4, who did perform them in the end reflected that if this was made known more overtly to Christians from other churches that he felt he might suffer correction. This proved to be an excellent example of a Christian discourse in action that has normative proprieties in regulating what is knowledge and ideology that needs defending within different expressions of Christianity.

One of the core reasons I selected General Practitioners as the key medical profession for this study was because I believed that they held a more autonomous methodology in how their could shape the style and expression of their medical treatment. While this was definitely true for many of the participants in this study, it was simultaneously not absolutely true. Instead, for the Christian General Practitioners each opportunity to refer for an abortion or engage in a conversation about faith proved to be a individual instance in which boundary work was performed. Thus, boundary work and the negotiation of discourses of professionalism for the

participants in this study is something that is an ongoing process that is never really complete. For the participants like Participant 1 who saw referring abortions as a test of faith; there will be more tests of faith to come for him in his career. This was made obvious by Participant 7's reaction to caring for post abortion patients where he felt his test of faith was won in the caring for his patients even if they had a procedure he disagreed with. In this respect then, discourses of medical professionalism are not just conflicted within these instances but also renegotiated towards an outcome that is in adherence to the discourse of the physician's faith or towards a simultaneous appeasement.

Due to this almost perpetual nature of the Christian General Practitioners' encounters of overlap between their faith and discourse of professionalism, each instance is a chance for new boundary work as each patient is different and holds different needs and sensitivities which create the obstacles that needs to be navigated by the Christian General Practitioner. In this regard, my work is much like that of Harold Koenig (2014) and Sarah Jensen and Christine Philips' (2013), in that all these authors found that with their Christian and religious physicians that caution and sensitivity with patients was paramount as patients are now active agents of enforcing discourse of professionalism.

Another key finding overall was the observation that for eight out of the ten participants they had been trained over two decades ago and three of which had been registered as doctors in South Africa. The implications of this was that these participants were trained and licenced under a discourse of professionalism that was an expected and inexplicit form of professionalism that was rarely discussed or inspected so directly. Over the course of their careers they have had to receive in not only the new discourses of professionalism but also be subject to its investigative and prying nature, which was a source of frustration for some of the physicians in this study. Furthermore, these veteran clinicians are now expected to be bastions of the new discourse of medical professionalism to their juniors and to medical students who come and observe. This in turn leads to a begrudging inconsistency that is observed as a duplicity of medical professionalism in the work of Jaye and colleagues (2006).

For the two newer General Practitioners in this study, their experience of medical professionalism as an inspecting regulatory force was considered to be normal and wholly beneficial. For these two participants, their attitude towards medical professionalism was also supplemented by and fostered through a culture that sought to see medical professionalism not only serve the patients but also to serve themselves. This was observed in the context of the recent refutations of the Resident Doctors Association to New Zealand District Health Boards that are seeking a form of medical professional discourse that protects the wellbeing of the physician in addition to the patient (Sasha, 2016). Such a contention and proposition for an alternative discourse is a kindred finding to that of the work of Brain Castellani and Fredric Hafferty in which they propose seven alternative discourses of medical professionalism. I believe that the reason that this project yielded a similarity to nostalgic and lifestyle professionalism is due to the fact that the majority of the authors alternative discourses of professionalism were the product of a heavily commercial health care system. Their nostalgic discourse could be observed in Participants 3 and 5 where they expressed concern for the rate at which the understandings of medical professionalism were changing.

This study, however, observes another alternative discourse of medical professionalism that is unique to the Christian and religious physician being that of 'faithful professionalism.' Rather than being an entirely new discourse, this is rather the sum of two discourses of the physicians' faith and personal conviction in duality with the current medical professionalism. Like all discourses, it is an attempt at a status or ideology rather than a final destination. Subsequently, as the Christian General Practitioners and indeed other medical specialists labour towards a working harmony of their faith and their medical professionalism, a bridge is created upon which there is overlap of both discourses but is also a place of transition to swap between each discourse. That is to say, that while both the discourse of faith and the discourse of medical professionalism have similarities under a 'faithful professionalism', in practice the participants tended to favour different discourses at different times, giving each moments of hegemony.

In dialogical fashion, this was revealed in the fact that many of the participants disclosed to me after the completion of their interviews that it was the first time that

had thought about how their faith directly related to their sense of professionalism. Thus while they clearly had thought about how their faith and their career as a physician overlapped before, they had not done so in the explicit juxtaposition of professionalism. This proved to be consistent with the large scale surveys conducted by Call42 in South Africa in which it was revealed that of the Christian respondents, many felt ill-equipped to negotiate the integration of their faith and their occupation and instead sought to see them as predominately separate so as to preserve both (2013 b).

While groups such as Christian Medical Fellowship exist in most major cities in New Zealand, they are more readily attended by medical students than physicians. Thus in light of the lack of literature (that I located) focusing on the spiritual elements of Christian physicians, a more religiously diverse and larger scale project would do well to investigate further such a 'faithful professionalism' discourse. By specifically focusing on Christian General Practitioners this project contributes towards the emerging field of Anthropology of Christianity and the already blooming field of health care and religion.

Utilising Aaron Franzen's typologies of different forms of religiosity and spirituality would too aid the researcher in coding results of a larger project into their self-identified categories, which in turn might offer a rich source to explore potential other alternative discourses even within that of faithful professionalism. Performing a larger study with more than ten participants could also afford the new researcher to obtain data saturation. Other future projects would do well to compare responses of registrars to that of veteran clinical practitioners so as to create a more intentional comparative study as was observed on a small scale within this project.

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# **Appendix A: Interview Questions and Topic Prompts**

## **Faith:**

1. Church?
2. Describe your faith/ what do you define yourself as
3. Rewarding elements of being GP?
4. How do you think your faith encourages your medical practice (if in any way)
5. Times your faith has aided you in practicing medicine?
6. Verses/ scripture that guide the way you practice?
7. Can you recall any times where you struggled to find a balance between what you considered best practice and what you value in your faith in your practice?
8. How do you describe your faith involvement outside of the clinic?
9. Call42's work (based in SA) shows that most Christians feel they do not know how to comfortably integrate their faith into the work place. What is your experience of this as a GP?
10. Literature focus in recent years has been on *patients* experience of spirituality. What would say is the value of understanding the physician's spirituality and faith?
11. Expression of worship for yourself?
12. Do you think you can offer something different as a Christian GP that regular GPs could not?
13. Faith help -psychiatric patients?
14. Do you think being a GP is a better speciality for harmonizing faith and professionalism?



15. How has trust in GPs changed over your career?

**Professionalism:**

1. What made you want to be a GP?
2. How would you describe yourself at your workplace?  
-how would your colleagues describe you?
3. During your time as a GP, how has the focus on professionalism changed?
4. What challenges would you say new generation of GPs face that you didn't?
5. What are some elements of profession that you find worthwhile / unnecessary
6. Have you ever experienced any times where being a Christian has caused difficulty in your medical practice?
7. How do you feel about your colleagues knowing you are a faithful GP?
8. How do you identify boundaries for when you think that practicing your faith, as a physician in the clinic might not be seen as professional?
9. Can you recall any times where you felt you let a patient down?
10. Being a GP practicing in [SA]/NZ, what would you say are some of the key cultural things that you have to be aware of?
11. In some of the other interviews, GPs have mentioned that peer review plays a large part in regulating their understanding of professionalism- what is your experience of this?
12. Have you ever been told 'to be more professional' ?
13. Other GPs have mentioned having to fill out a professionalism performance plan; how worthwhile have you found this?
  - Anything you want to add?
  - How many years as a GP?
  - Age/ Place of practice?
  - Can I get in touch afterwards ?