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Remembering the medical practices: how health workers narrate their most negatives experiences

Abstract

People from different labour contexts and practices often narrate diverse memories about their past professional experiences. By analyzing professional memories we can increase our understanding of how health professionals are able to integrate the diverse problems which they may encounter within their profession. We have focused on the analysis of the most negative memories of a particular group of doctors related to their work experience. After interviewing twenty-four professionals of different specialties, their narratives were analyzed using the criteria of specificity, agency, and theme of the memory. Most memories were considered specific as they were vividly remembered with attention to detail. Men have more narratives linked to agency, while the majority of women develop narratives linked to communion. Furthermore, five clearly differentiated topics were observed regarding the professional's degree of experience. A qualitative analysis of the memories of these professionals, as well as a description of the appropriation process of the discursive features is presented.

Keywords

Identity, autobiographical memory, health professionals, narratives, agency, cultural practices.

Introduction

Autobiographical memory (AM) is a form of memory that integrates experiences of self with cultural frames in order for us to make sense of our lives (Fivush, Habermas, Waters and Zaman, 2011). This form of memory is closely related to the self and to the experience of personhood, that is, to the experience of enduring as an individual, in a culture, over time. As an important function of AM is to provide a sense of continuity of the self across time from the past to the future, it can be said that self and AMs construct each other, that autobiographical memory allows us to exist through time (de la Mata, Santamaría, Hansen and Ruiz, 2015). Culture plays a key role in AM, because people from different cultural contexts narrate diverse stories about their selves and about their past experiences. And this is crucial for the ways the selves are constructed in different cultural settings.

From this perspective, AMs play an important role in the construction of personal and professional identity. Wilson and Ross (2003), like many other authors, claim that identity construction is an active process in which individuals search for information that helps them confirm how they want to perceive themselves (and confirm how others perceive them). These memories are used to understand others and construct individual identity (Fivush and Merrill, 2016), but they are not formed in isolation, in the individual mind. For Fivush et al. (2011), autobiographical memory is socially and culturally mediated in many different ways, and Wang (2016) views it as an open system immersed in the cultural milieu where the individual is in constant transaction with the environment. However, this field has given little or no attention to the role of specific cultural settings and practices in this memory process.

A vast and growing field of research about culture and AM has recently emerged. Studies in this field investigate how values about self that predominate in different cultures influence how

individuals construe themselves and remember their personal past. This research has revealed systematic differences in various aspects of AMs across cultures. Such aspects include content (in terms of autonomy and relatedness), structure (specific vs. general), valence (positive vs. negative), the characters involved (self vs. others), the age of earliest memories, and functional usage (self-definition, relationship maintenance, behavioral guidance, and emotion regulation) (Nelson and Fivush, 2004; Pasupathi; 2001; Santamaría, de la Mata, Hansen, and Cubero, 2017; Wang, 2004; 2016). Thus, this "autobiographical self" is constructed through the process of recalling, evaluating, and sharing memories of personal experiences from an individual's life (Nelson and Fivush, 2004), which is crucial for identity and psychological wellbeing (Habermas and Bluck, 2000; McAdams, 2001).

However, not all perspectives that focus on the analysis of cognitive processes based on cultural variables do so by comparing data of people from different countries. Cultural psychology has paid special attention to the analysis of the role played by specific development contexts and activity scenarios. Undoubtedly, the school and the learning processes have been the ones that, for many reasons, have received more attention. There is a long tradition of research on the topic of learning and development processes of children while they are in school. It is a line of research closely linked to developmental psychology, and which considers the school as a new environment, beyond the family, in which to learn and develop, that is fundamental for socialization in our society. Furthermore, it has also been related as a fundamental cultural practice in adults with different levels of literacy in areas such as comprehension, memory strategies, concept formation and categorization, reasoning, argumentation or autobiographical memory (Santamaría et al., 2012, de la Mata et al., 2015).

Beyond equating culture and nation, in which transcultural models fell, from this perspective it is understood that sociocultural settings offer their participants various interpretative frameworks and symbolic resources such as images, concepts, narratives or discourses. Lehman, Chiu and Schaller (2004) in a major review on the relationship between psychological processes and culture, show how individual thinking and actions influence cultural norms and practices, and these norms and practices influence the thinking and actions of individuals. They support these ideas with research from very different areas such as the development, attention, communication, perception, self-regulation, agency or narrative thought.

People create meaning of their own lives by developing narratives of the self that integrate past, present, and possible future experiences (McAdams, 2001). These stories provide unity and purpose to one's life, thereby contributing to personal identity. In this way, cultural self-construal serves as a kind of filter for individuals' personal memories, and these memories can help to develop a particular cultural self-construal (de la Mata, et al., 2015). According to some authors, "with the emergence of culturally different self-conceptions, different forms of autobiographical remembering and different modes of social interaction and communication, *different* human persons emerge" (Wang and Brockmeier, 2002). From this perspective, the different cultural practices in which we participate favor the construction of different selves and can explain many differences in psychological functioning (Cross and Madson, 1997).

The study: how healthcare professionals narrate their most negative medical memory

The present paper aims to integrate these fields to allow the study of health/medical practices (as a socio-cultural practices) contributing to the acquisition and development of specific forms of autobiographical remembering. It leads us to question whether certain cultural practices promote diverse forms of autobiographical remembering and diverse ways of narrating the

professional self. These ideas focus on the importance of a narrative approach to professional identity in specific cultural contexts, such as hospitals or healthcare agencies.

When choosing which memories to share, there is tension between what is culturally dominant and prescriptive versus what is not. This creates narratives of resistance and deviation, which, according to Fivush (2010), leads to the dialectic between voice and silence. This implies the need to choose a particular narrative and a particular way to share it for each particular audience at each particular moment. For this author, *gender* is a critical filter through which the identity and personal memories are built. Such is reflected in the many differences between the memories and narratives of men and women that can be found in literature (Grysman and Hudson, 2013). For Grysman, Merrill, and Fivush (2017), both the sociocultural theory of AM and dynamic models of gender identity focus on developmental processes, so future studies need to take a more developmental perspective to understand how gender, emotion, and AM develop dynamically across the lifespan.

According to Singer (2004), there are many studies that analyze the presence of agency and communion themes have illustrated the power of narrative identity and meaning-making in adult development and personality growth across different phases of the adult lifespan. Individuals vary according to the role agency (a sense of mastery, dominance and independence from others) and communion (a sense of integration, connection and submission to a larger whole), play in their lives. Although connectedness with others is usually stereotyped as a feminine quality and agency as masculine, past research has been quite mixed on whether gender differences emerged in these orientations (Grysman et al., 2017). For instance, Niedźwieńska (2003) hypothesized that women would be more motivated to remember personal experiences that referred to communion, whereas men's most vivid memories would be more focused on agentic themes. Although she found no

significant gender differences in agency, men described experiences related to competition, power and prestige more often than women. In this research, we have focused on analyzing the content of memories about the work experiences of men and women depending on the agency or the communion they may present.

For us, the *degree of professional experience*, as one of the most relevant cultural practices we develop, is another crucial filter, a point that will be returned to later. How are memories of an individual's personal past linked to the valence of her or his past? Some authors suggest that "bad is stronger than good", which implies that people recall negative memories better than positive ones (Baumeister, Bratslavsky, Finkenauer, and Vohs, 2001). Thus, the analysis of the characteristics and issues that are considered in the most negative memories, along with the way they are expressed, is of particular relevance. And to this day, there has been no research with relevance to the examination of these memories in medical practice.

For Brown and Reavey (2014), autobiographical memories of difficult and troubling events, especially those that involve violence, are different to other sorts of recollections. Particularly negative autobiographical memories develop a central importance compared to other autobiographical memories for different reasons. They are generally longer and more elaborated than positive or neutral memories (see Christianson, 1992 for a review) and they break the expected narrative canonicity (Bruner, 1986). Therefore, Singer and Salovey (1993) suggested that negative memories have a special weight among those considered self-defining memories. This could be explained considering our subjective experience and subsequent ruminations of different negative events that could determine how we elaborate these events and the impact they have on our lives (Bohanek, Fivush and Walker, 2005).

As said above, there is no doubt that the specific cultural context in which personal experiences is recounted, such as hospitals or healthcare agencies, plays a fundamental role. What we can do with our memory and the forms our memories take is interdependent with institutional contexts (Brown and Reavey, 2014). Being able to share one's experience is undoubtedly related to a higher quality health and social care as well as better relationships with the professional team.

Yagil and Medler (2015) gave examples of how doctors experience conflict amongst their identities as clinical experts, caregivers and service providers or resources. They use various strategies to confront the tensions generated, such as changing the meaning of the identity or the event by implementing cognitive and relational tactics. This generates different narratives of the self that, for Ibarra and Barbulescu (2010) help to review and reconstruct identities in times of crisis or career changes.

In relation to the importance of the degree of professional experience (medical/healthcare experience, in this paper), literature shows that, as relationships with patients and colleagues and the ideas about the professional activity change as experience is gained. The schemes of life stories, models of autobiographical memory and many other narrative tools are acquired through the gradual contact and engagement with cultural practices in which every medical doctor and professional is involved. Therefore, it is necessary to analyze how this process evolves while medical doctors acquire more experience.

In order to do so, we think the concept of Master Narratives (McAdams and McLean, 2013), could be of special interest. The Master Narratives are the result of social practices, including privileged discursive practices in contexts where we interact that can be found in familial, political and, religious contexts (Fivush et al., 2011). These narratives are characteristics of a particular cultural group, which is not defined by a physical border, language or historic

moment. They are cultural products and are essential for socialization. And the analysis of these memories could help us better understand the interdependence between autobiographical memories, identity construction and professional conflicts. This is why the study of health professionals' most emotionally-charged memories is considered to be highly relevant.

When researching interdependence between autobiographical memories, identity construction and professional conflicts, the study of health professionals' most emotionally-charged memories is considered to be highly relevant.

The main aim of this paper is to contribute to the existing literature about the relationship between culture, autobiographical memory, and self by studying how healthcare professionals remember and narrate negative events of their medical experiences. Specifically, our research examined the role of gender and professional experience, in terms of social practices, on autobiographical memories and narratives.

The specific objectives of this study were the following: (1) to explore the most negative memories within medical practice, (2) to analyze how professionals structure the narratives of these memories in terms of specificity vs. generality, (3) to analyze the content of these autobiographical narratives in terms of agency vs. communion and (4) to explore the differences or similarities in these narratives according to the gender or degree of experience of the medical professionals. We expected to observe common patterns in memories, as the participants share many similar social practices, but also differences depending on their participation in discursive communities beyond the scope of health work.

Methods

Participants

All participants voluntary and were recruited intentionally. The principal criterion of inclusion in the study was that participants be currently practicing medicine within the city of Seville, Spain, or the surrounding urban areas. In order to obtain a paired sample of gender and level of professional experience, four professionals from each subgroup were recruited.

The sample consisted of twenty-four professionals from both public and private healthcare agencies in the city of Seville, Spain, of which twelve were men and twelve were women. The subjects were further divided into three groups in regards to their work experience (five years or less, between six and nineteen years, twenty or more years of experience). The ages were situated between twenty-five and sixty-two years of age (M = 40.1), with an average of 14.4 years of experience. Group one had an average of 27.9 years of age and 3.3 years of professional experience. Group two had an average of 37.8 years of age and 12.6 years of experience. Finally, group three had an average of 54.8 years of age and 27.3 years of experience.

Seven pediatricians, six family doctors, three surgeons, three emergency doctors and two radiologists were interviewed. The sample also included one gynecologist, one psychiatrist, one cardiologist and one hematologist. The twenty-four interviews were audio-recorded and transcribed verbatim for their later analysis.

Procedures

A psychologist specializing in human resources designed an *ad hoc* autobiographical interview. The intention of this interview was to both respond to the questions of the research and to learn about the memories related to their jobs, and learn how these memories have changed their lives. From the existing prompts, the following was the one chosen to be analyzed.

“I would like you to recall a memory of your professional experience which you consider to be particularly negative, specifying the emotion with which you would describe it”.

The interviews, conducted by the first author and principal researcher, had an average duration of thirty minutes and were conducted in either the participant’s office or a meeting room in the healthcare agency.

Analysis

After the verbal transcription of the memories, two trained researchers analyzed the narratives following three steps and using version fifteen of the program Atlas-Ti for the coding. In figure 1 a summary of the process *which could be considered a mixed-method type study,* is presented.

First, following the categories of Conway and Pleydell-Pearce (2000) narratives were coded as specific, referring to events that once occurred at a particular time ("the night my first patient died"), or general, referring to events that occur regularly or multiple times ("when I was not allowed to do an intervention because the lack of funds").

Secondly, in order to categorize the orientation to agency the "Coding autobiographical Episodes for Themes of Agency and Communion" (McAdams, 2001) was used. In this system of categories, an agentive orientation is when a narrative focuses on the self; a self that becomes the center of the narrative, is held or expanded. These memories may include ones in which personal learning, a significant achievement, or a new sense of empowerment occurs. On the other hand, it is noted that the main theme in communion is memories that focus on individuals belonging to another group, and when love or friendship becomes the center of the narration. In these narratives, the relationship established with another person, the care given or received, or the feeling of

togetherness or belonging to a group is expressed. The degree of inter-rater reliability in all cases exceeded 0.85.

Finally the interviews were analyzed individually by three researchers and later collectively as a group looking for the most important issues remembered. In accordance with our aims, a thematic analysis was used for the qualitative interview's analysis since it is a robust and parsimonious methodology of enquiry data (Braun and Clarke, 2006). Thematic analysis is a method for identifying, analyzing and reporting patterns from raw data. A theme or category can be described as significant utterance about the data in relation to the research aims, and involves a suitable and meaningful articulation of information provided by participants.

The process of empirical verification was performed using iterative comparison until saturation was achieved. Through group analysis the categories were confirmed, redefined or eliminated. This iterative procedure of individual-group analysis was repeated until the analysis did not show any relevant new information. This provided the categories and descriptions that formed the main results. We have only included those categories and interpretations in which there was 100% agreement. This procedure is considered a reliable method and is referred to as peer review to validate qualitative research (Cohen and Crabtree, 2008).

[Insert Figure 1]

Results

Specificity and agency

With regards to specificity, it is important to note that twenty-one of the analyzed memories were specific events, compared with only three cases of general memories. This tendency appeared as much among men as it did among women (see table 1). None of the cases concerning generic

memories involved doctors in group one. The majority of memories were remembered vividly with attention to detail concerning topics such as specific conversations, patients or medical procedures. In the three general cases, the interviewees referred to their first experiences in the emergency room, where, in their own words “everything was extreme”.

Moreover, it can be observed that most narratives were categorized as agency-oriented rather than communion. However a distinct difference in gender was also observed; female participants tended to remember more themes related to communion, whereas only two of these types of memories were recalled by men. In two of the four agency memories, females reported feeling debilitated or experiencing a personal crisis. In the other two narratives the main topic was the lack of achievement, failing to help someone or to resolve a problem. In other words, the individuals felt that they had failed in their endeavors. The narratives coded under communion included four cases of either incapacity of curation, providing help or showing empathy towards the suffering of a patient or their family. There were also three cases which included a dispute with a coworker or manager resulting in a loss of confidence, and a single case which noted a lack of perceived unity among the work team.

[Insert Table 1]

Male participants presented more agency-oriented narratives than their female counterparts. In total, there were only two male narratives that were coded under communion. Both cases discussed an inability to heal their patients, resulting in strong feelings of empathy. However, the same theme concerning the inability to cure patients was also found in narratives that emphasized a lack of achievement or an experience of personal failure or crisis, which implies a marked agentive orientation.

Referred categories in the negative narratives about medical practice

Although the narratives did not observe crucial differences between male and female participants within the categories, differences were observed regarding the degree of experience of the participants. In Table 2, the five themes are shown, extracted by their codification. It can be observed that 13 of 24 refer an interprofessional conflict and some themes are more present in Group One (those with the least amount of experience), while other themes do not appear until the level of experience of the professional has increased.

When we think in a hospital, we may expect that the worst that could happen would be the death of somebody. However, maybe because this is what is expected, it is not the most remarkable event that those professionals remember. In contrast with daily routine, *stress in emergency rooms* appears as a very important theme. Younger professionals, regardles of their speciality, are often obligated to dedicate at least one day of the week to work a night shift in emergency rooms. In these moments, they have demands from patients whose health could be at grave risk, but receive insuficient attention from their supervisors. The fact that professionals may not have the ability ot respond to their patient's needs coupled with the risk of accidentally harming the patient, usually causes anxiety, fear, loss of enthusiasm and in particular, a high degree of stress. This is a period that many professionals consider to be very stressful but informative because it forces them to put their knowledge into practice. Although they are often at risk of committing fatal errors.

In this type of situation, the *fear of error* in the diagnostic or treatement, the comission of that error, or the subsequent management of the emotions involved is a fundamental theme in the narratives of these professionals. For these motives, narratives of fear of causing irreversible consequences in the patients, fear of being sued and even fear of losing their jobs are expresed. This is why, although these narratives are very close to the theme of *stress in emergency rooms*, they have been considered as part of an independent theme.

Also related with the previous theme, but with more specific characteristics, is *dispute with patient*, which may not necessarily derive from a medical error. In fact, in the majority of the cases, the conflict derives from the demand of a patient in order to realize a particular medical procedure, which the professional, for different motives, did not consider necessary. The demands of a diagnostic test and the complaints from patients for a lack of improvement in their health, or for a medical error, comprise a very important category observed in the narratives of professionals of all three levels of experience. In our opinion, this is probably the topic that appears the most because it may be the least expected, in as much as what they expect from patients is precisely "patience" and gratitude. However, it is not uncommon for patients to come with very specific requests, derived in numerous cases from their own searches on the internet, which contrast with the professional's criteria. This is a challenge to which health professionals will undoubtedly have to face more and more.

Considering the emotions involved, the *death of a patient* is a theme that appears in many narratives, although death is not always considered the nucleous of the narratives. Occasionaly, remebering the death of a patient elicits other themes for the medical professionals, such as fear of error or stress in emergencies, but in other cases it generates a completely new narrative constituting a unique thematic category.

Lastly, a theme that was only observed in professionals in Group Three, is *conflict with supervisors*, reflecting problems about politics, management and conflicts of interest within the healthcare agencies. These type of narratives are considered to be critical and, when phsycians share them, they express strong feeling of stress, disappointment and even rage.

We will now begin with the analysis of each group of professional experience in order to create an indepth understanding of the themes that were discussed and how the were narrated. Narratives in which the professional conflict seems to be ubiquitous will be analyzed.

[Insert Table 2]

Among the professionals in Group 1, the most common feelings are those of broken expectations of what their professional experience would entail. When faced with reality, the individuals experienced emotional distress in their daily tasks, and expressed feelings of frustration caused by having to work with limited resources and by witnessing the suffering of the loved ones of deceased patients. Furthermore, in many situations, the expressed feelings of loss and helplessness, after failing to help a patient, were exacerbated by a lack of support or advice. Situations were also reported which involved failures in collaboration by colleagues causing inadequate attention to patients.

Extract 1. Female, Six months after surgery experience.

> *"The two patients arrived in critical condition. They had spinal cord injuries and it was likely nothing could be done to prevent them from becoming parapalegics. But they'd still have at least some motor functions if the team had worked together more effectively.*

In these cases, the worst feeling is the inability to help someone. Young professionals may try to help a patient that is dying, but they often do not have the resources or capacity to do anything. This could be the first time they become aware of the limitations that exist in public health services. The use of a large number of verbs in the conditional, as can be observed in extract 1, suggests that they are subtly criticizing the actions and decisionsof their colleagues. They consider themselves restricted in the number or types of diagnostic tests that they can perform. They also criticize the reduced number of professionals that are available to face the demands of the increased amount of patients who can wait hours before being attended to.

In other occasions, because of the workload, their low practical experience and a bad supervision, physicians in Group One recalled responding to the demands of the patients with a high degree of stress. These demands and the interprofessional conflicts cause them anxiety, fear of failure, and feeling of being ignored. These experiences have been reflected, for example in extracts 2 and 3, which include very negative emotions and feelings of surprise, rage and imcompetence.

Extract 2. Male, Nine months after emergency experience.

“The adjunct [supervisor] just ignored me, and, in my very first day, he didn’t explain ANYTHING to me. And the most outrageous thing, because it was really outrageous for me, was that not only did he not explain anything to me, but he made me feel useless “do this”, “I mean, I don’t know”, “print this”, “ I don’t know where the computer prints, or even where the computer is. I don’t even know what document you’re asking me for”.

Considering that they have to respond autonomously to some claims that involve high responsibility, a state of pressure and shortage of resources, an error is something hanging over their heads like the sword of Damocles. Moreover, a fundamental aspect of their work is human relationships with patients and their relatives. They find patients, that not only do not thank them for their work, but that also criticize their performance when they have to wait or do not receive the diagnostic tests they desire. These situations can lead doctors to question their professional vocation and their choice of action.

Extract 3. Woman, 21 months experience in gynecology.

"You don’t expect to be responded to like that... I guess it’ll be because of the stress or whatever... In fact, nothing happened to the woman, and it was not a life or death or an absolute-gravity issue, but you... They treated you in a way that you don’t deserve and that doesn’t make any sense".

Thus, we can see that in this group what is most shocking for doctors is not death, which may appear tangentially. Rather, not being able to do more because of a lack of knowledge or resources, the fact that patients do not recognize their work, as well as the fear of error are reported

to be the three worst memories among young doctors. They complain that their efforts are not valued, and they try to safeguard their professional self-esteem in a period in which they are building a professional identity which can be called into question by certain events.

In the narratives of participants in Group Two the protagonist continues to be a patient rudely requiring a number of diagnostic tests or medical procedures. When the death of a patient is cited, it is done in a way that takes a social perspective beyond medicine. Thus, one young doctor outlined how she had to perform palliative sedation on a woman her age because she had an incurable cancer which caused her great suffering. The woman ended up dying and leaving her young children behind. This is also related to the fear of prematurely telling a patient that they are healthy or performing certain practices that may endanger the health of a patient who could subsequently become worse and sue for malpractice or negligence. This generates a fear of dismissal or professional sanction.

Extract 4. Female, 9 years of experience in pediatrics.

"The allegations are really there, and anytime ... every day, you think a child is healthy, but medicine isn't perfect, and this is something the people don't know. We can guess in some way what a patient has, if we see them once we may have an idea, if we see him twenty times we will be closer to a diagnosis. And if you see a child once you can make a diagnosis a priori ... but the problem is that failure in this work can lead you to... to lose your job, to go to court... so that's very stressful".

Thus, the initial shock about what was originally expected makes way for other issues. Errors feared by younger professionals, become major conflicts with patients and, in some instances, lead to court cases. In these episodes, exemplified in extracts 4 and 5, it is highlighted that a patient criticized a doctor, questioned his knowledge and even aims to get an economic benefit. In these narratives, the daily difficulties, pressures and responsibilities that they face are highlighted.

Extract 5. Male, 13 years of experience in surgery.

"We completed eight months of treatment (...) two years later we were in court. They did not say hello to me, and it's very frustrating that you'd been side by side with the patient and his mother, and they suddenly don't greet you because you're saying that the kid is relatively well and thinking "we had a relationship, it was almost filial". But there are other interests that get through, and everything is forgotten, and makes it very unpleasant, very, very nasty".

In participants of Group 3, who have a large repertoire of experiences to share, there are countless topics. However there are two categories that stand out above the rest and are encompassed: conflicts with management and reflection on the death of a patient. Only one professional in Group 2 describes a discussion with the director of the health center for treating him unfairly. However, in Group 3, this issue can generate significant personal conflicts. In fact, discussions with administrators for managing the department or center may become so important that they are remembered after many years with great emotional charge. A doctor with extensive experience dealing with child abuse (an issue that could easily impact anyone) and who has dealt with very hostile situations, remembered an injustice done to her by her supervisor in her second year of work as her most negative experience of her career. She narrated a very vivid memory that still elicited clear emotional distress during the interview nearly twenty years later.

Extract 6. Woman, 19 years of experience in pediatrics.

"As a pediatric, second-year resident, I remember it was Christmas holiday and ... I was called by the director of the hospital in order to make me stay the 31^{s} overnight in care of all pediatric emergencies at the hospital without any supervision. So, it seemed to me so unfair... so much irresponsibility, especially at dinner time, that no one remembered me, that I was there without dinner, alone, without having ate. It was December 31st, I felt like... it is the most negative feelings I've ever had in the hospital."

On the other hand, the death of a patient is a very common theme with this group, which is often analyzed and narrated in depth. This is contrary to the narratives of the younger doctors who used the patient's death as a way to refer to other issues. The narratives of these professionals, who have undoubtedly witnessed the death of a patient on numerous occasions, acquire specific nuances. They often report the death of someone close, someone who has come to affect them

personally. There are also cases in which they found themselves incapable of being able to help someone. These events had sometimes occurred more than thirty years previously.

Despite the fact that the themes are considered very similar, differences in the narrative styles between men and woman can still be found. Men and women handle with these personal conflicts differently. Women were more focused on the suffering of their patients and on their inability to do more to help heal them. Men on the other hand, tended to focus more on their own personal struggle with feelings of guilt caused by having committed a mistake.

When comparing gender between extracts 7 and 8, a difference is observed in the number of times the patient is referred to. Women are more likely to focus their memories on the patient, while men are more focused on the self or their own actions.

Extract 7. Woman, 22 years of experience in family medicine.

"A man came with his wife in his arms, he came with his wife in arms because she had just had a child, and he said that the woman had fainted, right? The woman was breastfeeding and had fainted, then he came with his wife and we saw that the woman was dead, and of course, at the time, you pass her to the resuscitation and everything, but of course, she was dead, and we had to go to tell the man... that was very tough ".

Extract 8. Male, 25 years of experience in psychiatry.

"I was 25 ... I did not know much, but I more or less handled the situation well… except for one case of a patient who died of a heart attack that I wasn't able to diagnose in time (...) I held on for too long having second thoughts and eventually the man died. Probably the man would have died anyway if I had acted..., but I have that story in my head as something ... I didn't do well, and that had consequences on the lives of other people. I don't know how much of the responsibility I shared, but I of course made a mistake".

If we look at the emotions referred to, we can also see gender differences. After losing a patient they may express how hard it was to tell her husband that she passed away or that they had been unable to do anything, as in extract 7. This would be considered a communion theme. However, the remorse and guilt involved in the inability to perform a timely diagnosis or an

inability to do more for a patient as in extract 8 can also be referred to, what could be an example of an agentive narration of inability or lack of control.

Discussion and conclusions

In this study professionals have been interviewed from different medical and surgical specialties whose daily activities can vary greatly. In some of these specialties more cooperative work is required, such as those involving rehabilitation. In others, the relationship with the patient is less direct, and the work is more solitary in laboratory fields such as radiology or hematology. Pediatrics, in dealing with both children and their parents, involves different types of people. The relationship with patients differs depending on whether it is a medical and/or surgical specialty, such as ophthalmology and gynecology. All these characteristics result in differences in either the way the individuals appear in the narratives, in the actions that occur to them, and the manner in which they are referred to.

However, all specialties have common aspects. Medicine as both a university degree and a professional career has a very demanding acceptance criteria. All medical doctors physically share the different areas of the hospital and, in all cases, they are required to do a period of mandatory training activities as residents which are performed in public hospitals. In this training period they are also required to work in the emergency room. This is a period in which, in addition to living under stress and sleep deprivation, they are in need of general medical knowledge beyond their field of expertise, which they struggle with in their early years and of collaboration in multidisciplinary teams. In short, it is possible to affirm that all interviewees share certain social practices, because they share expectations, meanings, and spaces, and have been socialized in a series of particular techniques and a discursive genre.

From the data collected we can state that the particularly negative memories that have been recollected have not at all been random. Many themes and memories have presented many aspects in common. As we have exemplified, the inability to cure a patient and their death is a recurring theme. The first experiences in the emergency room are also very present in these professionals' memories, however, they are expressed differently depending on the degree of experience and gender.

The existence of narrative patterns in professionals' memories should be analyzed taking into account the years of professional career, since experience explains what social practices are or are not shared by doctors. In doctors with less experience, we have observed that they very often experience feelings of inadequacy, of not having been helped or appropriately supported by someone with greater experience, and feelings of "being lost" or not being able to help a patient in need. These conflicts result in feelings of incapacity or abandonment and especially shock. In the early years of work the so-called "shock of reality" occurs. Previous expectations of new employees are confronted with the newfound reality of their profession and organization, what it is expressed in time-pressured and impersonal narratives even in health science professions students (DeMatteo and Reeves, 2013). These authors also observed a shift in the ideas of young professionals from providing care to providing a service and from patient-client relationships to customer-consumer relationships.

As their professional experience increases, they leave behind idealizing relationships with peers and bosses, with whom they have had a problem of greater or lesser degree. In fact, not all narratives focus on what happens in the emergency room with patients. Medical doctors also consider other kinds of problems such as those from peers, superiors or patients including the consequences that may arise from complaints, lawsuits or the fear of these issues. Conflicts with

colleagues are mainly related to the lack of understanding of each other's roles and the lack of understanding of the scope of practice of other colleagues.

In Group 3, apart from referring many of the topics covered by Groups 1 and 2, there are events like the death of a patient or the conflict with a manager that acquire central importance. Rogers (2004) described how managers of multidisciplinary teams face difficult dilemmas in managing competing interests, diverse perspectives and interpersonal conflicts. Therefore, issues that in one way or another appear in narratives of younger professionals are referred to again from a very personal perspective, without referring to the responsibility of anyone but themselves in the death.

Following these and other examples we can consider that certain themes such as the death of a patient, the first experiences in the emergency room or participation in a difficult case, could be considered in the medical profession authentic master narratives (McAdams and McLean, 2013. In our case study, they could serve an important function, specifically for understanding a new professional culture, for strengthening emotional ties with coworkers, and for learning within the professional field. Medical doctors belong to a specific professional group that shares the same type of experiences and social practices. They could be use some Master Narratives as frameworks to guide their interpretations of specific events, which could also affect the way they would retrieve elements of episodic memories (Pasupathi; 2001). Therefore, we can confirm the hypothesis suggested in the end of the introduction.

Could we say that the structures that make up Master Narratives and have guided autobiographical memory from youth to professional maturity, are beginning to fade in Group 3? At the end of professional life, social practices change and there is a gradual disengagement of people from the expectations and goals that had previously governed their lives. By knowing that

the main function of memory, as of all cognitive processes, is the adaptation to the environment, in this case the social environment, this hypothesis is reasonable.

These narratives, as analyses have shown, are particularly specific. That is, the very moment in which the incident occurred is clearly recalled. This is usually more common in the narration of negative events rather than positive events (Conway and Pleydell-Pearce, 2000), since negative events break what is canonical, that which is expected in a given scenario. In addition, these are events that threaten their professional identities and job performance.

The analysis on the orientation towards the agency or communion reflects that men have more narratives linked to the agency, while more women develop narratives linked to communion. For example, we have observed that the very fact of the death of a patient, although it is referred to often by men and women, is narrated differently. Males are more focused on their own experience, the crisis suffered by questioning their own abilities or failure committed; while females focus their discourse on the suffering of the patients and their families, and the frustration of not being able to help.

The way in which men and women expressed their emotions was also different. While male doctors felt guilt by the death of a patient, female doctors tended to emphasize the complicity and empathy for the suffering of the patient's relatives. According to Grysman et al. (2017), some aspects of gender, such as emotional expression, are socialized at such an implicit pervasive level that they become part of an implicit gendered way of being in the world. But emotions are hardly an intrapersonal and private experience. The process of emotional sharing can yield multiple benefits, and social sharing partners play a decisive role in the regulation of emotional experience (Nils and Rimé, 2012). From an evolutionary point of view, the process of sharing autobiographical memories is dominated by the force of coherence in order to achieve a stable and

integrated self. Master narratives help us recall our experiences in the best way, so that we can face with identity challenges throughout our lives (Conway, 2005). Master narratives would work like “schemas” that lead our recalling process (Barlett, 1932).

According to McCormack, Gore, and Thomas (2006), to establish their repertoires of professional practice in the reality of their specific work young employees must be able to create their own meanings of professional discourses and the various contextual influences. In this way, they will be able to understand the occupational discourses appropriate for them and integrate them as part of their professional and personal identity. This is one of the main challenges of medical training and of the professional life in general. Therefore, to understand that the training process and becoming a professional are complex processes is one of the biggest challenges faced by every organization. This is especially true because of its reliance on multiple sources of learning, and the fact that it is different for men and women of every level of experience.

As possible limitations of this research, we consider that the data should be taken with caution because the type of sampling, with 24 professionals interviewed, could generate some subgroups too small to analyze the interaction between the three variables considered. Furthermore, the low incidences of some narratives could not be sufficient to conclude that the memories described are cultural narratives. So we believe more research must be done with this population in order to determine if similar themes are found in medical professionals of different experiences or backgrounds. In addition, another aspect that could be controlled in future research is the field of medical expertise. This is because some of the workers interviewed in the same profession, performed very different activities, such as pediatrics, hematology or anesthesiology. This observation leads us to believe that in the future, it might be interesting to replicate this

research within a specific professional group, such as surgeons, since other narrative patterns and gender differences may be observed among them.

The first and second goals of this study were to explore the most negative memories about medical practice, and how these memories are recalled. Through the narratives of the most negative professional events recurring themes have been observed, events such as requiring certain diagnostic tests or treatment, patients' complaints about their treatment, death of patients, or the tensions and conflicts arising from the relationship with other professionals in the hospital. In fact, we have considered that certain issues, due to their prevalence and the importance given to them, could be considered authentic Master Narratives of medical occupation.

With regard to the third and fourth questions presented in the introduction, we can say that the existence of themes and recurrent structures in the recall of doctors' experiences does not imply the absence of nuances. In fact, we have found remarkable differences in the autobiographical recall depending on the level of experience and gender of the participant. This is explicable due to gender being a fundamental, transversal factor of socialization and the degree of experience determines the social practices in which medical professionals participate. In particular, we have found a greater degree of the theme of communion in the memories of women, even though their memories refer to the same ideas as those of men.

Furthermore, it has become evident that at every level of professional experience the different events remembered as more negative are developed. As doctors gain experience, little by little they appropriate the discursive features of this professional group. While younger professionals highlight events that shatter their expectations with which they started to work, intermediate experienced practitioners refer to these issues as well as to others such as fear of error or stress in emergencies. Other issues such as conflicts with managers and reflection on the

responsibility for a patient are more characteristic of the narratives of highly experienced professionals.

Through interviews regarding the most negative memories of various medical professionals, from three levels of experience, we have observed common themes and patterns in their narratives that have led us to conclude that these could be considered master narratives. These narratives, in our opinion, can fulfill numerous functions, such as: 1) helping to maintain the emotional connection with fellow healthcare professionals; 2) to serve as a frame of reference and give meaning to the work they have developed and 3) to serve as guides for the development of one's own autobiographical professional memories and professional identity. These are, undoubtedly, some of the most important challenges that any young professional faces.

In our case, we have detected differences in these memories based on gender with the narratives of men more oriented to agency and those of women more oriented to communion related issues. We have also found interesting differences according to their experiences. For the youngest professionals, their most important challenge is to consolidate their own identity as good healthcare professionals. While those highly experienced may be able to afford to criticize aspects of their profession and even question their ability as professionals, considering that sometimes they are unable to help others.

For all these reasons, in our opinion, the study of labor autobiographical narratives could help us to identify other master narratives, or master narratives in other professional settings, which makes it a very promising research field. For example, it could allow us in the future to better understand the complex mechanisms of construction of professional identity, facilitate professional acculturation processes in different contexts such as healthcare, and even explore their use in the training of future professionals. Talking about and understanding these memories may

help them better understand the dynamics of work in a hospital setting and the possible sources of conflict, as well as the coping methods that other colleagues had discovered by sharing their worst moments as professionals.

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