Dyslexia and Medicine:

The experience and the impact of dyslexia on the education, training, and practice of doctors.

Volume 1 of 2

Submitted by

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I certify that all material in this thesis which is not my own work has been identified, and that no material has been previously submitted and approved for the award of a degree by this, or any other University.

(Signature): .....

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Abstract

Introduction: Dyslexia is the most common specific learning difficulty, affecting of about 6% of the population. In medicine, the numbers of learners disclosing a diagnosis of dyslexia is rising. Small-scale studies have begun to venture into the effects of dyslexia on the education of medical students, and doctors in foundation year training and beyond. There is a call for research to develop a more nuanced understanding of how dyslexia affects doctors during their training and practice.

Methodology: Using interpretative phenomenological analysis, this project aimed to develop a greater understanding of the ways in which dyslexia affects the training and practice of doctors. The data collection followed a three-phase approach, employing semi-structured interviews, a Self-Characterisation Sketch exercise, and Critical Incident Reflection audio-diaries.

Analysis: In-depth, idiographic analysis of anonymised case studies for 10 doctors in training across a variety of specialties, from England and Wales was undertaken. The detail of the analysis cannot be adequately captured in a short summary but the overarching themes identified in the data included: *Self*; *Belonging*; and *Coping*. Each theme is supported by subthemes: *good enough, chaos* and *power of the label*; *black sheep, conformity,* and *community*; and *difficulties and capabilities, agency and attribution,* and *strategies and risk*, respectively. Notable 'pearls' within the data included the notion of *partitioning*, and that of *brute failure*.

Discussion: The in-depth analysis of these doctors' experience of their dyslexia, with reference to their education, training and practice, provides a unique insight into an unstudied aspect of lived experience of doctors. The analysis of the data from these doctors offers a unique understanding of self-concept, attribution and learned helplessness. These findings bear significance for engaging with, and seeking help from the team and wider structures in medical education. Synthesis of this analysis with wider literature would suggest a role for self-compassion and individual counselling approaches in medical education.

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Abbreviations

Abbreviation	Definition
AoME	Academy of Medical Educators
AMBDA FE/HE	Associate Member of the British Dyslexia Association (Further Education / Higher Education): is a professional specialist status, indicating that I am qualified to assess and tutor learners, above the age of 16 years, with Specific Learning Difficulties.
ARCP	Annual Review of Competency Progression
BDA	British Dyslexia Association
BMA	British Medical Association
CCT	Certificate of Completion of Training: formal recognition of completion of an approved training programme within a particular medical or surgical discipline, enabling the certificate holder to work as a consultant or general practitioner in that discipline.
CIR	Critical Incident Reflection (reflective debrief using a prompt structured on the Critical Incident technique)
CIT	Critical Incident Technique (as developed by Flanagan, 1954)
CMT / CST / CT	Core Medical Training / Core Surgical Training / Core Training: this refers to a junior doctor in a training programme beyond foundation years, but prior to higher specialty training.
CPD	Continued / continuous professional development
CS	Clinical supervisor: a senior clinician who has responsibility for supervising a junior doctor's work, and elements of training, during a specific clinical rotation / placement (which can be from 4 months to a 1 year, depending on the specialty and level of training).
EA	Equality Act (2010)
ES	Educational supervisor: a senior clinician who has overall responsibility for supervising an element of [e.g. 1 year] or the entirety of [e.g. in GP training] of a junior doctor's training).
FE	Further Education
FP	Foundation Programme: the two-year rotational programme that doctors complete after graduating from medical school in the UK.

FY	Foundation Year (often seen as FY1 or FY2): denoting the specific year within the foundation programme.
GMC	General Medical Council: the UK's sole regulatory body that has the legal duty to issue, and police the licenses to practice for all UK practitioners. This body also maintains a register of all practitioners, and details the status of their license, as well as any restrictions on, or sanctions against them.
GCSE	General Certificate of Secondary Education (British)
GP	Commonly used abbreviated noun referring to both General Practitioner as an individual, and General Practice as a discipline
HE	Higher Education
ICF	The International Classification of Function, Disability and Health (WHO, 2001): a model to consider the interactive role of environmental, biological and social factors in impairment and disablement.
IDA	International Dyslexia Association (which was formerly known as The Orton Society)
Int-	Interview- (followed by number, 1 or 2, to indicate initial or interim nature of the contact within the project programme)
IPA	Interpretative Phenomenological Analysis
MRCGP / MRCP / MRCS / MRCPCH / MFPH	Membership of the Royal College of: General Practitioners / Physicians / Surgeons / Paediatrics and Child Health / Membership of the Faculty of Public Health. These are post-graduate examinations that form part of the process of training and specialising in disciplines within the medical profession.
RCP	Royal College of Physicians
SCS	Self-Characterisation Sketch
SpLD	Specific Learning Difficulties
ST	Speciality Trainee: a junior doctor who has completed foundation, and often 'core' training, to enter a programme that qualifies them in a certain speciality, such as paediatrics, or orthopaedic surgery.
UKFPO	United Kingdom Foundation Programme Office: the office that administers Foundation Year training applications for junior doctors in the UK.
WHO	World Health Organisation

Part 1: Background & introduction

In this part of the thesis, I will provide a background to the work undertaken in this project, by means of an introduction to myself as the researcher, the field as the subject of research, and the approach taken to the research.

This section contains:

Chapter 1: Introduction

Chapter 2: Literature Review

Chapter 3: Methodology

Chapter 1: Introduction

It is traditional in human sciences, to begin a doctoral thesis with a personal introduction. The importance, and significance, of this will be explored in more detail in Chapter 3. In this chapter, I will introduce myself, and answer the key questions of 'why me, why this project, and why now?' I will then set the context for my doctoral research project, by describing the unique characteristics of the field of medical education. I will also briefly introduce the subject of dyslexia, before outlining the rest of the thesis.

1.1. An introduction to myself

When considering how to craft a personal introduction, I reflect on how I see myself. First and foremost, I would usually say that I am a doctor, and a trainee in general practice (GP). I also see myself as a son, a brother – several times over, and many other things besides. An autobiographical narrative could pursue any one of these lines of perspective, but to remain relevant to this project, I will recount experiences that influenced my journey to, and through, this doctorate.

Reading has never been pleasurable. Numbers and times tables have been slippery beasts for as long as I can remember. I have always felt the need to ask lots of questions to join my patchwork quilt of understanding, often for concepts that my peers appeared to grasp with speed and ease. I was first diagnosed with dyslexia just after sitting my GCSEs (General Certificate of Secondary Education exams) at the age of 16 years. My mother took me to the Dyslexia Institute, as it was known then, in a nearby city. I sat with an educational psychologist for several hours and completed a battery of psychometric assessments. The result of this was an extensive report that appeared to explain a great many of the difficulties that I, and by extension my parents and teachers, had faced during my education to that point.

I went through sixth form ('A-level' study) pursuing my ambition to go into medicine, although I stumbled a few times along the way, failing and having to re-sit several

exams. Once in medical school the pace quickened and for the first two years it felt like I might not ever quite keep up. However, I adapted and coped (at times, only just).

The pattern of difficulties I had experienced in my earlier education persisted. This was particularly problematic with the sheer volume of reading required, and the speed with which complex concepts were covered during taught sessions. In small group teaching sessions I was often the one asking questions, instigating sighs of exasperation around the room. Later when moving into clinical placement things fell into place a little more readily. I was often caught out when asked to read notes aloud or report radiographs, but working with patients made more sense and things felt a little easier.

After my second year at medical school I took a year out to 'intercalate'. Which is where medical students are, conditionally, given the opportunity to complete either a bachelors or masters degree in an aligned subject. That year, I studied neuroscience, and worked in a laboratory alongside someone who was very interested in education and who taught at a local FE college. Through her, I became involved with that college, and eventually got a job teaching biology in adult evening classes. Several of these adult learners encountered difficulties that I recognised as being similar to mine, but they attributed themselves as being 'slow' or 'not good enough in the first place'. It was here that my interest in learner support began.

During the remainder of my time at medical school I was elected as a student representative onto various committees. This brought me into contact with many people and processes involved with curriculum development, assessment, and welfare. It was because of these opportunities, combined with my experience, that I began to look at learning difficulties through a new lens. I became curious and wanted to understand more. I read about dyslexia and sought to understand what caused Specific Learning Difficulties (SpLD) and how they were diagnosed, but was often left feeling that I understood little more than I had when I began. After completing my medical degree, I undertook training in how to assess for and support learners with dyslexia with the Open University. Whilst I developed a good understanding of the literature from the worlds of cognitive psychology and psycholinguistics, what I learned didn't seem to match up with what I experienced or felt. In short, there was a disconnect between what I thought I was getting to 'know' through study of authoritative sources

of information, and what I thought I understood from my experience as a teacher, and learner, with dyslexia.

This brief story represents the origins for the interest in the focus of this research, and begins to demonstrate how the subject of dyslexia is intertwined with my sense of identity. It is this that makes a reflexive account of my past so vital, to be transparent with myself as the researcher, the audience, and participants in my research. This begins to set out the philosophical position from which I operate, and corresponds with my belief that no research can be truly neutral or dispassionate. The research in this project has been wholly influenced by my experiences, as it would be unlikely that I would have embarked upon this particular journey had it not been for the interests borne out of them. Therefore, to claim anything otherwise - to subscribe to a sanitised, objectivist view of research – could be construed as dishonest, and would feel inauthentic. Moreover, it would place the process of analysis and interpretation of data at risk from unacknowledged biases. The experiences that have brought me on this journey, however, also serve to demonstrate the legitimacy with which I access the field, and the credibility of my claims to leadership of thought, and contribution to knowledge. This will be critiqued and explored in greater detail in the methodology chapter (chapter 3).

1.2. The field

In order to locate the context of this project I will introduce the fields of medical practice, medical education, and dyslexia in adults. A more complete exploration of dyslexia, and what research tells us about how it affects adults, will be presented in the literature review in the next chapter. For now, however, a brief primer accompanies my personal introduction.

1.2.1. Medical education

Typically medical education in the United Kingdom (UK) begins with a university programme taking 5 years, resulting in a bachelors of medicine and surgery (MBChB or equivalent). Once this has been attained, newly qualified doctors usually enter a ‘Foundation Programme’, which comprises of two years of rotations (typically 4 months

each) in general specialties[1] designed to afford a broad experience from which they can inform their future practice and career decisions. During the second foundation year (termed 'FY2'), trainees are expected to apply to further training opportunities, which broadly comprise of 'core training' options in medicine or surgery (where you undertake 2 years of further general rotations, before specialising in a particular branch of medicine or surgery), or a 'run-though' training programme. Such programmes are designed to train in that particular specialty from the outset, and they exist for certain disciplines, such as paediatrics and general practice (British Medical Association (BMA), 2012).

During training, a doctor will be expected to maintain an electronic portfolio of evidence of their learning and practice. This will usually consist of entries into a reflective diary, as well as records of conversations with seniors, and feedback from observed procedures. These portfolios are used in conjunction with post-graduate exams, and other forms of assessment, to determine if a trainee is demonstrating sufficient progress to remain a doctor and continue their training. A trainee will typically have an Educational Supervisor (ES) overseeing a component, or all, of their training and a Clinical Supervisor (CS) who supervises work and certain aspects of training in a particular clinical environment (National Association of Clinical Tutors (NACT) UK, 2013). There is usually a requirement to pass a battery of assessments aligned to the specialty in which junior doctors are training. These assessments contribute towards the qualification for membership of the Royal College for that specialty. Membership is hierarchical, with fellowship usually denoting an advanced level, corresponding with a significant contribution to the field or profession. For some specialties, such as GP, this membership is tied to the requirements of completing a recognised training programme. For other specialties, trainees must progress from membership to fellowship in order to qualify to be a consultant (BMA, 2012).

A trainee's progress in formal assessments, as well as judgements based on workplace discussions with and evaluations from colleagues, combined with evidence on the electronic portfolio are usually judged on an annual basis, by a panel of educators and

[1] This may seem like an oxymoron, but there are areas of medicine that are more 'general' than others, each discipline area being marked out as a 'specialty'. For example, General Practice is itself seen as a specialty.

experts. This process is known as the Annual Review of Competency Progression (ARCP). Being judged as satisfactory in this process is necessary to remain employed as a trainee, and to be allowed to continue along your training pathway. The evidence that culminates from successive ARCP processes, Royal College exams, and the portfolio are ultimately what are used to determine if a doctor has demonstrated the progress and competence required to qualify in that specialty, securing a certificate of completion of specialty training (CCT). This certification process qualifies a doctor to have their status with the General Medical Council (GMC) altered, whereby they may be entered onto the medical register as a GP or specialist in another field (BMA, 2012). The one notable difference to the above process is found in public health. Traditionally, training in public health was open to those who are medically qualified, but this was broadened out to other professionals suitably qualified in a related healthcare field in 1997 (Evans & Dowling, 2002). Once on a training programme, the experience gained and requirements of these professionals would be equivalent for those from medical and non-medical backgrounds (*ibid.*)

After completion of training, there are on-going requirements for doctors to engage with continued professional development (CPD), and keep up-to-date with contemporary medical evidence and practice. A national process of revalidation evaluates a clinician's portfolio evidence of CPD and other activities (such as quality improvement, audit and clinical governance). This process is intended to ensure the regulatory body (General Medical Council (GMC) in the UK) issues licenses to, or maintains them for, practitioners that meet and maintain professional standards and are therefore deemed 'fit to practice' (GMC, 2013). Therefore, the field of medical education is not restricted to the formal setting of Higher Education (HE), but is concerned with the entire professional lifespan in medicine[2]. The discipline of medical education is broad, and primarily aimed at the study and promotion of high-quality learning and assessment within the profession, to ultimately ensure that patients receive the best possible care from competent clinicians, which is reflected in the professional standards of the Academy of Medical Educators (AoME, 2014).

[2] In this context, I refer to 'medicine' to encompass all specialties. This clarification is important, as often the term medicine is used to differentiate from surgical disciplines.

1.2.2. The daily job of the 'junior doctor'

In order to provide context for this project, and background to some of the literature and participant narratives that will be explored in later sections of this thesis, it is necessary to briefly outline the nature of the work undertaken by trainees, or 'junior doctors'.

All doctors in training are considered 'junior', regardless of chronological age, until they complete training and become a consultant or general practitioner (GP) via the routes briefly outlined above (for a more detailed overview of postgraduate medical training, see: BMA, 2012). The daily life of a junior doctor would vary greatly according to the day and time, of the week, the specialty and hospital they work in, and their stage of training. What I present here is a very broad overview, drawing on experiences of a personal, and shared nature within the profession. It is not intended to be comprehensive.

Turning up on the ward on your first day as a doctor can be daunting. New faces, new terminology. You have been primed with medical knowledge, and a basic set of skills, but need to learn the variants peculiar to your new place of work. You may work within a multi-professional inter-disciplinary team, with some colleagues being more experienced than you. Your work schedule may have you working 'nine to five', Monday to Friday, or it may have you working from eight in the morning, through to 10 in the evening. You may rotate through night shifts, covering wards, patients, and specialties you are unfamiliar with. You may be tasked with completing jobs that the daytime staff were unable to do during their pressured days. It is daunting. You are simultaneously trying to do your best for your patients, and make a good impression on those around you. This is especially the case concerning your supervisor, and the senior nursing staff. To progress successfully through your training, it becomes clear very early on that you need to make friends of your colleagues, not enemies. First impressions count.

An average daytime shift on a medical ward may start with a ward-round with a consultant. You see the patients one by one, updating the consultant on the progress based on investigations you have undertaken or arranged. You highlight problems and areas of concern. You get corrected for things you have missed, misunderstood, or got wrong. Sometimes this is done unkindly, and sometimes it is done in a genuinely

constructive way. This ward-round may take several hours. When it is over, you may be thirsty, hungry, tired, or need to answer a call of nature. You don't always have time. There is a vast list of jobs that has been generated by the ward-round. 'Mrs Bloggs needs an ultrasound of her abdomen today'. You already know there is a 4-day wait for an inpatient ultrasound. 'Mr Smith needs intravenous antibiotics'. You know, but between 4 different doctors, nobody could get venous access, because he had been in hospital for so long, all of his superficial veins had thrombosed (clotted, gone hard and tender). The team who go around the hospital siting lines into other, deeper, veins has been too busy to help so far, but you resign yourself to trying again.

Before you know it, it is approaching 5 o'clock. When your schedule tells you that you are supposed to finish and go home. However, there is a pile of discharge letters to type up. They should have been done in the morning, so the patients' discharge medication could have been finished. This is what the hospital management say. But who, then, would have done the ward-round and all the other jobs? You sit and start working at the pile of letters. A nurse comes to you, timidly, informing you that the elderly lady with dementia has pulled out her venous cannula. Again. She is on intravenous fluids and insulin, so does need to have another one sited. Except it isn't straightforward. The patient does not want one, she becomes distressed and combative. It was determined that she didn't have capacity, so you have to work in her best interests…you are told that this is in her best interests, yet something feels wrong inside. As gently as you can manage, you try over and over to site a new cannula. You get one in on your third attempt, and return to your paperwork. Eight o'clock passes and you still have letters to write. Your next few days will be long too. Knowing that there will forever be a pile of administrative work to complete, you go home, so that you can come back, fresh, the next day for more.

That weekend, your night-shifts start. You are providing cover for all the medical wards in the hospital. Sixteen wards, with an average of thirty patients. Each ward will be staffed with nurses, some of whom will be very experienced, some much less so. You are supported by advanced nurse practitioners, who help with some tasks, and a registrar (a senior junior doctor). You go to the room where you take handover from the day-team. This is a meeting where the doctors who were looking after patients across the hospital during the daytime pass on vital information about outstanding jobs,

or on-going concerns relating to patient care, so that you are able to continue the work overnight. In such a meeting, it would not be unusual for the crash bleep to go off, alerting you to a cardiac arrest on one of the wards. You run and work on that poor patient as much as you can. You stop. There was no hope of success. Their family had been called by the ward staff, and they arrive. You gesture for them to take a seat in the office, so you can have 'the talk', just as your crash bleep goes off again. Another arrest on a different ward. Success this time. You go back to the relatives, nearly an hour later, to talk to them. They understand. The patient you just resuscitated 'crashed' again. Again, you run and the team converges on this one person, working for another hour. His heart re-starts, and we stabilise him. Now you can turn to some of the tasks the day-team couldn't get to. In amongst that, you get called to see people on various wards who have become unexpectedly unwell, each one requiring about an hour's worth of work in assessing them, taking blood for the necessary tests, siting intravenous lines and starting treatment.

When the daytime staff arrives, you are exhausted and crave your bed. First, however, you must handover, in a meeting that can sometimes take an hour or longer. You go home and prepare to do it all again, faces and names whirring through your head, interrupting your sleep.

Of course, there are moments where the job seems to run at a more reasonable pace, where workload is manageable, and the team supportive. My overwhelming memory of my earlier years, however, is reminiscent of the caricature above. Chaos, demand, and frenzy. Stress is understandably prevalent amount the medical profession, and this is associated with greater rates of burnout and mental illness, compared to the general population (Brooks, Gerada & Chalder, 2011). Sadly, this corresponds with a higher rate of suicide (Mata et al., 2015) in a group of people who are believed to experience, or institute, unique barriers to accessing support (Grant et al., 2013; Brooks, Gerada & Chalder, 2011).

1.2.3. Dyslexia

Dyslexia is the most prevalent Specific Learning Difficulty (SpLD) (British Dyslexia Association (BDA, 2007), with as many as 4.1% students declaring a diagnosis of dyslexia on entry to medical school in 2009 (Higher Education Statistics Agency, 2012).

This is proportionally higher than the rate of disclosure among students entering other healthcare disciplines, such as nursing (*ibid.*). The condition is characterised by impaired phonological skills and difficulties with literacy, organisation and working memory (Moody, 2010; Reid, 2009; BDA, 2017). However, it is worth noting that a full consensus on the definition of dyslexia does not yet exist (Rice & Brooks, 2004). There is also conflict within the scientific community regarding the true aetiology of the SpLD, although research largely suggests that a verbal skills deficit is probably central to the problems associated with the condition (Snowling, 2006; Rice & Brooks, 2004). Frith (1999) proposes a helpfully holistic view of dyslexia, accounting for biological, cognitive and behavioural factors, and their relationship to environment in giving rise to the externally observed symptoms, presenting as dyslexic behaviour (see figure 1.1).

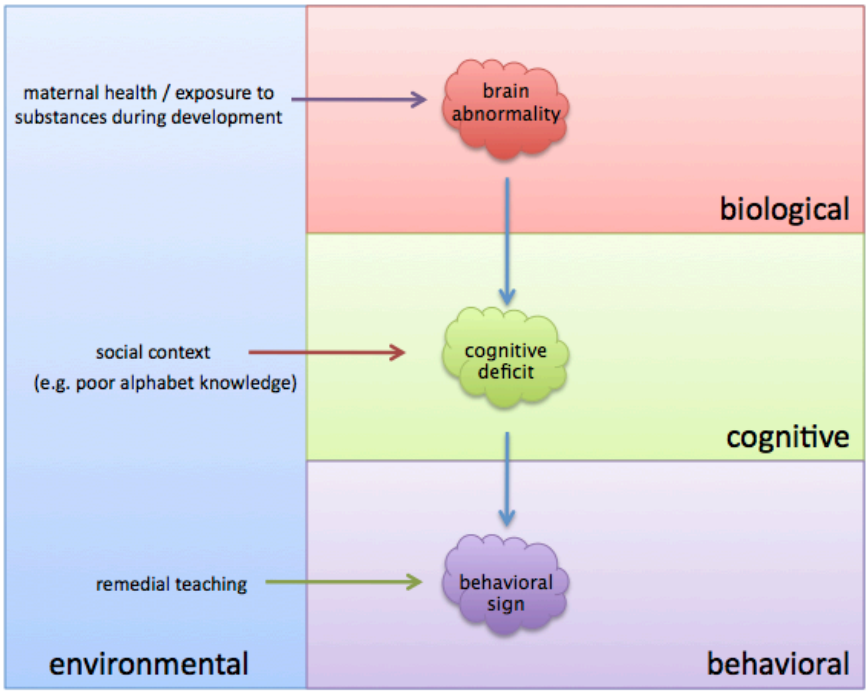


Figure 1.1: Uta Frith's multi-factorial model of understanding and defining dyslexia (from Frith, 1999).

Frith's model accounts for how non-dyslexic learners may exhibit dyslexic traits in their work, for example through lack of orthographic awareness, due to inadequate awareness or instruction, manifesting at the cognitive level. Likewise, the model also explains how those with dyslexia can mask, or 'pass' (Goffman, 1968), by employing compensatory strategies operating at the behavioural level (Frith, 1999). The view proposed by Frith is reflected in elements of the World Health Organisation's (WHO) International Classification of Functioning, Disability and Health (ICF) (WHO, 2001). This classification system considers the contextual factors of environment and personality,

their interaction with the functions of the body and the health condition to impact on activity and participation (figure 1.2). This corresponds to Frith's environmental, cognitive, biological (functions of body and health condition) and behavioural (activity and participation) factors respectively.

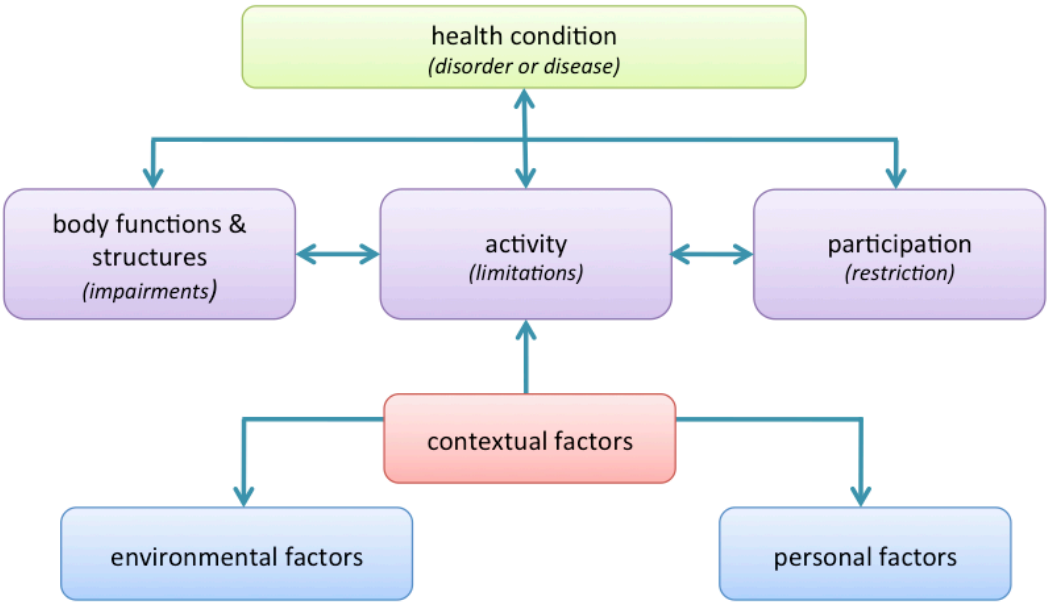


Figure 1.2: The international classification of functioning, disability and health (WHO, 2001)

The majority of definitions of dyslexia locate the difficulty *within* the learner. Riddick (2001) shifts the focus onto the environmental and social factors, explaining how vagaries of the English language exacerbate literacy difficulties experienced by those with dyslexia. Compared to other languages based on the Latin alphabet, English is the least phonetically transparent and has many irregularities, with many more homographemes (e.g. lead and *lead*) and homophonemes (e.g. there and their). This is reflected in the disproportionate difficulties experienced by dyslexic learners working with the English language (as native and non-native speakers) compared with those working with German, for example (Landerl et al., 1997). Riddick (2001) draws upon the example of Turkey, which underwent a reformation of the Turkish language in the 1930s (Lewis, 2002), to highlight how some societies can consciously re-construct their orthography so as to avoid the difficulties like those that plague the English language. From this perspective, it would appear that it is society's preoccupation with using fluency in written communication and success in following obscure orthographic

traditions as a marker of general abilities that creates the social element of the disability, and that constructs the barriers that highlight the behavioural emergence of dyslexia.

1.2.4. A note on disability in the context of SpLD

In discussing dyslexia, I have touched on the ICF and referred to social conventions that may be disabling. At this point, it is important to acknowledge that dyslexia may, or may not, be considered a disability. In my professional experience, learners with dyslexia either embrace the notion of dyslexia being a disability, or totally reject it. Considering how disability is defined in UK law, it is possible to see that SpLD may be considered a disability under certain conditions (box 1.1).

Box 1.1: Disability, as defined under the Equality Act (2010)

In the Act, a person has a disability if:

- they have a physical or mental impairment
- the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities

For the purposes of the Act, these words have the following meanings:

- 'substantial' means more than minor or trivial
- 'long-term' means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions)
- 'normal day-to-day activities' include everyday things like eating, washing, walking and going shopping

From a brief review of this definition, it is possible to see that the wording of this piece of legislation is open to subjective interpretation, even in light of the qualifying statements about 'substantial' and 'long term'. There are normative frames of reference within this definition that can both aid, and confound, interpretation. For example, if a learner's dyslexia was to impact on day-to-day activities, such as reading commonly encountered instructions (e.g. safety warnings) or signage, their impairment may be considered a disability in the legal sense. A learner who has dyslexia, but mostly notices their difficulties when trying to keep pace with reading medical textbooks, for example, may not be considered to have a disability (again, in the legal sense). This is

because it would not be considered a 'normal' day-to-day activity. A more nuanced discussion of disability and labelling with regards to SpLD is presented in Shrewsbury (2015).

When discussing disability, it is important to acknowledge the complexity of issues of labelling and disablement. There is no consensus on 'correct' terminology (Rix, 2006). However, where I do refer to learners with dyslexia as having a disability, I have opted to use *doctor/learner with disabilities*, following the Person First convention: placing the inherent value of the individual, before the disability (Shakespeare, 2006). In doing so, however, I do not deny the factors implied by the social model of disability, that positions disablement as a process that is imposed upon individuals by societal mores (Oliver, 1990; Thomas, 2004).

1.2.5. Interpretive focus on experience

In briefly introducing dyslexia, I have alluded to cognitive and biomedical models of deficit and difficulty. Indeed, the cognitive and psycholinguistic paradigms dominate the authoritative literature in the field (Snowling, 2006; Shaywitz et al., 2006; Goswami, 2008; Rice & Brookes, 2004). Correspondingly, the literature that explores, explains and contributes to how dyslexia is construed focuses on observable behaviours, and measurable parameters – predominantly related to literacy (Rice & Brookes, 2004). This limits the view of what dyslexia may mean to individuals who identify as being dyslexic, and how their dyslexia may affect them. Qualitative researchers have begun to explore the nuanced experience that certain groups of people have of their dyslexia, which reveals difficulties with aspects of life, and learning that are not captured in the accounts dominating the psycholinguistic or cognitive paradigm (Gwernan-Jones, 2010; Riddick, 2010; Pollack, 2002; Edwards, 1994). The hegemony of different types of research, and of different literature outputs, is reflected in the subsequent influence and power that the corresponding discourse has. In the medical world, this is reflected in the 'hierarchy of evidence', which has historically prized randomised controlled trials or meta-analyses as the epitome of empirical evidence (Greenhalgh, 2014). Accordingly, academically privileged work focused on cognitive aspects of dyslexia (restricted to the parameters that are measurable, such as reading speed) informs the way dyslexia is defined by a discourse of cognition and measurement. Reducing the phenomenon of dyslexia to phonological processing or literacy difficulties fails to capture the wider,

more nuanced, implications that this has for an individual's life. The ICF introduces environmental and social domains (WHO, 2001), which is also partially considered in Frith's model (1999). This adds perspective to a deficit-oriented view of dyslexia, but again falls short of conveying the essence of the way in which dyslexia is actually experienced by learners. I would argue that developing an understanding of this experiential essence is crucial in order to be better equipped to support learners with dyslexia in clinical training and work. The project reported in this thesis is an attempt at beginning to meet this need.

1.3. A personal reflection on diagnosis and labelling

The process of diagnosing a SpLD, and labelling someone as having dyslexia or being dyslexic, has been reported by some authors as far from neutral (Ho, 2004; Lauchlan & Boyle, 2007; Riddick, 2000). There are many facets of these processes that are relevant to this thesis, and will therefore be explored in more detail in a review of the literature in chapter 2. However, whilst my initial diagnosis was made nearly 15 years ago, I recently went through a re-assessment that provided me with a fresher insight into some of the considerations that the literature touches on. This re-assessment was necessitated by a requirement of diagnostic reports being no older than 5 years in order to qualify for reasonable adjustments in postgraduate medical assessments. Therefore, in acknowledgement of the reflexive nature of this chapter, I will present a brief reflection of the process of re-assessment, and a reflexive discussion of issues arising from it. Of note, this re-assessment was mandated in order to qualify for reasonable adjustments in my postgraduate exams (which form an essential part of my training). Because I have 'specialist teacher' status ('AMBDA FE/HE'), and am able to assess for SpLD, my assessment had to be conducted by an educational psychologist. This was so that different assessment tools could be used, so my familiarity with psychometric tests (as an assessor) wouldn't affect my performance in them (as an assessee). In presenting my reflection, I will follow narrative convention to avoid editing.

The very idea of going for a re-assessment was laden with anticipation:

I approached my assessment with some trepidation. I have lived with my learning difficulties for my whole life- but only got identified as having dyslexia when I was 16. Prior to this, many of my difficulties were attributed to being 'disruptive' or 'lazy' for asking too many questions, or not keeping up. This, of course, led to a significantly troubled educational journey, somewhat clouded by turbulent events in my family life.

Although I recognise that I am able to function, work and, indeed, achieve to a relatively high level- I have always identified as having difficulties and being different. Having the label of 'dyslexia' has been a helpful way of incorporating this in my life, and has also helped me accept my struggles as caused by something out of my control- somehow absolving me of responsibility and 'fault' whilst simultaneously recognising the need to subsequently work harder to compensate for these difficulties.

The prospect of being re-assessed, and having something that has become so personal be interrogated by an absolute stranger, was rather daunting. What if they came to an alternative conclusion, and took away my diagnosis? What if they denied the legitimacy of my lifelong struggles, however externally 'trivial' or 'minor' they may appear?

This touches on issues relating to a differential in power between the assessee, and assessor, as well as the palpable threat to a sense of identity and control. The reflection then turns to examine the psychologist undertaking the assessment, his characteristics, and interaction with my history and evidence:

At the beginning of the assessment, the charismatic psychologist introduced himself and took a partial history of my educational journey and how I had come to be diagnosed with dyslexia. He reviewed my previous assessment and considered my achievements to date. He initially picked fault with my initial assessment for subscribing to the 'discrepancy model' of diagnosing specific learning difficulties, which it did indeed do, at least in part. He also commented that, as I was studying for a doctorate in education and was already a doctor- my achievements would put me in the 'top 2% of the country' (I might have

remembered the percentage wrong!) and that I clearly didn't have any difficulties with learning.

This excerpt recalls a potential effort, on the part of the psychologist, to discredit elements of the original diagnosis and assert his expertise. However, it may also represent an unconscious attempt, on my part, to undermine the assessment through negative recollection. The mention of the discrepancy model is interesting, as it represents the professional unease with a model that has, itself, been largely rejected by the academic community (e.g. Stanovich, 2005). However, the normative reference to being in the 'top 2% of the county' suggests a pervasive subscription to such a model that conflicts with his previously expressed stance.

My reflections on the actual process of assessment highlight some other important considerations about the way in which dyslexia is assessed, especially in adults:

A clear difficulty with working memory and auditory processing was identified. However, as I read all of the (un-timed) non-words without error, and as I read the passages from the assessment booklet without significant difficulty, and as my spelling was at least average, the psychologist determined that there was no evidence of a literacy difficulty that would support a diagnosis of dyslexia.

I remember thinking to myself at the time "of course I can read properly, and spell these simple words...I am now 27 and have been learning and working in environments that have helped me get better at that, I had special lessons at school to help with that, and have little rhymes and rules to stop me getting things quite so wrong anymore...". However, I didn't challenge him. Instead, I colluded, occupying the role of the 'helpless patient'...and agreed with 'yes sir, no sir...' as if I had no thought of my own on the matter.

I was shocked. I was hurt. What did this mean and what did this make me? Although it sounds silly, or trivial if you haven't been in these sorts of positions before- but this really brought everything all back. Flash-back to times at school when I was chastised for asking questions, or being secluded- copying from grammar textbooks for being too slow. Was all of this now because I was, in fact, disruptive, naughty and stupid? Did this mean that difficulties at home were because of some fault of my own?

My anxieties had been confirmed, and this resulted in uncertainty and feelings expressed as pain and shock. Issues relating to basing a diagnosis on an assessment of literacy skills (e.g. reading), rather than cognitive components (e.g. phonological processing) will be explored in more detail in the next chapter. Reading this now, however, I am struck by how I felt at the time: specifically with reference to the 'flash-back'. Such sentiments appear to correlate with themes of trauma arising from the literature, which will be explored in the next chapter.

The impact that this process had on me is illustrated in further reflection, where I attempt to reconcile the outcome of the assessment with my own professional knowledge. In doing so, there is another attempt to devalue the process and result, possibly in an attempt to retain some sense of identity:

> *It took quite some time to calm down and reflect on this with the benefit of the awareness I have gained from my own work and training over the years. I could systematically pick fault with the whole process- noting how it only partially meets the requirements as laid out in the DfE SASC* [Department for Education SpLD Assessment Standards Committee, 2016] *guidelines. How the professional bodies regulating teacher-assessors would not consider it sufficient to make, let alone 'un-do' a diagnosis. However, this is not helpful. What I need to do is move on with the information gained and the lessons learned from the process. The assessment highlighted my difficulties with working memory and auditory processing. This is good, this is information I can do something with and about. Whether the process annuls my identity is doubtful. I still identify as having dyslexia, and will continue to do so. I know that the pattern of my on-going difficulties could be considered 'classical'. I know that such profiles of difficulty can be displayed by people regardless of their abilities and successes in other domains, and irrespective of academic qualifications attained(!).*
>
> *Perhaps the most important thing this taught me, though, was how significant an impact labelling can have on a person. How adding, removing or toying with a label or diagnosis can have profound consequences, and that the process is not inert. The same would apply for labels of other kinds, and diagnoses of other another nature.*

It is perhaps a reflection of my background in general practice (GP), as well as education, that my thoughts turn towards what can be learned from the experience. The integration of professional knowledge into reflective practice is not uncommon in medicine (Sandars, 2009). Indeed, it is actively encouraged (*ibid.*). In doing so here, I benchmark my experience with that expected of the professional standards that govern the practice of SpLD assessments, and assert my own professional opinion in justifying my retained sense of identity.

This reflection has touched on a number of contentious areas that require further exploration. In presenting it here, I have resisted analytical interpretation. However, the salience of my experience, and this reflection, will be borne out in later sections of my thesis, as I explore: researcher authenticity and reflexivity in chapter 3; the analysis of data presented in chapter 4 onwards; and the discussion, which will assimilate the analysis, the literature, and my interpretation in chapter 16.

1.4. Outline of the thesis

This preliminary chapter has presented a focused account of myself, and what brought me to doing this project. I have outlined the context of medical education, and briefly introduced the topic of dyslexia in adults. The personal introduction and reflective account are an important declaration of the factors that have influenced my interest and understanding in the field. The relevance of this form of declaration, and the contents of my reflection, will become clear as the remainder of this thesis unfolds.

This first chapter raises further questions about what dyslexia actually is, how it is diagnosed, and how it affects adult learners. These questions, and more besides, will be systematically explored and addressed in the next chapter: the literature review. Following from this, chapter three will outline the methodology that has underpinned this project: interpretative phenomenological analysis (IPA). This section will include a statement outlining and justifying my philosophical position, as well as a detailed explanation of the theoretical framework on which the investigation and analysis is based. Following from methodology, I will present an extensive analysis of the results of my inquiry in chapters 4 onwards. This will be complemented by chapter 16, which will discuss the findings of the analysis in the context of existing literature and theory.

This final chapter will synthesise key arguments from the project, and clarify the unique contributions to knowledge that characterise a doctoral-level piece of work.

Chapter 2: Literature Review

In the second chapter of my thesis, I will present a review of the literature that explores the experiences of adults with dyslexia. This will draw on the literature pertaining to ways of understanding dyslexia, from the experience of diagnosis, to the discourse that those with the condition draw on when discussing their experiences. I will then explore the impact of dyslexia on the daily lives and education of adults, as well as the impact it may have on identity formation. Finally, I will present a review of the literature specific to dyslexia in medical education, constructing a synthesis of current literature on experience, evidence, policy, and practice.

2.1. What is dyslexia?

Dyslexia is commonly understood to be a type of learning difficulty associated with the development of literacy-related skills (Rice & Brooks, 2004). In this chapter I will explore the literature in order to represent a more detailed and nuanced understanding of dyslexia. Although more general concepts will be discussed, the specific domains of adult and medical education, and medical practice will contextualise the exploration of the literature. In turn, this will outline the specific context of, and define the niche for, the doctoral research I report in this thesis.

2.1.1 A brief history of dyslexia

The term *dyslexia* was first used in the context of a 'special kind of word blindness' in the late nineteenth century by German ophthalmologist Rudolf Berlin (1887; Wagner, 1973). Prior to Berlin's description, Kussmaul, a German neurologist, had coined the term 'word blindness' in a description of unexpected difficulties that adults had with reading in 1878 (Miles & Miles, 1990). It is the graphic term 'word blindness' that captured the attention of other professionals, and was later used in descriptions of other cases where children with what was considered 'average intelligence',

experienced profound difficulties with reading and writing. Notably, a case study of a 14-year-old boy called 'Percy F' was reported in the *British Medical Journal* by a GP (Morgan, 1896). Percy knew 'all his letters, and [could] write them and read them.' However, when 'writing from dictation, he [came] to grief over any but the simplest words' (*ibid.*: p1378). In his report, Morgan described a pattern of letter reversals, and profound spelling errors from dictated test-words (*ibid.*). Hinshelwood, an ophthalmologist who researched the effects of brain injuries and abnormalities on literacy skills, also published a series of articles around the same time as Morgan, differentiating a *congenital* form of 'word blindness' from that caused or acquired through injury (Hinshelwood, 1917). Hinshelwood's (*ibid.*) observations mirrored Morgan's (1896) but went on to propose a defect in the parts of the brain concerned with visual processing and memory.

Later in the Twentieth century, American neuropathologist Samuel Orton was inspired to study the phenomenon of 'word blindness' in children identified by their schoolteachers as 'dull, subnormal' or 'retarded' (Orton, 1925: p581). After his death, Orton's wife set up the Orton Society, now the International Dyslexia Association (IDA), to continue his work into investigating the cause of, and remediation for, children with reading difficulties (Orton, 1937; IDA, 2017).

Thomas and Elaine Miles (1990) observe that the dominance of visuo-spatial-centric language in the earlier descriptions of dyslexia exerted an influence on how the term was understood by the scientific community and wider society, and how further investigation into the field was organised. Research into dyslexia has subsequently been shaped by disciplinary focus: education, cognitive psychology, neuropsychology, and the biomedical. It is therefore unsurprising that the diverse literature around dyslexia often correspondingly focuses on development, performance in standardised psychometric tests, structure and function of the brain, and genetic or cellular causes of reading difficulties (Rice & Brookes, 2004). These generate perspectives that are necessarily[3] exclusive of more holistic and complex notions of what dyslexia may constitute to the learner, which presents a challenge when reconciling and synthesising

[3] Necessary, by virtue of the focussed way in which scientific inquiry is conducted in these paradigms.

the information that each perspective brings to the understanding of the phenomenon of dyslexia (Rice & Brooks, 2004; Miles & Miles, 1990). Scholars in more recent years have been more aware of the nuanced way in which the environment and learning contribute to literacy development, and therefore dyslexia (Frith, 1999; Riddick, 2001, 2010; Rice & Brooks, 2004). However, learners with dyslexia often report non-literacy related difficulties too, which are not accounted for in the academic literature (Riddick, 2010; Edwards, 1994; BDA, 2017). This is reflected in the diversity of definitions that are used for dyslexia, and discourses used to understand it. In presenting a review of the literature in this chapter, I will attempt to represent the nuanced contemporary debate around what dyslexia is and how it affects adults. I will then explore considerations for education and society, before bringing the focus to medical education, and the medical profession specifically.

2.1.2. Approaching a definition of dyslexia

Since the original descriptions by Kussmaul, Berlin and others described above, many different definitions have been offered to explain dyslexia. These have been arrived at through research, expert consensus offered by stakeholder groups, or derived from 'folk psychology' (Rice & Brooks, 2004: p18). In unpicking these definitions, it is helpful to consider their purpose. Reid (2009) suggests that definitions of dyslexia serve different functions, and how definitions are manipulated may reflect socio-political and economic agendas:

- **Allocation** of resources
- **Explanation** for teachers and professionals
- **Understanding** for parents and sufferers

A diagnosis of dyslexia is made with reference to a definition that is recognised by the professional community (Jones & Kindersley, 2013; Reid, 2009). Such reference points are sourced from key stakeholder organisations that have offered 'authoritative' definitions of dyslexia. Table 2.1 summarises a simple analysis of the components of these definitions, according to criteria set out by Jackson and Coltheart (2001). Here, it is possible to see that Rice and Brooks' (2004) criticism of the British Psychological Society's definition being too general, tautological, and open to misunderstanding and misuse is justified.

	British Dyslexia Association (BDA, 2009)	International Dyslexia Association (IDA, 2002)	British Psychological Society (BPS, 1999)	Task Force on Dyslexia (TFD, 2001)
Subordinate label	…a specific learning difficulty	…a specific learning disability	-	…in a continuum of specific learning difficulties
Description of reading and related performance	…affects the development of literacy and language related skills…characterised by difficulties with **rapid naming, working memory**, processing speed, and the **automatic development of skills**	…characterised by difficulties with **accurate and / or fluent word recognition** and by poor spelling and decoding abilities	…evident when **accurate and fluent word reading and / or spelling** develops very incompletely or with great difficulty	…related to acquisition of basic skills in reading, spelling, and / or writing…characterised by inefficient processing, working memory, **rapid naming, and automaticity of basic skills**
'Proximal cause'	…characterised by difficulties with **phonological** processing	…typically result[ing] from a deficit in the **phonological** component of language	*…focuses on literacy learning at the 'word level' and implies that the problem is severe and persistent*	…can be described at the neurological, cognitive and behavioural levels… including difficulties in **phonological** processing
'Distal cause'	*…likely to be present at birth and [is] lifelong*	…neurological in origin	-	
Comparison	…may not match up to an individual's other cognitive abilities	...is often unexpected in relation to other cognitive abilities and the provision of effective classroom teaching	-	…being unexpected in relation to an individual's other abilities and educational experiences
Mitigation	…tends to be resistant to conventional teaching, but can be mitigated by appropriately specific intervention		…severe and persistent despite appropriate learning opportunities	-

Table 2.1: A comparison of definitions of dyslexia as offered by stakeholder organisations (often seen as 'authorities'). The definitions have been broken down according to constitutive elements, proposed by Jackson and Coltheart (2001). Words are underlined to highlight differences between definitions, **emboldened** to highlight key **similarities** or *italicised* to highlight the *tenuous* nature of the component.

The features common to most definitions appear to define dyslexia as a set of difficulties with acquiring literacy skills, presenting as problems with accurate reading or writing and working memory. The definitions tend to converge on a deficit in phonological processing as a proximal cause for the difficulties at a cognitive level, but few propose a distal cause (Rice & Brooks, 2004). Distal causes will be explored in more details later, but the idea of proximal causes, which Jackson and Coltheart (2001) describe as always operating at the cognitive level, requires further attention here.

Snowling (2006) presents a comprehensive synthesis of research from the fields of cognitive psychology that supports a case for a phonological deficit as the key

processing disorder in children who experience difficulties with reading and writing. In children identified as dyslexic, the measurable discrepancies are not believed to be ameliorated by traditionally employed interventions, whereas children who generally struggle with reading tend to improve with time, practice and other pedagogical interventions (Snowling, 2006, drawing on Yule, 1973). The principle of resistance to intervention conveyed in this sentiment is represented in the BDA (2009) definition seen in table 2.1. This persistent phonological processing deficit is believed to underlie difficulties in the recognition and manipulation of sound-components required to work with and learn new words, as well as difficulties in acquiring orthographic awareness, and automatisation of reading and spelling (Snowling, 2006).

Dyslexia is diagnosed by employing a battery of tests to assess for symptoms that are detectable at Frith's (1999) behavioural level (Jones & Kindersley, 2013; Reid, 2009). The tools used operate on the assumption that there is something that differentiates learners with dyslexia from those who have difficulty with literacy because of other reasons. However, research has consistently, and systematically, demonstrated that this is not the case. We *cannot* reliably discern differences between 'dyslexic poor readers' and 'low IQ poor readers' using current assessment strategies (Vellutino et al., 2004). Controversially, whilst a body of scholarly work recognises that there is an experience recognisable as 'dyslexia' (Rice & Brookes, 2004; Snowling, 2006), it would appear that the lack of consensus in defining what constitutes this experience, and how it can be measured calls into question both the discreteness of this category, and the utility of the label (Elliot & Grigorenko, 2014). The failure of currently employed psychometrics to capture the complexity of the dyslexia experience may be reflective of a more fundamental issue: It is easy for definitions and theories from contrasting psychological and pedagogical domains to conflate literacy to a set of decontextualised technical skills, which operates from assumptions of cognitive and functional views of literacy (Rassool, 2009). Subsequently, the interventions that are supported by such evidence tend to be limited to skill routines and targeted cognitive domains, which do not address the underlying difficulties or disadvantage (Vellutino et al., 2004; Weldhall et al., 2009). This is particularly demonstrated by the 'standardised' extra time in exams: if the learner is dyslexic, they must take longer to read. Therefore, the solution is to give them longer to read. It is possible that the central conflation of literacy with

decontextualized technical skills that has led to current assessment and remediation practices also informs the tautological nature of how dyslexia continues to be defined: as a decontextualized skill-deficit that is resistant to decontextualized skill-based interventions.

The inconsistencies in defining dyslexia reflect the complex, and often conflicting, notions of causality (briefly explored in section 2.1.3). Some have argued that the very label 'dyslexia' lacks utility, which is a criticism shared by many of the neurobiological causal models (Elliot & Grigorenko, 2014). In an extensive review, Snowling and Hulme (2012) develop the notion of dimensionality of the concept of dyslexia as part of a broader phenotype. In this model, risk facts (individual, environmental *etc*.) interact to manifest a 'cognitive endophenotype' (*ibid.*: p.600). The notion of a phenotype is developed further to include a 'broader phenotype' of dyslexia, which includes learners who have undergone 'Illusory recovery', in which earlier remedial work helps develop coping strategies that mask aspects of the SpLD, but area easily overwhelmed in later life (*ibid.*: p.600). This would afford the learner the ability to 'pass' alluded to in section 1.2.3 of Chapter 1. A solution is proposed by the recent revision of the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5, American Psychiatric Association, 2013). In revising the diagnostic categories, the DSM-5 shifts focus away from narrow and arbitrarily defined disorders (e.g. 'dyslexia') to a broader 'overarching category of specific learning difficulties with 'specifiers' to characterise the specific manifestations' (Tannock, 2013). This, in effect, recognises the nuanced and individual nature of the experience of SpLD, and provides educational utility through alluding to the broad nature of difficulties (e.g. reading, writing or arithmetical), without restricting understanding or recognition to a falsely crystallised and narrowed concept.

Indeed, this narrowed concept of dyslexia is further complicated by the fact that it often co-occurs with other SpLD, such as ADHD, dysgraphia, and dyspraxia (Döhla & Heim, 2016; Russell et al., 2015; Moody, 2015). Various statistics have been proposed to illustrate the extent of co-occurrence and overlap among these various conditions (e.g. Shrewsbury, 2012). However, given the lack of consensus definition, the manner in which diagnoses for these conditions are variably accessed and conferred (see Miles, 2004), it is unlikely that such figures would be an accurate representation of reality, or

serve any practical use. This has implications for the idealised study of dyslexia in isolation, and relates to arguments proposed by Julian Elliot and colleagues about the validity of labels that allude to discrete conditions (Elliot & Grigorenko, 2014; Elliott & Gibbs, 2008). The proposed changes to the International Classification of Diseases - currently in its 10th edition (ICD 10) (WHO, 1992) may be an attempt at reflecting this tension, but evening out the nature of diagnostic information relating to mental and behavioural disorders (First et al., 2015). The revised 11th edition was due to be released in 2017, but is now anticipated later this year (WHO, 2017).

2.1.3. Considering causality

The framework reflected in table 2.1 draws attention to the 'distal cause' component of how dyslexia is defined. 'Distal' refers to being further away from the 'observed task performance' and may refer to 'internal cognitive or biological causes, or they can be biological and psychological events and conditions' (Jackson & Coltheart, 2001: p.33). Hitherto, the focus has been on the processing difficulty at the cognitive level, which equates to the 'proximal cause' (*ibid.*). Frith (1999) proposes a simplified means of situating and conceptualising the variety of theories relating to the causes of dyslexia, in a way that demonstrates their potential compatibility and complementarity (figure 2.1).

Goswami (2009) draws upon an array of international studies designed to elucidate the underlying neural activity correlating to the cognitive processes involved in reading. Although the studies cited used small samples (ranging from 3 to 70), which *should* (but appears not to) restrict the confidence with which generalising conclusions are drawn, Goswami surmises that structures in the left: posterior temporal, inferior frontal and occipitotemporal regions are involved in the cognitive pathways for reading. There is a 'high degree of consistency' (*ibid.* p.13) between the brain structures that are activated in readers of all levels of experience, children and adults, and readers with and without dyslexia. The critical difference appears to be in the timing, where 'neural activation is delayed in core components…of the reading network' or that the sequencing of the activation is 'in a different order in dyslexia compared to typical readers' (*ibid.* p.18). The altered brain functioning is believed to lead to difficulties with development of phonological processing, which is central to the *cognitive* processes that underlie dyslexia (Snowling, 2006). Arguably, such findings need to be interpreted with a great

deal more caution than is conveyed by the authority in conclusions offered by such works (e.g. Goswami, 2009; Shaywitz et al., 2002). This need for caution is reinforced by a recent meta-analysis of neuroanatomical research into dyslexia, which highlighted design flaws in the body of research, dogged by small sample sizes and inconsistencies (Ramus et al., 2018). Further need for caution is illustrated by the "dead salmon study" (Bennett et al., 2009), which demonstrates the risks involved in interpreting research based on variably controlled functional magnetic resonance imaging (fMRI) studies. This caution is added to by the note that brain imaging studies struggle to 'consistently replicate' and are often not optimally powered to address complex brain-behaviour relationships (Krishnan et al., 2016).

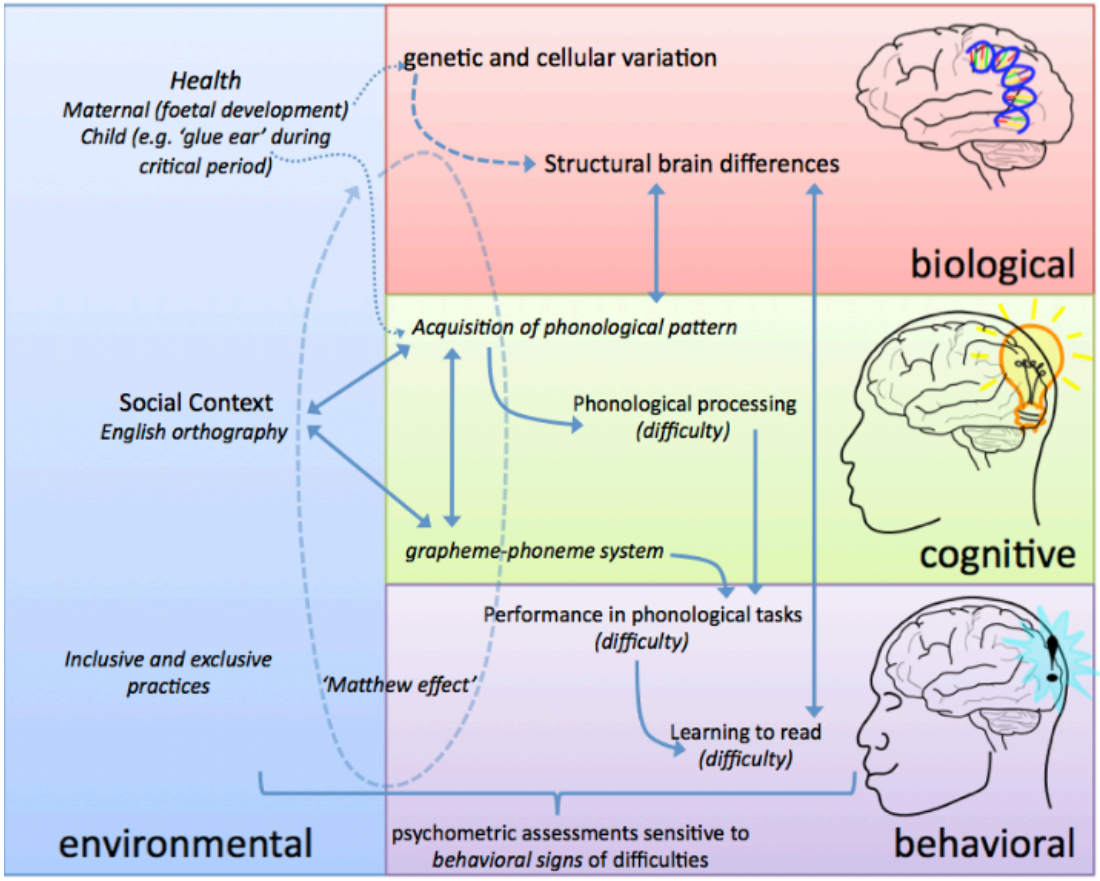


Figure 2.1: Factors contributing to the development of 'dyslexic' pattern difficulties, *original illustration*- adapted from Frith (1999) using Lineform and PowerPoint for Mac.

These biological explanations are contingent on a fixed view of the brain, which is inaccurate. The brain is considered 'plastic': continually remodelling and responding to learning and disease. Learning has the potential to change the very structure of the brain (e.g. Woollett & Maguire, 2011). Subsequently, the process of learning to read would change the brain. Likewise, not learning or struggling to read, would lead to

differences in brain development and structure (double-headed arrows in figure 2.1). This is illustrated when recurrent ear infections ('glue ear') during a critical period in childhood leads to difficulties in acquiring phonological awareness, interacting with literacy development resulting in the symptoms of dyslexia (Rice & Brooks, 2004). In relation to this, Frith (1999) proposes that 'true' dyslexia (neurodevelopmental reading difficulty), is distinguished from phonological difficulties of different aetiologies (e.g. 'glue ear') by demonstrable patterns of pre-birth origin and heritability. However, the educational and psychological benefit of such distinctions to learners who experience these difficulties is dubious. Reading practice, family environment and parental education (or dyslexia) exert environmental influence over phonological development, and can interact to exacerbate the literacy difficulties in a process dubbed the 'Matthew effect' (Stanovich, 1986; circular dashed arrow in figure 2.1). Heritability, therefore, could become indistinguishable from the environmental influence that parents' difficulties would have on their 'dyslexic' child, challenging both Frith's (1999) assertion and the very notion of distinct biological causality.

Thus far, the focus has been on the individual, which may be reflective of my background influencing a medically oriented view. Broadening the perspective of dyslexia beyond the individual, it is possible to see strong arguments for a socially constructed locus, operating in a fashion that is reminiscent of Oliver's (1990) social oppression model view of disability. As mentioned in Chapter 1, Riddick (2001) illustrates the social construction perspective of dyslexia by drawing on how the vagaries of the English language manifest or exacerbate literacy difficulties experienced by those with dyslexia. This is highlighted by Riddick (2001), with the use of the example of the reformation of the Turkish language alluded to in Chapter 1. By judging capability from a narrow scope of specific skills (e.g. literacy), society institutes barriers at a sociocultural level that can be stigmatising and exclusive of those who struggle to follow obscure orthographic conventions. The social oppression perspective of dyslexia is also reinforced by the 'social scepticism' surrounding the concept, illustrated by the notion that 'dyslexia is the middle-class name for stupid' (Gwernan-Jones, 2012: p.20). Discrediting the idea of a difficulty, whatever it comes to be called, in order to reinforce derogatory evaluations of *other* can, in this sense, be seen as a mechanism by which society maintains order to the dominant system of meritocracy.

2.1.4. Labelling

The process of defining and diagnosing dyslexia leads on to the dilemma of labelling. Labels can serve a variety of functions and are associated with a myriad of both positive and negative connotations. In the context of dyslexia, specifically, Riddick (2000) contends that there is potential for the stigma that is often associated with a label such as dyslexia can exist in the absence of a formal diagnosis. Riddick (2000 & 2010) draws attention to the experience of learners who acquired a diagnosis and label of dyslexia later in their schooling. They were subject to ridicule for poor spelling, messy handwriting and slow reading in advance of any diagnosis being made. This highlights the complex relationship between experience, perception and labels and supports the conclusion that stigma is not conditional on whether a label or diagnosis is known. Indeed, labels can name or draw attention to an issue, and subsequently have a positive effect on the awareness and acceptance of a disorder. Lauchlan and Boyle (2007) suggest that labels for disability categories can have several uses and be associated with both positive and negative consequences. A summary of the key functions is provided in table 2.2. Looking to a system-level function, Ho (2004) adds the caution that labels have the potential to drive a medical, and therefore inherently individual-focused, view of difficulties. This, she argues, provides an excuse for institutions and allows them to ignore the problems in the educational and social systems that contribute to the experience of learning difficulties (Ho, 2004). However, how labels develop and evolve in the way they are adopted, used and re-appropriated is a dynamic process (Norwich, 2014; Hastings & Remington, 1993).

The label functions that are most pertinent to the discussion of negotiating resources for dyslexic students in HE are the aspects of 'bargaining chip', stigma, self-reassurance and campaigning. Riddick (2000 & 2001) discusses the relationship between the label of dyslexia and learners perception of stigma. In doing so, she also draws attention to the reassurance that having a name for a difficulty can afford, as exemplified in one student's comment:

> 'It had a name, I wasn't stupid, the psychologist said I wasn't stupid, and it was a lovely feeling'
>
> (Riddick, 2001: p.659)

Another example included in Riddick's paper demonstrates how a label can assume a protective function, acting as amour against prejudice and victimization:

> 'No teacher now brands me as thick, cause I've told them I was dyslexic'
>
> (*ibid.*)

These two beneficial functions of the dyslexia label relate to the differential private and public functions previously described by Riddick (2000). The first example demonstrates the private function of the label, where it serves to comfort the dyslexic individual in the form of self-reassurance. The use in the second example demonstrates the public function of the label. Here, the dyslexic learner has accepted and embraced the label in order to use it to their advantage. Such use would be consistent with the campaigning function of disability labels (Lauchlan & Boyle, 2007). These examples highlight the complexity of the relationship between labels, their use and the perceptions of those that use them.

Positive functions of labels	Negative functions of labels
Recognizing and labelling something as different, or problematic, the label can lead to recognition, diagnosis and treatment. Subsequently, they can be used to negotiate access to support and rationed resources.	The label can lead to a state of complacency, where minimal effort is expended on understanding the nature of the underlying condition, the individual and the interventions necessary- resources are often allocated in a 'one size fits all' manner
Labelling can help raise awareness. They provide a banner under which campaigning can be done. Their use can improve the understanding of the individuals and their disabilities.	Labels can be used against individuals in a derogatory fashion, leading to stigma. Such as the negative connotation with 'special' that evolved from special needs.
Labels can be used as a professional communication device, acting as shorthand for conferring information relating to a particular disability.	There is inconsistency in the use of labels, and their true definitions. Labels can lead to harmful generalizations, leading to individual-specific difficulties being overlooked.
Giving a disability a name helps those with disabilities, and their families, understand and come to terms with the difficulties they have experienced.	Labels can promote a 'within-child' view of the impairments associated with the label. Subsequently, disabled individuals could be underestimated, and their self-esteem damaged.
Labels can bring people together, and contribute to a sense of personal and group identity.	As with stigmatization, labels can assume negative connotations, but also can lead to marginalization and victimization.

Table 2.2: Key positive and negative functions of labels with regards to disabilities (Lauchlan & Boyle, 2007)

2.1.5. The bargaining chip

The use of labels in the process of negotiating access to resources is of most interest to the discussion of reasonable adjustments in assessment. Therefore, the function of the diagnosis of dyslexia as a 'bargaining chip' will be explored further. However, in order for a label to be used to successfully secure rationed resources, it is clear that the

diagnosis itself must be understood, accepted and possess a level of credibility. The concept of credibility is pertinent to dyslexia, as it has been subject to uncertainty in the educational and psychological professions (Riddick, 2001). This is, in part, due to the 'deficit model' that was, and still is to a certain extent, used to describe and diagnose dyslexia (Stanovich, 1994 & 2005). Subsequently, confusion contaminates negotiations around dyslexia, with resultant reticence to acceptance and flexibility persisting towards learners campaigning for access and accommodations.

Campaigning from groups promoting the social model perspective of dyslexia advocates the use of the term 'neurodiversity' and 'learning difference' with reference to dyslexia (Developmental Adult Neuro-Diversity Association, 2011). The purpose of this appears to be aimed at reducing the stigma surrounding learning difficulties, and helping individuals with neurodiverse conditions, such as dyslexia, autism spectrum disorder or attention deficit hyperactivity disorder (ADHD). The movement, which was started in the 1990s, drives a sociopolitical agenda to protect and promote the civil rights of the 'normal person trapped behind the [disability]' (Jaarsma & Welin, 2011, p.21). However, the movement is considered controversial due to the potential for disabilities to become normalized by adopting minimizing language, such as *difference* in place of *disability* (*ibid.*). Consequently, bids for access to resources could be harmed by deprioritising the conditions of need. Furthermore, the promotion of new labels (e.g. neurodiversity), before a uniform acceptance of the original terminology (e.g. dyslexia) can only worsen the problems of confusion and uncertainty that impede progress in advancing awareness and negotiating access to resources.

Riddell and Weedon (2006) identify specific issues faced by dyslexic learners in HE. In the context of negotiating for reasonable adjustments, such as accommodations in assessments, students reported both positive and negative attitudes from academics with regards to their difficulties and requests. Subsequently, one student felt that they had been disadvantaged as the accommodations they received were not adequate (which was also reflected in comments from his tutor). Students who embraced and used their diagnosis were more successful in securing support in the form of assistive technology, extra time in exams, and the (now defunct) disabled students allowance (*ibid.*). However, one student, who did not feel that she had a disability, shied away from using her diagnosis to campaign for the same resources. In the same study,

academics were interviewed to gauge their views and opinions on the issues of allocation of resources and provision of accommodations to dyslexic learners. As well as tensions between the protection of academic standards and facilitating widened participation, the authors found that academics struggled with uncertainty, variable distribution of resources and efficacy of accommodations. As there is a variation in practice of provision for reasonable adjustments, academics felt a great degree of uncertainty about the improvised nature of their practice with regards to providing additional support or compensating for poor writing in the marking of assessments.

2.1.6. Reasonable adjustments

Reasonable adjustments are measures employed to alleviate disadvantage, the most common example in higher education being additional time in exam (Equality Act, 2010; Earl et al*.,* 1999). Before exploring the concept of reasonable adjustments in assessments in medical education, the scene needs to be set by first highlighting the critical factors that make assessment in medical education, and the provision of reasonable adjustment so contentious. In assessment *of* learning, performance in a standardised test is measured against either set standards and criteria (criterion referenced), or the performance of peers in the same test (norm referenced). The information generated by the assessment is interpreted in light of a variety of standardisation methods and psychometric theories to give the statistical likelihood of the mark gained being an accurate reflection of that individual's abilities in the domain being assessed (Wass et al., 2001). The standardisation of tests, through providing all examinees with the same questions and conditions under which to answer them is considered fundamental to the reliability of the test and the subsequent interpretation of the results attained (Epstein, 2007). Reliability refers to the consistency of data generated by a test over a period of time or number of sittings, whereas validity relates to a multifactorial quality of test data evidence supporting the claim that the test measures what it purports to (Downing, 2003). Neither reliability nor validity are intrinsic qualities of assessment tools but are reflections of the nature of the evidence provided by the data generated (Downing, 2003; 2004). Additionally, both reliability and validity are contingent on freedom from bias, and inform the psychometric principle of generalisability (Downing, 2003; Gibbs et al., 2006). Although these concepts may seem abstract from the issues of dyslexia and reasonable adjustments,

the importance of the true definitions of both reliability and validity will come into play when exploring the discourse dominating the debate around these issues. Additionally, criterion referenced standardisation of assessments may provide an answer to the concerns of accommodations threatening 'reliable' and 'valid' interpretation of a student's test scores, under accommodated conditions, when interpreting such results in the context of a large cohort of students assessed differentially.

Concerns have been raised about the potential for reasonable adjustments to alter the tacit constructs of the assessments, by changing the conditions under which they are sat (Earl & Sharp, 2000). Subsequently, it is thought that the adjustments, such as extra time, could undermine the validity of the test results, and the reliability of test scores, as groups of students are assessed differentially (Earl & Sharp, 2000; Sharp & Earl, 2000). Downing (2003) cautions against the common pitfall of interpreting test scores in terms of validity and reliability, suggesting that test outcomes 'have more or less evidence to support (or refute) a specific interpretation' (p.830). This warning highlights the elements of probability and chance in psychometrics. For example, a high mark could be scored by luck, if the questions arising happen to coincide with the examinee's favourite topic, what they most recently revised, or a candidate could guess the correct responses in a multiple choice question by chance.

The reason assessments, the conditions under which they are sat, and the interpretation of their results is so critical in medical education is because successful completion of a medical degree confers a vocational qualification to an individual, granting them access to the medical profession. This is reflected in the Medical School Council's statement on admission of disabled students:

> 'Selection for medical school implies selection for the medical profession. A degree in medicine confirms academic achievement and in normal circumstances entitles the new graduate to be provisionally registered by the General Medical Council and to start practising as a doctor.'
>
> (Medical Schools Council, in General Medical Council (GMC), 2010: p.46)

As the medical profession directly interacts with members of the public when they are at their most vulnerable, medical professionals are trusted to act in their patients' best interests, doing no harm and drawing on the most contemporary evidence to support an informed decision (GMC, 2009; Royal College of Physicians (RCP), 2005). This trust

is arguably foundational to the doctor-patient relationship and is based on the belief that the doctor is in possession of the right skills and knowledge. Therefore, any process that is designed to discriminate those who have attained and can demonstrate the desired level of skill and knowledge, from those who have not, is critical in determining who is suitable to be admitted to this position of trust.

2.1.7. Reasonable adjustments in assessments

As a profession that serves the vulnerable public, medicine is bound by rules and is regulated by law and external watchdogs. These guiding principles affect medical education in asserting the standard against which professionals are measured, in order to rationalise admission to the profession. One key point at which such standards act is in assessments. Therefore, it is here that I would argue the issue of reasonable adjustments is most contentious. The terminology used in the context of reasonable adjustments in assessments can be somewhat inconsistent, table 2.3 delineates the meaning of key terms used. Accommodations, modifications and compensating are all forms of reasonable adjustments. A clear and uniform use of this terminology should be encouraged to avoid the misunderstandings that fuel polemics about 'compensating students' and compromising academic standards, when referring to the practice of accommodating different access arrangements, where the latter is clearly less problematic than the former (Earl & Sharp, 2000; Sharp & Earl, 2000).

There is variation within and between HE institutions as to what accommodations are provided for which assessment strategies (Earl et al., 1999). Tensions surrounding the provision of accommodations, such as extended time, stem from academic concerns of fairness and academic standards (Riddell & Weedon, 2006; Earl & Sharp, 2000). Additionally, it has been suggested that the provision of reasonable adjustments may act as an incentive for students to feign dyslexic-like difficulties (Harrison et al., 2011).

In the context of medical education, the most frequently afforded accommodation is an extension to the time in which students have to sit an assessment, and is usually restricted to written assessments. Extended time is seen to confer advantage on students in earlier phases of their education, where both disabled and non-disabled learners improve performance with this accommodation (Elliott & Marquart, 2004). However, in students at the level of HE, this effect is not seen and the accommodation-

disability paradigm effect is seen, where only disabled learners benefit from accommodating conditions, such as extra time (Philips, 1994; Runyan, 1991; Alster, 1997).

Term	Meaning	Reference
Reasonable Adjustment	is a measure employed in order to alleviate or remove the effects of a 'substantial disadvantage'.	Equality Act (2010)
Accommodation	a measure that differentially affects a student's performance in comparison to a peer group. An accommodation does not alter the nature of the construct being assessed, but does provide differential access so that students with certain characteristics may complete the test with influence from confounding variables minimised (e.g. change in administration or response format)	Tindal et al. (1997)
Modification	a change in the test, for example the way it is administered, format of response, that results in a change in the constructs being measured. Modifications affect all students with similar or equal effect.	Hollenback et al. (1998)
Compensation	in the sense of academic performance rather than remuneration in the context of settling a claim or complaint, compensation can be seen as either an **internal** or **external** process. **Internal** compensation: a process by which individuals employ strategies to overcome or minimize the effects of their disability. **External** compensation: a process by which those assessing performance make allowances for difficulties associated with the disability (e.g. not deducting marks for poor spelling of dyslexic learner's work). In assessment, compensation is also used to refer to the practice of allowing higher marks in one assessment to compensate for sub-standard marks in another.	My interpretation Informed by Association of Dyslexia Specialists in Higher Education (2011)

Table 2.3: Table defining the terminology of adjustment, accommodation, modification and compensation. These are terms that are frequently misused in debate of widening participation initiatives.

The GMC devolves the responsibility of administering assessments and the employment of accommodations to HE institutions. Whilst this regulatory agency sanctions the provision of reasonable adjustments in medical education, it stipulates that:

> 'Compensation can be appropriate but should not be used in ways that would allow students to graduate who are unable to demonstrate all the high-level outcomes and the practical procedures.'
>
> (GMC, 2011)

This statement allows flexibility for institutions to interpret the guidance in favour, or against the provision of reasonable adjustments in the basis of a belief as to whether the student could demonstrate their ability to meet the high-level outcomes. Such

flexibility could be dangerous as it leaves room for misuse. There are those who believe that providing any form of reasonable adjustment is interfering with a form of educational natural selection: survival of the smartest rather than survival of the fittest (Earl & Sharp, 2000; Sharp & Earl, 2000; Hafferty & Gibson, 2001). In this instance, however, the selection method (assessments) preferentially filters out orthographic and lexical abilities. However, there is no evidence to suggest that the provision of accommodations does afford unfair advantage to dyslexic learners (Pitoniak & Royer, 2001). Indeed, it is important to remember that the accommodations are made for individuals who are *otherwise qualified*, in order that they demonstrate their ability within a discriminatory system of assessment. The key here is that, after the rigorous selections processes, and demonstrating good performance in other forms of assessment, it can be inferred that trainee doctors are otherwise qualified and non-substandard. Therefore, concerns that accommodations 'compensate' for dyslexic students (Earl & Sharp, 2000; Sharp & Earl, 2000), which I believe is a misappropriation of the term, are not valid.

2.2. The effects of dyslexia

As alluded to hitherto, experiencing dyslexic difficulties as a learner can be associated with challenges, such as stigma and negative perception of self, by self and others (Riddick, 2010). This appears to be possible before a diagnostic label is conferred, although the knowledge of the diagnosis appears to augment the experience further in both mitigating and exacerbating ways (Riddick, 2000; 2010). The effect that this has on the individual's sense of self, and their identity formation is complex. Specific facets of self, such as concept, image, esteem and efficacy, are represented and explored in the literature relating to learners with dyslexia. Definitions for these terms are offered in table 2.4, although it should be noted that these terms are often used interchangeably, inappropriately, or with different operational definitions, causing divergence and incoherence in the synthesis of findings from this field of work (Burden, 2008a; 2008b).

Studies operating from positivist perspectives often offer slightly conflicting conclusions about the difference in measures of self-concept and self-esteem between learners with and learners without dyslexia. Recent research suggests that children with dyslexia may suffer greater anxiety and poorer self-esteem in the specific context of school settings compared to their non-dyslexic peers, but that general measures of anxiety and self-esteem were equivalent to their non-dyslexic peers (Novita, 2016). However, whilst exact quantification is problematic, learners with dyslexia do appear to score more poorly on measures of general, and academic self-concept compared to their non-dyslexic peers during childhood (Chapman, 1988; Zeleke, 2004). In contrast, learners with dyslexia may score slightly better than their non-dyslexic peers in the domain of social self-concept (Zeleke, 2004). Through his extensive work, Burden (2008b) cautions that the risk that scores in some self-rated measures of such nebulous concepts may be unreliable. However, they illustrate the effect that repeated experiences of difficulty and failure may have during developmental educational experiences. This may be due to the concentration of social comparisons, and visibility of markers of achievement accessible in the contextual setting of school. Teasing and bullying experienced by dyslexic learners compounds this, leading to reported feelings of isolation (Humphrey & Mullins, 2002). The isolation that many dyslexic learners may feel is particularly concerning, as social relationships are protective of self-esteem, especially for children with dyslexia (Shehu et al., 2015).

Self-Concept	…broadly seen as a multi-dimensional concept constructed of perceptions of how the individual functions in specific spheres. 'Global Self-Concept' believed to be comprised of academic, social, emotional and physical constructs. There are also temporal facets (past, present and potential future) to the construct (Shavelson et al., 1976)
Self-Image	…a mental picture, comprised of: how the individual sees themselves, how others see them, and how they perceive others to see them. This construct incorporates past, present and aspirational notions (Rosenberg, 2015)
Self-Esteem	…how an individual feels about themselves: globally, but also with specific reference to aspects of self-concept. 'General Self-Esteem' is often considered synonymous with 'Global Self Worth' (Burden, 2008a)
Self-Efficacy	…an individual's feelings of confidence and competence in the face of specific challenges (Bandura, 1997; Burden, 2008a)

Table 2.4: Definitions of terminology used with reference to notions of self.

Research into the effect of dyslexia on teenage and adult learners suggest that greater confidence and self-esteem is associated with academic success (Alexander-Passe, 2006; Ingesson, 2007). Conversely, learners with dyslexia tend to report greater levels

of frustration, stress and anxiety, which is associated with depression and negative self-talk (Riddick, 2010). This is a pattern that continues and worsens throughout the continuum of compulsory education, through to HE and vocational training (Carroll & Iles, 2006; Burden, 2008a; Riddick et al., 1999). Riddick (2010) suggests that learners with high self-esteem tend to believe they will succeed, whereas those with low self-esteem tend to show 'little confidence, in their own ability, give up easily, and are often fearful or [avoidant]' (*ibid.* p.39), which implies a potential for learned helplessness (Riddick, 2010; Burden, 2008a; after Seligman, 1972). Strategies, such as avoidance, that learners with dyslexia employ to cope with their difficulties can often be seen as behaviours driven by frustration and a need to protect self-esteem (Alexander-Passe, 2006). Burden (2008a) highlights that exploration of self-concept and self-esteem in learners with dyslexia is a means of understanding a sense of identity and identity development. Therefore, factors that may negatively influence aspects of self (concept, esteem, efficacy and image) can be considered threats to identity, and attempts to modify these threats, or the internalisation of them, as coping strategies (Breakwell, 1986).

2.3. A systematic review of dyslexia in medicine

To establish the current level of understanding about the impact that dyslexia has on the education, training and practice of medical professionals, a systematic review of the literature was undertaken (table 2.5). Results were restricted based on: date range (1960 – December 2017); published in English language; and full text availability. The results of the search were more limited than expected, based on wider reading, and were augmented by a hand search. Of the resulting publications, 8 papers were based on original research, 2 were based on systematic reviews, and 11 were based on opinion pieces, editorials or reviews of a more narrative nature (table 2.6). Due to the heterogeneity of the literature, this section will present a narrative overview of the literature relating to dyslexia in medical education. I will then proceed to expand on this by drawing on literature relating to education and training in wider, allied, clinical fields.

Systematic search of Ovid Medline (1960 – December 2017).		
Title to include:		
Dyslexi* OR	AND	Doctor OR
(specific learning difficult*) OR		Physician OR
		Surgeon OR
		Surgical OR
(Learning disab*) OR		Resident* OR
		Intern* OR
(Reading disorder*) OR		(medical student*) OR
		Trainee*
Results		96
Review of titles		13
Review of abstracts		11
Hand search		9
Total		20

Table 2.5: Boolean search terms used for a systematic search of the literature pertaining to the field of medicine and medical education, with resulting output.

Dyslexia is the most common Specific Learning Difficulty (SpLD), with an estimated global prevalence of about 6% (Miles, 2004). Within medical education, the numbers of students and trainees disclosing a diagnosis of dyslexia is steadily rising internationally (Hafferty & Gibson, 2003; Shrewsbury, 2011; Gibson & Leinster, 2011). Data from the Higher Education Statistics Agency (HESA, 2012) reveals that in the 3.3% of medical students entering medicine in the UK between 2008 and 2009 declared a diagnosis of dyslexia. This overtook the figures for nursing (which has historically had a higher number of dyslexic trainees) in which only 2.1% declared a diagnosis (*ibid.*). However, this rising figure remains disproportionately low, compared to general population estimates of prevalence of dyslexia. This challenges the efficacy of current widening participation practices. This is reflected in a recent analysis that demonstrates that widening participation schemes in the UK has led to a greater influx of students who would have traditionally been accepted onto a programme, and has made little difference to the representation of learners from diverse socioeconomic backgrounds, or learners with disabilities[4] (Mathers et al., 2011; Do et al., 2006).

[4] I acknowledge that SpLD are not inherently disabling, but are included within the category of disabilities for the purposes of monitoring inclusion within HE.

Table 2.6

Research

Authors	Title	Note
Locke et al. (2016)	Doctors with dyslexia: strategies and support	A mixed-methods approach study, drawing on a questionnaire responses from 6 doctors with dyslexia, semi-structured interviews with another 6 doctors with dyslexia, 'in situ' interviews and observation of 2 doctors with dyslexia, and 'informant interviews' from professional support unit staff. The study concluded that decisions around disclosure were problematic, reasonable adjustments and individually developed 'workarounds' were helpful, and enabling environmental factors were supportive.
Searcy et al. (2015)	Association of MCAT scores obtained with standard vs. extra administration time with medical school admission, medical student performance, and time to graduation.	Retrospective statistical analysis of 2 cohorts of medical students in the United States, comparing Medical College Admissions Test (MACT) scores with performance in the United States Medical Licensing Exam (USMLE). There was a lower first-sit pass rate in the USMLE, and lower graduation rate for students who reported receiving reasonable adjustments in the MCAT compared to those that did not.
Newlands, Shrewsbury & Robson (2015)	Foundation doctors and dyslexia: a qualitative study of their experiences and coping strategies	Qualitative study based on interviews with 7 FY1 doctors with dyslexia. Identifying 3 themes: difficulties, coping strategies, and acceptance
McKendree & Snowling (2011)	Examination results of medical students with dyslexia.	Retrospective statistical analysis (MANCOVA) of standardised assessments data from years 1 and 2 in one English medical school, across 4 cohorts. Demonstrating that dyslexia was not a significant predictor of performance in multiple assessment formats, when students received extra time in exams. The study alluded to a non-significant trend in second year assessments,
Shrewsbury (2011)	State of play: supporting students with specific learning difficulties	A survey of UK-wide medical schools demonstrated an increase in the number of students declaring a diagnosis of SpLD on applying and after being offered a place at medical school. All institutions provided (variable) reasonable adjustments, but only 5 provided adjustments in clinical placements or assessments.
Gibson & Leinster (2011)	How do students with dyslexia perform in extended matching questions, short answer questions and observed structured clinical examinations?	A retrospective statistical analysis of end-of-year assessments for 5 cohorts. Differences in performance were noted between students with dyslexia and those without in years 1 and 2 of the programme. This was attributed to a higher proportion of these students not receiving reasonable adjustments. Such observed differences disappeared in later years.
Ricketts, Brice & Coombes (2010)	Are multiple-choice tests fair to medical students with specific learning disabilities?	Retrospective statistical analysis (ANOVA) of assessments data from 5 year groups (5 cohorts) in 1 English medical school, demonstrating no significant difference in performance between learners who declared a SpLD (and received extra time) and those who did not.

Julian et al. (2004)	The impact of testing accommodations of MCAT scores: descriptive results	Retrospective analysis and statistical description of observed patterns in MCAT scores for all examinees between 1994-2000. Describes a small, statistically significant, difference – whereby examinees receiving reasonable adjustments performed better in all domains of the MCAT compared to examinees who did not.

Table 2.6

Systematic Review

Authors	Title	Note
Shaw, Malik & Anderson (2017)	The exam performance of medical students with dyslexia: a review of the literature	Aimed to perform a limited meta-analysis of 3 identified studies. Due to data limitations, restricted to review of a more narrative nature. Concluding that there may be discrepancies in performance between students with dyslexia compared to those without, but progression through later years of medical school, and reasonable adjustments minimise observed differences in performance.
Locke et al. (2015)	Clinicians with dyslexia: a systematic review of effects and strategies.	This review found few studies reporting work exploring the learning and work of doctors and nurses with dyslexia. They found evidence to suggest doctors with dyslexia drew on assistive technologies, and that nurses with dyslexia drew on support networks, and environmental adaptations to assist their work.

Table 2.6

Editorial / Opinion / Narrative Review

Authors	Title	Note
Shaw & Anderson (2017)	Twelve tips for teaching medical students with dyslexia	Synthesising recommendations from stakeholder and practitioner sources, combined with reflections on personal experience from one of the authors. Offering a combination of simplified practical measures, such as pastel coloured paper for handouts, as well as advice about attitudinal approaches to teaching learners with dyslexia.
Shrewsbury (2016)	Dyslexia in general practice education: considerations for recognition and support	Drawing on wider literature, modifiable attributes associated with success for adult learners with dyslexia were identified, e.g.: self-awareness, perseverance, appropriate goal setting, individuals' emotional responses / coping strategies. Supportive coaching is proposed as a strategy for educators to collaboratively facilitate the development of these attributes in learners.
Shrewsbury (2012)	Trainee doctors with learning difficulties: recognising need and providing support	Raises awareness of the prevalence of SpLD in medical education, and how learners may be affected. Makes suggestions for ways to skill development, and augment teaching approaches to benefit learners with and without SpLD. The proposed suggestions are not evidence based.
MacDougall (2009)	Dyscalculia, dyslexia, and medical students needs for learning and using statistics	Drawing on professional experience in supporting learners with a variety of SpLD, a range of suggestions are made for improving teaching statistics, including suggestions about: the approach to teaching (repetition and flexibility); the production, format and availability of resources; tutorial support; and the use of assistive technologies, such as online 'story books'.

Hafferty & Gibson (2003)	Learning disabilities, professionalism, and the practice of medical education	In an intentionally provocative response to Little's (2003) piece, they unpick the complexity around labelling and norm-referenced definitions of disability. They suggest reasonable adjustments would need to be extended into the clinical workplace, causing problems with workload distribution and economics of practice.
Little (2003)	Learning differences, medical students, and the law	Drawing on recent court proceedings regarding a law student (Bartlett) refused reasonable adjustment in State Bar exams, Little argues that the ruling offers lessons that can transfer to medical education, and that reasonable adjustments in assessments of clinical skills in the USMLE
Rosebraugh (2000)	Learning disabilities and medical schools	Raises awareness of prevalence and traits of students with learning disabilities in medical schools. Makes recommendations for medical schools around: policy development; faculty development; faculty structure; clarified identification of essential requirements of the medical degree programmes.
Little (1999)	Learning disabilities, medical students, and common sense	Discusses the United States' National Board of Medical Examiners (NBME) decision to refuse reasonable adjustments to a student with learning disabilities. She draws attention to commonly experienced difficulties by such learners, and argues a case for inclusion and reasonable adjustment.
Frank-Josephson & Scott (1997)	Accommodating medical students with learning disabilities	Drawing on her personal experience (Frank-Josephson), and the literature, they argue that attitude towards people, and learners, with disabilities in medicine need to 'readjust'.
Guyer (1988)	Dyslexic doctors: a resource in need of discovery	Drawing on a case study of a 'genius with reading problems' Guyer illustrates difficulties experienced by students with learning disabilities, and explores common misconceptions. She illustrates approaches to supporting such learners by means of discussing the Tutorial Programme she developed at Marshall University.

Table 2.6: Results of the systematic and hand search of the literature around dyslexia in medical education. Learning disabilities is the term used in North America to refer to SpLD, and often used synonymously with dyslexia. The NBME refers to the organisation that administers the USMLE.

2.3.1. Diversity in medicine

Before considering the relationship between dyslexia and higher or medical education, it is important to consider the value that diversity, and therefore disability, has within the medical profession and subsequent trainee workforce. Debate has surrounded the issues of fitness to practice, support and provision of reasonable adjustments for medical trainees with dyslexia for several decades (Guyer, 1988; Little, 1999, 2003; Rosebraugh, 2000). Anecdotes and hypothetical examples distract attention from the lack of evidence, instead focusing on fuelling fear of potential consequences that may befall a practicing dyslexic doctor. Although exploratory studies have ventured into the

difficulties experienced, and strategies employed by nurses and doctors during their training (Locke et al., 2015; Morris & Turnbull, 2006), these remain superficial snapshots, with conclusions that do little to advance beyond the often recited unevidenced recommendations popularised by stakeholder organisations (as illustrated in Shaw & Anderson, 2017; Shrewsbury, 2012). It is understood that a great deal of perceived professional stigma still surrounds the issue, and that more needs to be done to support learners on clinical placements (Newlands, Shrewsbury & Robson, 2015; Locke et al., 2015; Morris & Turnbull, 2007). However, the nature and extent to which dyslexia impacts on the training and practice of doctors remains beyond our understanding.

A study conducted by Roberts et al. (2005) surveyed the opinions that various groups of lay public, disability support groups and groups of professionals within medicine had of disability within the medical profession. The overall response was positive, and it was felt that doctors with personal experience of disability would be far better equipped to deal with disabled patients, than those without such experience. However, specific mention of dyslexia was made in the report, citing the concern that dyslexic doctors may by more prone to making prescribing errors. This is reflected in articles appearing in national media when a dyslexic medical student's struggles at medical school became public (Bennett, 2008). Prescribing errors appear to be particularly prevalent among trainee doctors (Lewis et al., 2009). Mistakes are mostly related to dose (Dornan et al., 2009). However, it is important to clarify here that there is no evidence to support the suggestion that being dyslexic would make a trainee doctor more prone to making mistakes than their non-dyslexic peers.

Diversity encompasses difference and variation in many traits and characteristics, and includes disability. The medical profession serves an ever increasingly diverse population (RCP, 2005). Therefore, I would argue that, in order to better serve this diversifying population, diversity within the profession should be embraced and valued. Viewed as such, it could be argued that it is a social responsibility to ensure the makeup of the profession better reflects that of the population it serves.

2.3.2. Impact of dyslexia on training and practice

Data pertaining to assessments undertaken by medical students and doctors, post-qualification paint an inconsistent picture. Overall, it is believed that medical students with dyslexia do not perform differently to their non-dyslexic peers to any degree of consistent statistical significance (Ricketts et al., 2010; McKendree & Snowling, 2011). However, where accommodations are not provided, there may be potential for discrepant performance in some forms of assessment (Gibson & Leinster, 2011). Looking at the timeframe before medical school, analysis of admissions and aptitude test data suggest that learners with dyslexia who receive reasonable adjustments may possibly attain better first-sit scores compared to their non-dyslexic peers (Julian et al., 2004; Searcey, 2015). However, longitudinal analysis suggests that subsequent performance in professional exams (the USMLE) is comparatively poorer in dyslexic learners (Searcey, 2015). Until recently, in postgraduate professional assessments of GP trainees in the UK, doctors with dyslexia had a lower first-sit pass rate compared to their non-dyslexic peers (Shrewsbury, 2016). The amelioration of this discrepancy is believed to be due to a number of factors, such as the increase in support provided to trainees, as well as changes made to examination conditions (*ibid.*). A lack of coherence in the conclusions that can be drawn from studies of assessment performance may relate to the questions driving the individual projects: one (Ricketts et al*.,* 2010) was explicitly designed to test the fairness of the medical school's assessment strategy, to defend allegations made by a student with dyslexia who failed (Gammell, 2008). Therefore, such research appears to actually assess assessment-format discriminatory properties with reference to a specific minority group, rather than holistically explore the impact that dyslexia may have on performance in specific contexts.

Qualitative inquiries into the impact of dyslexia on the working lives of doctors has begun to illustrate what difficulties may be encountered in specific situations, and how these may be met with the use of strategies (Newlands, Shrewsbury & Robson, 2015; Locke et al., 2016). Musto (2013) found doctors' self-reported difficulties associated with dyslexia to be related to fear of risk and impression management, which included challenges around disclosure decisions. Interestingly, she found that over half of her sample of 40 doctors with SpLD openly discussed their diagnosis to their colleagues (*ibid.*). The insight into the difficulties faced afforded by these aforementioned studies

offers a novel contribution to the field (summarised in table 2.7). The data from the studies by Newlands et al. (2015) and Locke et al. (2016) focus on the perspective of the individual with dyslexia, and does not draw on comparisons with non-dyslexic practitioners. This may be considered a weakness of these inquiries, but may also be a tacit and pragmatic acknowledgement of the complexity of individual experience, as well as the value in providing voice to a marginalised group. Both studies also offer suggestions for coping strategies, but achieve little more than reinforcing the practical, albeit contextualised, skills-based approaches that are extant within the field and practitioner literature (e.g. Shaw & Anderson, 2017; Shrewsbury, 2012). These studies are unable to quantify the nature of difficulties experienced by doctors with dyslexia, nor are they able to delineate the difference between such difficulties experienced by those who are non-dyslexic too. This is an important tacit acknowledgement of the complexity of the concept of dyslexia, overlapping with the complexity of learning and working in the medical profession. Efforts to present a simplified quantification of difficulty should be resisted, largely because of the inherent inaccuracy in any resultant claims and conclusions, but also because it is likely that such figures would be open to misinterpretation or manipulation. This could then misinform debate around the nature of inclusion and support, misattributing risk to an individual-focused perspective.

Difficulties	Details
Reading	Perceived slow reading speed Perceived difficulty in reading aloud Misreading of information Difficulty in reading others' handwriting
Writing	Perceived poor spelling Letter and number reversal Poor handwriting Difficulty in structuring written communication Concern of risk of spelling leading to prescribing errors
Verbal Communication	Receiving telephone messages Reading aloud in front of patients and colleagues Presenting
Organisation and Time Management	Prioritisation of tasks Sequencing the order of tasks (especially handover)
Working Memory & Attention	Easily distracted Difficulty recalling names and information
Anxiety	Performance anxiety Stress

Table 2.7: Summary of difficulties that doctors with dyslexia identified (Newlands, Shrewsbury & Robson, 2015; Locke et al., 2016; Musto, 2013)

What is more meaningful is: how doctors recognise and then engage in mitigating difficulties that they experience; and understanding how the experience of these difficulties impacts on the training and professional identity formation of these doctors. Our understanding of the individual experience of dyslexia in doctors is far from complete. Therefore, if more research is not undertaken to address this knowledge gap, the community will be unable to effectively support inclusive education and practice of learners who experience difficulties. Following this chapter, I will outline how the extant literature, and the niche described herein, has informed the development of the questions and methodology that underpin this thesis project.

Chapter 3: Methodology

In this chapter, I will explain the aims of my project, and explore the development of the guiding research questions. From there, the focus on lived experience will be drawn out in a discussion of a branch of philosophy, and inquiry, called phenomenology. This will form foundations, from which I will describe the methodology that underpins the project, known as Interpretative Phenomenological Analysis (IPA). After establishing the methodological framework, I will describe the sample of participants who were involved in the project, as well as methods of recruitment, data collection and analysis. I will conclude by revisiting the process of data analysis within the context of IPA.

3.1 Project aims

The context of this research project has been set, by means of an introduction to my own background and interests in chapter 1, as well as by carving out a niche for the work in an exploration of the literature pertaining to the field of inquiry in chapter 2. The general orientation is towards developing an understanding of the personal experiences of dyslexia, in the specific context of medical education, and how dyslexia may interact with: the experience of becoming a doctor; training within practice; and the practical work of being a trainee doctor. The term 'trainee' or 'trainee doctors' is used to include all those who are qualified as doctors (i.e. have completed a medical degree) and are in training posts (i.e. junior doctors). Doctors are considered trainees or 'juniors' until they have completed their training, attaining a Certificate of Completion of Training (CCT) and become appointable as a consultant or general practitioner GP. For stylistic ease, the terms 'junior doctor' and 'trainee' will be used synonymously throughout. However, it is recognised that there are negative connotations of condescension associated with the term 'junior'.

The complex nature of the aims of this project demands an approach that can offer a nuanced insight into the idiosyncratic experiences and perceptions of dyslexic trainees.

The exact details of the research strategy, and the underpinning theoretical perspectives, will be explored in more detail a little later. To begin with, and to frame this exploration, it is necessary to start with what research questions have evolved. From these questions, we can discern the underlying assumptions of reality (ontological perspective) and knowledge (epistemology) in order to guide the selection of an appropriate methodology.

3.1.1. Development of research questions

With the broad aims of *developing understanding*, central to this project in mind, an interpretive frame of inquiry is called upon. Research of this kind follows an iterative and evolving process (Crotty, 1998). The questions that evolved through the early stages of this PhD journey, and have guided this inquiry, can be stated as:

1. What are the challenges that trainee doctors with dyslexia face that are specific to their dyslexia?
2. How do trainee doctors with dyslexia make sense of their successes and failures (academic and / or clinical) in relation to their learning difficulty?
3. How does having dyslexia factor into the negotiation and development of identity within a learning and professional team environment?
4. How do trainee doctors with dyslexia cope with their learning difficulties?
5. What learning strategies do junior doctors with dyslexia develop and use in their training?

In approaching the issues central to this project, I identify that I operate from an interpretive perspective in that I believe that meaning is derived from experience at the interface of the interaction between the individual and their reality. Placing the individual *experience* at the centre of the inquiry requires an analysis of the assumptions and beliefs that underpin this project. One core belief is that the best way to develop an understanding of a phenomenon is to explore the experience of those who live with that particular phenomenon (i.e. dyslexia) from their perspective, and to explore their processes for making sense of their experiences. This view draws on assumptions of reality and knowledge that underpin interpretive work in general, and phenomenological work in particular (Crotty, 1998; van Manen, 1990).

3.2 Ontological and epistemological perspectives

Having studied neuroscience and medicine, it is fair to say that my early academic years were embedded in a biomedical, and therefore strongly positivist context. It seemed natural to value the "power"[5] and "significance" that results can be imbued with by virtue of large sample sizes, drawing on "objective" measures, processed through complex and obfuscating, yet widely-accepted statistical mechanisms. Indeed, there is a Hierarchy of Evidence (figure 3.1) that my profession widely subscribes to that converges on this view (Guyatt et al*.,* 1995). This form of science has historically dominated, promulgating a notion that knowledge can be objective, concrete, ahistorical, and value-free (Robson, 2011). From this tradition, it is clear that notions of reliability, validity and generalizability of the project design and subsequent data are key. However, Ezzy (2002) outlines that drawing on these aforementioned key tenets of natural science for human scientific work is flawed for a number of reasons: Firstly, if validity is understood to refer to the ability of a theory to accurately represent reality, a problem arises due to the infinite 'polyvalant' ways that social life can be experienced and interpreted (*ibid.*: p.53). Second, reliability refers to the potential to 'repeat a project and find the same results' (*ibid.*: p.52). The meanings and interpretations of social experiences that are the concern of human sciences are highly dynamic and ever changing. Therefore, the idea that they could be replicated, or indeed that they would need to be in order to be accepted also poses a significant challenge. However, it is important to be reflexive of this heritage within the framework of my current positioning and work.

[5] "double quotation" marks are used to highlight the contentious nature of these terms.

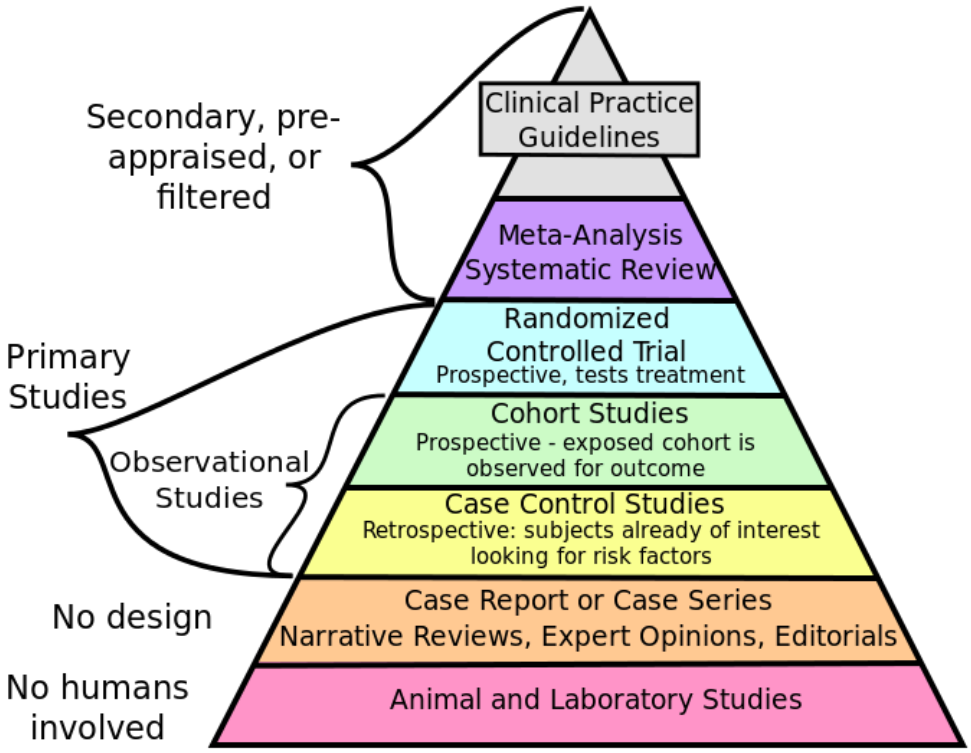


Figure 3.1: A diagram representing the ubiquitous 'hierarchy of evidence' used in teaching evidence based clinical practice (Fredrick, 2015). *Used under creative-commons attribution-share alike 4.0 license.*

3.2.1. Objectivism and objectivity

A premise of the objectivist epistemology that underpins the positivist perspective of biomedical (also termed 'natural') science is the notion of *a priori* knowledge: that knowledge can exist or be acquired in the absence of previous experience. This implies that there is a 'truth' that exists independent of consciousness, and is awaiting discovery or deduction (Crotty, 1998). This returns to the false notion that knowledge can be value-free and ahistorical (Robson, 2011). Underlying this belief is the assumption of realist ontological values: in the assumption that a truth is possessed by objects independent of conscious thought, they are dependant on reality being independent of consciousness also (Lincoln & Guba, 2003). In this regard, truth has stability and is unchanging. I believe reality, and our understanding of it, to be more dynamic and complex than is fully captured in this sentiment. Further, a limitation with the realist ontological perspective is that it neglects to accommodate *meaning*. While an object may exist independent of thought, meaning, which is contingent on social, cultural, historical, and individual conceptualisation, simply cannot. As Crotty puts it,

'the existence of a world without a mind is conceivable. Meaning without a mind is not' (1998: p.11).

The pursuit of knowledge through systematic inquiry is often termed 'science', and can be broadly categorised as a *natural* or *human* science, the distinction usually being drawn between the two based on positivist or interpretivist perspectives respectively (Ormston et al.., 2003). Natural scientific method is concerned with unearthing relationships and consistencies, in a nomothetic process of developing theory that can generalise from specific observations. Positivism itself is influenced by the belief in the objectivist values of knowledge and truth being attributes that objects have, independent of conscious thought (Cohen et al*.,* 2007). The value placed, by this perspective, on empiricising experience as a means of generating understanding and knowledge from observation, limits 'inquiry and belief to what can be firmly established...by reason alone' (Cohen et al*.*, 2007: p.9). However, interpretive inquiry acknowledges that the interaction of the researcher, and their experiences and values, with the subject[6], contributes towards the generation of data. This is in stark contrast with the neutrality and objectivity demanded of scientific inquiry (Cohen et al*.,* 2007; Crotty, 1998). I believe this contrast to be an acknowledgement of the illusory nature of objectivity, a concept that is articulated well by Ezzy: 'to try to be objective is therefore to pretend that our preconceptions and biases are not influencing our research when they actually are an unavoidable influence on research practice. It is better to acknowledge how our subjective preconceptions and biases shape the research, and to deal with these biases openly and honestly, rather than to pretend they do not exist' (Ezzy, 2002: p.53). It is plausible to extend the sentiments across all forms of research, even into the empiricist domains of medical science where objectivity is used as a veil to cover many unacknowledged factors that influence the conduct and interpretation of the research. Badley (2003) draws attention to the fact that interpretivist work has historically had to adopt a defensive, or even apologetic, stance in order to gain acceptance among audiences that are entrenched in positivist ways. Reconceptualising objectivity as an illusory concept calls into question the hegemony of work, and subsequent knowledge claims based on notions of objectivity

[6] 'Subject' is used here to refer to the discipline or subject matter, rather than participants in the research process. In this sense, 'subject' would include material contributed by participants.

and empiricism, and challenges the same hegemony that has historically deprioritised and devalued claims informed by interpretivism and reflexivity.

3.2.2. Knowledge and truth

Knowledge can be considered a shared understanding of a representation of what is, what happens and how. In other words: a shared belief in a truth. Maynard (1994) goes on to qualify this further, adding the requisites of possibility and legitimacy. Legitimacy implies conformity to rules and conventions. This relates to the practice of staking knowledge claims based on research findings: If a knowledge claim is to be accepted, it must possess plausibility and be communicated in a way that does not contravene societal mores (Harvey, 1981; Prasad, 1997). The vital nature of the elements of plausibility and legitimacy can be illustrated in the revolution stirred by Galileo's support of Copernicus' heliocentric model of the solar system. The model was later accepted as correct, but contravened religious dogma at the time. Subsequently, Gallileo was tried by the Catholic Church as a heretic, and consequently held under house arrest until his death in 1642 (Sherratt, 1994). The socio-cultural context at the turn of the 17th century meant that such a paradigm shift was unacceptable to the ecology of the widespread beliefs held by society. Therefore, the concept was rejected and the proposer persecuted. These ideas will be revisited later, in a discussion on quality and rigour in the research process. The example of Galileo serves to reinforce the notion that what is considered truth is socially determined, and that knowledge is subsequently socially constructed.

3.3 Investigating Lived experience

Common ideas that underpin branches of sociology and psychology centre on the human tendency to seek and ascribe meaning to objects, events, and interactions. The American social work scholar Brené Brown argues that 'our minds are engineered to seek out patterns, and assign meaning to them. Humans are a meaning-making species' (Brown, 2010: p.ix). This observation is resonant with existential philosophical positions argued by Kierkegaard and Nietzsche, who postulated that humanity engages with continuous projects to explore and explain the lived world around them. In doing so,

we impress, express and impose meaning on the world (Langdridge, 2007). The implication of meaning being imposed on the world is that there is in fact no pre-ordained meaning waiting to be discovered, which resulted in Nietzsche's notable exclamation that 'God is dead' (*ibid.*). If meaning is imposed on the world, there is no neutrality, and there can be no objectivism. Several philosophers, especially Heidegger, built on this standpoint in developing phenomenology, which is the study of phenomena in the lifeworld (van Manen, 1990; Moran, 2000). The research questions outlined in 3.1.1. are concerned with the lived experience of junior doctors with dyslexia as a means of developing an understanding for how their dyslexia impacts on their training and practice.

3.3.1. A brief history of phenomenology

The origins of the philosophical discipline of phenomenology are attributed to the Czech philosopher Edmond Husserl, whose work spanned from the middle of the nineteenth century to the early half of the twentieth century (Moran, 2000). At the time, phenomenology was seen as radical, and anti-traditional, because it rejected the dominant empiricism of the likes of Hume and Locke (*ibid.*). The phenomenological movement built on existential philosophy, but criticized Hegel's precursory work and standpoint as failing to develop a concept of the mind as more than mere consciousness (*ibid.*). The phenomenological movement hoped to revolutionize science and psychology, grounding philosophy and science in a thoughtful understanding of our conscious experience (Moran, 2000; Langdridge, 2007).

Central to the work of Husserl was his revolutionary belief that science was a second-order knowledge system, and in contrast experience was first order (Smith, Flowers & Larkin, 2009). Husserl posed that we look at the world with a Natural Attitude, that, in order to gain a deeper understanding, needs to be suspended in favor of a Phenomenological Attitude (Smith Flowers & Larkin, 2009; Langdridge, 2007). This Phenomenological Attitude comprises a level of reflective awareness, which is necessary in order to achieve a certain Eidetic Intuition. Eidos stems from the Greek for essences, and so eidetic intuition refers to an insight into the essence of a phenomenon (Moran, 2000; Langdridge, 2007). Suspending this natural attitude involves a series of Phenomenological Reductions. First, you suspend the 'taken-for-granted' Natural Attitude that everything just *is* and is *there*, and bring Intentionality to the

phenomenological gaze. Intentionality is simultaneously an action of directing conscious awareness (= noesis) and is referential, referring to the thing to which your awareness is directed (= noema) (Langdridge, 2007). By exercising this Intentionality, it becomes possible to ask a question of the experienced phenomena, such as what is it about this thesis that makes it a thesis? When such questions are posed, it is then possible to apply phenomenological techniques, such as Imaginative Variation, to change qualities of the experience (e.g. if this thesis was not in a written and printed form, but instead was digital, or visual would it still be a thesis?) until you achieve the Intuition of the noetic correlation (e.g. what is if that is essential to the experience of thesis-ness) (Langdridge, 2007). This form of phenomenology is descriptive in nature, attempting to apprehend the core essence of a phenomenon through rich description. This essence was believed to be able to transcend different contexts, to accurately reflect the nature of the phenomenon, and is often, accordingly, referred to as transcendental phenomenology (Moran, 2000).

Later philosophers and their subsequent schools built on and developed Husserl's ideas into a variety of different branches of phenomenology. Subsequently, although Husserl is thought to be the main founder of phenomenology, he denounced himself as the Enemy of Phenomenology as a result of the tensions between his 'brand' of Pure Phenomenology, and the Existential Phenomenology that evolved from the works of his student, Heidegger (Moran, 2000). This is illustrative of turbulence within a community striving to establish an accepted form of inquiry that continues to this day.

Martin Heidegger, a student of Husserl, felt uneasy about the essentialist core of Husserl's work, and also moved away from the focus on consciousness and intentionality, for he felt this needlessly complicated phenomenology (Moran, 2000). Central to Heidegger's project was the belief in needing to return to a state of being present in the *now* with ourselves and the world, and with one another (Langdridge, 2007). Heidegger believed returning to the *now* was necessary in order to appreciate connectedness and significance, and to re-discover the things that we now (unconsciously) take for granted. He suggested we do this by developing an awareness of Dasein ('there-being'), which was his particular mode of human appreciation of Being. This is significant, as out of all the 'beings' in the world, we are the only ones

with the capacity to ask ourselves the question of what our existence means (Moran, 2000; Langdridge, 2007; Smith, Flowers & Larkin, 2009).

Heidegger introduced the notion of our everyday existence being in an unaware pre-ontological state, which feeds into the notion of the pre-reflective state accessed in many branches of phenomenology, especially interpretative phenomenological analysis (Moran, 2000; Smith, Flowers & Larkin, 2009). Heidegger starts from the point of view that we are 'radically in the world'. We are thrown in, and as such our gaze or perspective is necessarily directive (Moran, 2000). This draws on Kierkegaard, who noted that nobody asks us when we would like to live or die, we just *do* (Langdridge, 2007). For example, imagine being in a darkened room: The only way you can see is by using a torch. By shining the beam in one direction, you may gain perspective of what is within the light, but then become blind to whatever else is in the room where the light doesn't shine, where you may have moved the beam from. Drawing on hermeneutics, traditionally the interpretation of biblical texts, Heidegger proposed the Hermeneutic Turn, which introduced an interpretative dimension to the phenomenological project (Crotty, 1998; Moran, 2000; Langdridge, 2007). Thus began the hermeneutic, or interpretative, branch of phenomenology.

From this brief historical sketch, it is possible to see two broad distinctions in phenomenological discipline: the transcendental, or descriptive; and the hermeneutic, or interpretative. Within these branches there are a myriad of different 'articulations' of phenomenological approaches (Smith, Flowers & Larkin, 2009: p.200). Indeed, in a public lecture delivered in 1927, Heidegger stated 'there is no such thing as the *one* phenomenology' (quoted in Moran, 2000: p.3). Accordingly, Moran advises 'it is important not to exaggerate, as some interpreters have done, the extent to which phenomenology coheres into an agreed method' (Moran, 2000: p.3).

3.4 Interpretative Phenomenological Analysis

In the process of completing his DPhil in psychology, Jonathan Smith (1996; 1998; 1999) established what is now known as interpretative phenomenological analysis (IPA). IPA is a qualitative methodology that holds its interest in the *psychological* world of the research participant. Meaning, and the processes of meaning-making are central to

working out how we interpret experience, and what may influence that process of interpretation (Smith & Osborn, 2015). Data used to access participant experience in IPA has traditionally consisted of text from transcribed interviews and focus groups. However, examples where diaries and asynchronous computer-facilitated data collection methods have been used also exist in the wider body of IPA work (Smith, Flowers and Larkin, 2009). The hallmarks of IPA are considered to be: the reflective focus on subjective experiential accounts; the focus on the idiographic; and the commitment to the cyclical hermeneutic approach (Finlay, 2011). The meaning, significance and historical development of these components will be explored below.

Originators and proponents of IPA describe it as specifically post-positivist, drawing on a critical realist stance (Smith, Flowers & Larkin, 2009; Smith & Osborne, 2015). Critical realism holds the central premise that objects may exist in reality, independent of consciousness but their meaning does not (Harper, 2012). To illustrate this view, Crotty (1998) neatly uses the example of a tree: it remains tree-like even if we have no knowledge of it (whether it makes a sound when it falls if nobody is around to hear it is another question). The critical realist perspective comes into particular significance when considering the role of the *individual* and their perspective when investigating lived experience. Indeed, this stance highlights the value of investigating lived experience itself, as it places meaning-making at the centre of the field of concern. The introduction of critical realism into a discussion of interpretative phenomenology has the potential to be problematic, caused by tensions relating to the assumptions of the nature of reality (Hood, 2016). However, considering Maxwell's (2012) comprehensive developmental account of realist traditions, critical realism is considered to take an emancipatory perspective that distinguishes between ontology and epistemology. Subsequently, 'critical realists thus retain an ontological realism (there is a real world that exists independently of our perceptions, theories and constructions) while accepting a form of epistemological constructivism and relativism (our *understanding* of this world is inevitably a construction from our own perspectives and standpoint)' (*ibid.*: p5). IPA is not concerned with objectivism, but with examining the subjective, unique and idiosyncratic (Smith & Osborne, 2015; Smith, Flowers & Larkin, 2009). It is a human science, with a focus of inquiry that is not of things that can be measured and counted, but the expression and experience of meaning (Smith, Flowers & Larkin, 2009).

Drawing on Rom Harré's work (1979), IPA focuses inquiry on the idiographic, the individual, the nuanced and idiosyncratic (Smith, Jarman & Osborne, 1999). Therefore, IPA does not aim to generalize, but instead may offer tentative suggestions that can be explored and tested through other means (Smith & Osborne, 2015; Smith, Flowers & Larkin, 2009). The idiographic focus provides a very rich account of experience and meaning-making, and subsequently lends the methodology to a profound exploration of some very nuanced concepts and experiences (Smith, Harré & van Landenhove, 1995). The positioning of IPA may demonstrate tension with aspects of realist ontology, but is compatible with the relational epistemological stance that characterises critical realist traditions, and is aligned to the idiographic and hermeneutic phenomenological underpinnings of IPA that will now be explored (Maxwell, 2012; Larkin & Thompson, 2011).

The discipline of hermeneutics is central to IPA (Smith, Flowers & Larkin, 2009). By drawing on hermeneutic cycles of analysis, the researcher is able to examine latent meanings within the data, and through a process of emergence is able to approach an understanding of the author's experience (*ibid*). Hermeneutics involves a continuous cycle moving between parts, and the whole of the data, usually text, such as: words, phrases, sentences, paragraphs and the entire text (Crotty, 1998; Smith, 2007). In this regard, the hermeneutic analysis in IPA is reminiscent of discourse analysis in the close scrutiny of the language used (Smith, Jarman & Osborne, 1999). The researcher undertaking a hermeneutic analysis is constantly triangulating with interpretation and ascription of meaning arising from an understanding of: the person (data source), the self (fore-understanding), preconceptions (fore-understanding / fore-structures), and literature (fore-structures) (Crotty, 1998; Smith, 2007; Smith, Flowers & Larkin, 2009). Accessing the data, and returning to the things themselves in the phenomenological tradition, requires a specific approach (the phenomenological gaze) and constant examination of fore-structures. When encountering a new phenomenon, there is a jarring experience as we resist any change to our existing level of understanding, before we revisit and revise this in light of emergent meaning (Smith, Flowers & Larkin, 2009; Smith & Osborne, 2015). In IPA, this process forms part of a Double Hermeneutic cycle, which can be seen as the researcher 'trying to make sense of the participant trying to make sense of what is happening [or has happened] to them' (Smith, Flowers & Larkin, 2009: p.3). The double hermeneutic is where this process is not only going on between

the participant (data) and the researcher (interpreter), but also *within* the researcher (a hermeneutic, or interpretation of them making sense of the participant making sense).

3.4.1. Note on phenomenological attitudes and bracketing

Key to the phenomenological gaze is the suspension of the Natural Attitude, and with that, the adoption of a reflexive awareness of fore-structures (preconceptions, assumptions, and beliefs) combined with a degree of empathy and suspicion (Smith, Flowers & Larkin, 2009). I interpret the combination of empathy with the participant and their data, with the suspicion of meaning and interpretation (being suspicious of the potential influence from forestructures) to mean an intense and authentic curiosity. This interpretation resonates with the case Galvin and Todres make for a suspension of the Natural Attitude: 'just as fish may take for granted the water they swim in, we as humans may find it difficult to notice and articulate the humanly qualitative nature of the world we live in' (2013: p.25). It is through rediscovering a curiosity for the water in which we swim, that we can begin to understand the nature of that experience. Suspension of attitudes, and being reflexive to the ways in which forestructures can influence interpretation relate to the notion of bracketing, or *epoché.* Bracketing was advocated by Husserl as necessary for the pure phenomenological inquiry into the experience: bracketing out preconceptions, to afford a naïve perspective of the phenomenon (Langdridge, 2007). Finlay (2011) cautions against conflating bracketing with objectivity, delineating bracketing as 'dwelling on the phenomenon….juggle[ing] the contradictory stances of being "scientifically removed from", "open to" and "aware of" while simultaneously interlacing with research participants in the midst of their own personal experiencing' (p.23). Smith, Flowers and Larkin (2009) draw on Heidegger's belief that the influences of our culture, history and beliefs are pervasive, and that we are continuously becoming both aware and ignorant of them. He conceptualized bracketing as a cyclical process that never truly reaches a state of absoluteness or completion. This highlights the importance of reflexivity in qualitative psychological inquiry.

The role that my experience and perspective has to play in my research warrants addressing here. Rogers (2011) discusses the emotive nature of researching a field of shared, invested, experience. She states that it is 'not easy or *necessary* to be

uninvolved' (*ibid.*: p.569), drawing on Oakley she notes that 'it requires...that the methodology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than a dangerous bias' (Oakley, 1981: p.58, quoted in Rogers, 2011: p.570). This is an important challenge to the objectivity valued in medical research, and indoctrinated through medical training. Not only is it not easy for me to divorce my current research practice from my past experience, it is not *necessary*. Indeed, Oakley's sentiments suggest that to feign un-involvement would not only be dishonest, it would reinforce a perverse view of research participants as 'subjects' and 'instruments of data production'.

Returning to Ezzy's (2002) critique of the very notion of objectivity, that 'to try to be 'objective' is therefore to pretend that our preconceptions and biases are not influencing our research practice' (p.53). It is no wonder, therefore, that the constructivist notion of being a co-constructor of meaning and knowledge (Crotty, 1998) is seen as somehow 'unhygienic' or contaminated. Whilst bracketing may not be explicitly equivalent to notions of objectivity, the proximity of the concept to ideas of being aware of and minimising the influence from other forestructures creates a tension that requires careful consideration. I believe that the position illustrated by the excerpts from Oakley (1981) and Ezzy (2002) is crucial to an honest, transparent and ethical research process, which is complementary to Heidegger's notions of forestructure and bracketing (Smith, Flowers & Larkin, 2009). Therefore, provided I am aware of, and openly acknowledge, what my experience brings to my research, my voice has an important role to play in developing the relationships with participants in which meaning-making and knowledge co-construction can occur. Following the phenomenological tradition, IPA traditionally resists the introduction or linking to literature and theory in the analysis stage instead focusing on the data (Moran, 2000; Smith, Flowers & Larkin, 2009). There were several occasions during the data analysis and write-up that I became aware of the similarity between the terms that came to represent emerging themes, and established concepts in sociology and psychology. Therefore, I have drawn on literature as part of a reflexive process during the write-up of the analysis, to delineate and clarify the specific nature of the concepts that have

emerged from the data. This would be considered unconventional in IPA research, but I would argue that it is not incompatible with the methodological origins.

3.5 Study design

This project is an exploration into the lived experiences of doctors in training who have dyslexia. This is to develop an understanding of how dyslexia may impact on education, training and everyday practice in the medical profession. The project will operate from an IPA methodology, drawing from a case study approach (Thomas, 2011). Data will be obtained by drawing on a combination of different methods, building detailed case studies of participants over three phases. The first phase will be an interview of two parts designed to ascertain background and contextualising information about the participant, and to begin to explore their sense of identity. The second phase of the case studies will be a self-diarising exercise structured around a Critical Incident Technique (after Flannagan, 1954) debrief. The data from the interviews and diaries (phases 1 and 2 respectively) will then inform a final phase of in-depth interviews. This plan has been summarised in figure 3.2. Following the convention of IPA, the individual case study analyses will then be analysed at the group-level in a cross-case analysis (Thomas, 2011; Smith, Jarman & Osborne, 1999; Smith, Flowers & Larkin, 2009). The data collection methods employed in each phase will be explored in more detail later (section 3.6).

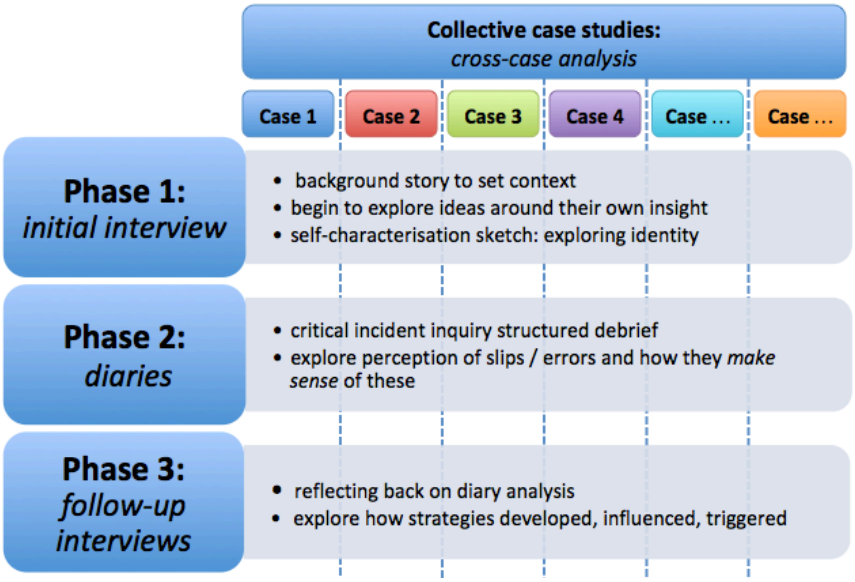


Figure 3.2: Graphic representation of the intended structure of this research project

3.5.1. Participants and sample

For the purposes of doctoral IPA work, Smith, Flowers and Larkin (2009) recommend a relatively small, homogenous sample. The focus of this study is the experience of doctors in training with dyslexia. Historically, trainees were referred to generically as 'Juniors', or 'House Officers' (equivalent to FY1), and 'Senior House Officers' (equivalent to FY2) or Registrars (summarised in table 3.1). There is an increasing move within the profession to draw on the specific labels of the particular training grade (e.g. FY1, or CT2, or ST5), but this practice is not uniform.

	Older Term	Newer Term	Years
	Medical Student		Undergraduate: 0-5 or 6
'Junior Doctors'	House Officers	Foundation Year 1 (FY1)	Post-qualification: 1
	Senior House Officers	Foundation Year 2 (FY2) Core (Medical / Surgical) Training ('CT') year 1 or 2	2 to 4 (5 in some specialties)
	Registrar	Specialty Trainee (ST) year 1 to 8	Variable (some specialties start at year 3, others year 5)
	Consultant / General Practitioner		Post-Certificate of Completion of Training (CCT)

Table 3.1: Illustrating how the older and newer terminology referring to 'Junior Doctors' relates to their stage of training

Smith, Flowers and Larkin (2009) advocate between 6 to 8 participants for a doctoral research project following IPA. The intention was to recruit about 6 trainee doctors to this study. This smaller number is justified by the virtue that each participant will provide several quanta of data to be used in slightly different ways. Furthermore, to allow for focused, in-depth analysis within the timeframe of the PhD, it is practical to limit the number of participants recruited to the study, so that the project does not become swamped with data.

The inclusion criteria used for this study were that the participant needed to:

1). Be a doctor working within a training post in the National Health Service

2). Identify as having a diagnosis of dyslexia

3.5.2. Recruitment

Following ethical approval for this study, by the University of Exeter's Graduate School of Education in 2014 (appendix 1), reciprocal approval was granted by Health Education England (HEE). Medical education research of this type was, at the time, considered exempt from other formal research ethics processes within the National Health Service. When approval had been granted, postgraduate Deans of local education and training boards (LETBs) within HEE and the devolved nations were emailed information about the study, and a request to cascade an invitation out to all doctors in training in their area. These LETBs hold distribution lists for regional trainees under their charge. All trainees were sent the email, which specifically invited those who know they have dyslexia (i.e. meet the inclusion criteria) to respond to me directly. It is not known how many trainees received, let alone read, the emails.

Within 8 weeks of sending the initial request to LETBs, I had received emails from 35 trainees expressing a wish to participate. Of these, 10 went on to agree a date and time to meet for our first interview. The remaining respondents failed to reply to a subsequent email reminder, which was considered a withdrawal of interest. The positive response was unexpected, and some trainees took up to two months to eventually respond. This made it challenging to anticipate how successful recruitment would be. Additionally, I found myself feeling compelled to continue allowing participants to join beyond the recruitment target of 6. This was, in part, due to an anxiety about some participants dropping out. It was also because I felt that I owed

them the opportunity to participate. Nine of the 10 project participants came from England (from the West Midlands, East Midlands, London and the South West), and one participant came from Wales. Eight weeks after launching the project, however, I received an email from a trainee in New York (USA) who wished to participate. He did not meet the eligibility criteria, given that he wasn't working within the NHS, and may come under the jurisdiction of different processes for research ethics and governance. Therefore, I felt it necessary to decline his offer of input, but noted a sense of guilt in doing so.

3.5.3. Anonymity

In the analysis and reporting of the data, participants, and others they referred to in their data, were assigned a pseudonym in order to protect their identities. In the spirit of participatory research, participants were given the opportunity to select an alias, but none did. It is acknowledged that some of the detail in the data from the participants may still be specific enough to reveal identities. Without altering the nature of the data, information pertaining to locations and other potentially revealing identifiers has either been redacted or altered (to a more general term or an alternative name). The risk of the idiographic case-study approach employed in this work, is that participants may still be identifiable despite these efforts. A compromise between an adequate level of detail to explore the idiographic, and the withholding of information to achieve a sense of anonymity must be reached in order to protect participant identity, and respect their contributions given in confidence. For example, one of the participants discusses her background, having grown up in a Jewish family, and having previously done a PhD. This is very specific information that may identify her. However, withholding this detail from her case study would negatively impact on the analysis, and may be interpreted as editing or sanitising her contribution in some way.

During the recruitment and consenting process, participants were informed that their data would be anonymised by means of masking their identity with a pseudonym, as outlined in the participant information sheet (appendix 2) and consent form (appendix 3). There was also the explicit opportunity to withdraw data should participants change their mind. With this in mind, the contribution of details to their data, and the continued engagement with the research project can be considered complicit

permission to draw on and represent these idiographic insights in a way that is sensitive to both their contribution and their need for identity protection.

3.5.4. Ethical considerations

Smith, Flowers and Larkin (2009) warn that the process of talking about experience can cause distress in participants. It is possible that having dyslexia may make sustained participation even more challenging for these trainees, as work may take them longer, their ability to time manage may be affected and the demands that participation could impose may cause additional stress or anxiety. Moreover, experience has taught me that the interview process can bring strong emotions to surface. Where participants became distressed, they were given the opportunity to stop. Additionally, I signposted supportive services in their region, and followed up on their wellbeing.

I have an ethical obligation to ensure that I do not bring about any form of harm to potential participants in the research project. However, this is in direct tension with another obligation: the one I have as a medical practitioner licensed by the General Medical Council myself. I am bound by duty and law to follow regulations that promote the protection of the public, of patients and of the reputation of the medical profession (GMC, 2013). Were a participant to disclose something that is of concern to patient safety, I am obliged to undertake steps in accordance with GMC guidance, initially encouraging them to disclose matters to their supervisors, before suggesting that I may have to contact the necessary bodies myself. This was delicately explained during the consent procedure, and outlined in the consent form (appendix 3).

Digital data have been securely stored on a password protected hard-drive belonging to me. Hard-copy data, along with signed consent forms, will be stored in a secure filing cabinet in my domestic residence. Original data will be stored for a 10-year period after completion of the project, in accordance with University of Exeter policy (Code of Good Practice in the Conduct of Research, Version 6).

3.6 Data and collection

Once launched, participants began to engage with the project in December 2014, and data collection across 3 phases of the project continued until March 2016. A detailed

account of the three phases of the project is outlined below. The first and second phase were piloted with a FY1 trainee who has dyslexia, who gave detailed feedback that was used to improve the methods employed in each phase.

3.6.1. Phase one

The first phase of the project comprised 3 components: the initial information gathering, in order to ascertain basic demographic and background information (box 3.1a); the semi-structured interview, to explore their experiences to date (box 3.1b); and a self-characterisation sketch exercise (box 3.2). The information from these three components was used to create a portrait of the participants' sense of self and their lives to that point. The intention was to hold all of the initial interviews in person, to build rapport and trust. All but one were conducted face-to-face, with the tenth being conducted via Skype at the participant's request. Each interview began with a preamble in which I introduced myself, my background, and the project in order to build rapport with the participants. The initial interviews were digitally recorded, augmented by field notes and concept maps. The questions that structured the background information and the semi-structured interviews were developed through a process of reflection on the research questions in the context of what is already known from the literature, and open dialogue with my supervisors, and with the FY1 doctor who assisted in piloting the project.

Box 3.1a: Demographic questionnaire:

Name: Age: Gender: M / F

Nationality: 1st Language:

Previous education (and where):

Age at diagnosis:

Support received in school:

Current role and rotation:

Box 3.1b: Prompts for preliminary interview:

"Thank you for agreeing to take part in my project. The first part, which is this meeting today, is so I can get to know about you and your experiences. I am particularly interested in your educational 'journey', and where dyslexia has featured in this. I have a few guiding pointers to help with the interview, but I want you to feel completely at ease to talk about whatever you see as relevant really. It is important to know that sometimes these sorts of conversations can touch on subjects that can be very emotionally charged, and bring feelings of sadness or frustration. This is normal, but if you wish to stop at any point, please do say so."

Guiding questions:

1). Could you tell me about your experiences of education up to now. You can start wherever you wish, from your first memories, to University or beyond.

a). Any experiences of specific talent or struggle?

2). Could you tell me about how you came to find out you have dyslexia

a). When did you find out, and how?

3). How do you think this has interacted with your journey through medical school?

4). How have your experiences shaped who you are now (and as a doctor, if not included)?

3.6.2. Self-characterisation sketches

The self-characterisation sketch exercise (box 3.2) is a particular method for eliciting data pertaining to the construction of self, which was developed as part of personal construct psychology (PCP) (Kelly, 1955a & b). Drawing on constructivism, and elements of pragmatism, the theory offers a means of exploring how an individual *construes* their reality, and therefore how they derive and interpret meaning from experience (Denicolo & Pope, 2001). The theoretical framework of personal construct theory provides a methodology in its own right (Fransella, 2003). However, individual methods of data co-construction, elicitation and collection may be drawn upon within complementary methodological frameworks. IPA was developed by psychologists, and

takes phenomenology further than the lived experience, to a deeper level of idiographic meaning-making (Reid et al., 2005). Butt (2003) argues that personal construct psychology can itself be construed as a phenomenological theory. He draws attention to many commonalities between the two: both are concerned with process, rather than product, and neither attempt to 'reify self'.

Denicolo (2005) refers to Butt (2003) in linking her exposition of self-characterisation sketches to the practice of phenomenological research, and the importance of adopting a 'credulous approach'. Additionally, the complementarity of personal construct theory with IPA was established in early work that drew on repertory grids, another technique employed in PCP, within a broader IPA exploration into the construction of self and transitions in motherhood (Smith, 1998 & 1999). This is, however, the first example of the use of the self-characterisation sketch technique within IPA that I am aware of, and represents a unique application of a method of visual elicitation in the field (Clark & Morriss, 2017).

Box 3.2: Self Characterisation Sketch prompts:
"Next, I wonder if you would consider an exercise whereby you come up with a series of 'character sketches', a description of you, from different perspectives. These sketches should focus on you as a person, and it would be helpful if the sketch gave consideration to you as a doctor and your dyslexia. You can write, draw and talk if you wish. The three perspectives I would like you to consider are:

1. How *you* see *yourself*. How all of the bits of you and your life fit together.
2. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.
3. How a *critical* other, someone who knows you very well, and is *critical* sees you."

"You could choose to summarise these ideas in a diagram, as a sort of map illustrating how different parts of you relate (a different map for each perspective may be helpful, but you may do one all-encompassing one if you like). This is called a concept map, a representation of how you are seen, how all of the bits of you and your life fit together".

Prompt: After initial draft (if dyslexia not included): 'it would be interesting to see where your dyslexia fits in there...'

3.6.3. Phase two and the critical incident reflections

The second phase of the project drew on a diarising strategy, to ascertain participants' reflections on their experience of difficulties related to their dyslexia in the workplace.

Reflective diaries were structured around a modified form of Flanagan's (1954) critical incident technique (CIT) debrief, that I have termed critical incident reflections (CIR) (box 3.3). John Flanagan, a psychologist in the US air force, developed the five-step CIT to provide a structured means of reflecting on performance of a specific task, from the perspective of an expert, in order to elucidate the components that lead to the performance being good or bad (*ibid.*). Flanagan's original idea has been developed by Brookfield (1990) into a means of helping teachers reflect on their practice, which is where I first came across the concept. In research, and medical education research specifically, the technique has been adapted further and now has a far broader approach compared to its origins (Butterfield et al., 2005 & 2009; Woolsey, 1986; Dunn & Hamilton, 1986; Cottrell et al., 2002).

The typical fifth stage of CIT analysis involves reporting thematic coding to 'experts' for independent review of 'usefulness' of the theme, with the intention of affording the analysis credibility (Flanagan, 1954; Butterfield et al., 2009). I have several issues with this: 1) the 'experts' in this situation are those reporting the incidents themselves, and 2) nobody else has the 'authority' or insight to comment on the usefulness, validity or credibility of their experience other than them. I would argue, at least within the paradigmatic context of this project, that the thematic representation of the data emerges from the formation of a collaborative relationship between researcher and participant, and the deep understanding involved therein. Therefore, the 'expert' checking process should really be replaced by a 'responder validation' process, in which participants are involved in a dynamic exploration of the analysis of preceding elements of the project.

Participants were given the opportunity to present a record of their lived experience of critical incidents. In the pilot, the trainee was given a digital audio recording device, but she lost the cable that connected it with the computer, enabling uploading and sharing of her audio file. Subsequently, I sourced digital voice recorders that were contained within a single USB (universal serial bus) pen-drive (figure 3.3). The option between submitting reflections digitally recorded with these devices, or as a written response to an email prompt were given. Email reminders were sent at monthly intervals with the reflective debrief prompt embedded (box 3.3).

Figure 3.3: Inexpensive USB stick digital recorder given to participants

For the purposes of the CIT, an 'event' or 'critical incident' was defined as the occurrence of something in the process of the doctor conducting their professional duties (as a doctor, or a learner) in the normal clinical working environment. The 'event' is made different, or 'critical' by the fact that the event itself, or something leading up to the event, occurred in a way that does not match up to expectations (either the learner's own expectations, or the expectations that are perceived to be from colleagues, supervisors or others).

Box 3.3: Critical incident reflection prompts:

"The next part of the project is based on you recording your thoughts and feelings in a form of structured reflection or debrief called the 'Critical Incident Technique'. The idea is to get detailed information about events that you feel are significant because they may not have occurred according to plan (for positive or negative reasons) and how this relates to your dyslexia."

- "Think of the last time you thing / feel you did something that was affected by your dyslexia...
- *What were you doing (what was the primary purpose of your activity)?*
- *What led up to this situation?*
- *Exactly what happened?*
- *What is it about this event that makes you think / feel it was affected by your dyslexia?"*

Participants were encouraged to record a diary entry after a shift at work, on alternate days, for at least two weeks. This frequency was chosen to be as comprehensive as possible in terms of capturing a true sense of their experience, without being over-intrusive. Email reminders were sent monthly for 6 months. Four of the 10 participants responded with CIR submissions. Two responded explaining that they were unable to submit CIRs due to other workload pressures, but intended to.

3.6.4 Phase three

Following the analysis of the diaries, participants were invited to an in-depth interview 6 to 8 months after their initial interview. These interviews were loosely structured according to the output from phase two, and gave participants the opportunity to: discuss incidents or reflections they had not yet submitted; review the analysis of their diaries; and to collaborate in reaching an understanding of the meaning making process (box 3.4). Participants were given the option of engaging with these interviews in person or over the telephone or Skype. All participants were invited to participate, even if they had not submitted any CIRs. Email invitations were re-sent if no response had been received within 2 weeks. Only one of the 10 participants engaged in phase 3, with non-response to two emails (after non-response to email prompts as part of phase 2) was considered a passive withdrawal from the on-going research process.

Box 3.4: Prompts for in-depth interview:

1). Looking back over the reflective debriefs, what has happened to the way in which you perceive these 'events' and how they relate to your dyslexia?
2). What are your thoughts on the analysis of the diaries, and of the process overall.
3). Emerging feelings
4). Interpretation and reflections on:
   i). Errors or slips
   ii). Coping strategies
   iii). Impact on self and others
   iv). Any changes over time (changes in self-concept / perception / beliefs)

3.6.5. To transcribe, or not to transcribe, that is the question.

Although there is no prescriptive rule that researchers must transcribe their own data in IPA work, Smith, Flowers and Larkin (2009) consider transcription a part of the analytical process. From previous work, I have come to find that my transcribing skills are hampered by my own learning difficulties. I am a slow and inaccurate typist. I have found the use of a reliable private company, with appropriate levels of confidentiality and security, to undertake verbatim transcriptions of my audio files a suitable solution. The transcriptions were conducted rigorously, with inclusion of notes representing non-verbal utterances, such as '(laughter)' and '...' for pauses. Rather than immersion through the process of transcription, I immersed myself in the data by reading and re-

reading the transcripts with the audio files playing (checking for accuracy, but also completing a preliminary analysis).

I am aware that some qualitative researchers see this as a significant deviation from conventions of quality, whereas others (e.g. Barney Glaser himself) suggest that transcribing data altogether is unhelpful and that field notes, memory and in-interview analysis could suffice (Halcomb & Davidson, 2006). I do not feel this latter sentiment would hold true for IPA. Indeed, Smith, Flowers and Larkin (2009) outline that the length, depth and detail of data involved in IPA projects necessitates recording and transcription in order to accurately capture the nuanced contributions from the participants. In addition, principles of phenomenological analysis advocate a sense of distance from the data, in order to allow the presentation, identification, and reflexive with fore-structures (Langdridge, 2007).

The arguments for personally transcribing do not hold exclusively true in my experience. Despite choosing not to transcribe the data myself, I felt intimately familiar with the data, recalling emotions and sentiment from the interviews several months later during the analytical process in a way that was equivalent and comparable to other projects I have undertaken, where I did personally transcribe data (e.g. Shrewsbury, 2011 & 2013). Therefore, I do not feel that the analysis has been hampered in any way by the use of a third-party transcription service.

3.7 Data analysis

The process of data analysis in IPA draws heavily on a close, nuanced hermeneutic inquiry of the text and image-based data contributed by the participants. The framework of IPA suggests the following process (Smith, Jarman & Osborne, 1999; Smith, Flowers & Larkin, 2009; Finlay, 2011):

> **1).** Initial familiarisation and re-reading of the data in order to develop a intimacy with it. I chose to do this whilst playing the digitally recorded audio data corresponding to the transcripts, which enabled me to check and correct the transcripts. This is accompanied by notation of free-association and

exploration of the content embodied in the language of text-based participant data.

2). With the transcript arranged in a central column of a page, a process of descriptive coding (conventionally in the left-hand margin). This coding may represent a summary of what that element of the data encapsulates, or it may propose a new insight from the initial reading.

3). This is followed by a process of interpretive coding. This form of coding represents emerging themes that may reflect the essential quality of what is being found in the data.

4). The descriptive and interpretive codes are then used in a process in which the data is re-interrogated: chunk-by-chunk, looking at parts and then the whole, linking from chunks within each participant's body of data, and then later (in the group-level cross-case analysis) across different participants' data for patterns and relationships to find higher-order qualities among the themes that resonate across the data corpus.

It is acknowledged that there may, at least superficially, be some similarities between IPA and thematic analysis (Smith, Flowers & Larkin, 2009; Braun & Clarke, 2006). What differentiates IPA is the philosophical background that underpins the methodology, orientating it to a uniquely idiographic psychological focus on meaning making (Larkin, Watts & Clifton, 2006). This process is observed for the entire corpus of data contributed by each participant, before a group-level cross-case analysis, looking for connections, relationships and patterns in the data. I chose to arrange participants' transcripts on an A3 page, with a large margin either side, text 1.5 spaced, and line numbers arranged along the left (figure 3.4). Stages 1 to 3 were performed by reading printed transcripts, and annotating them by hand using a pencil. Choosing pencil was largely due to personal preference – as they are easy to write with, and easy to correct where necessary. However, returning to these transcripts later, after several months of sorting and storing, the pencil markings have faded slightly. They remain legible, but the impact of this decay is visible in figure 3.4, where the scanned image does not fully show text in the right hand margin.

Following on from the hand-annotation of transcripts, the coding was detailed in a table in a word document. I designed this table of 'coding notes' to contain columns for: transcript excerpts, with line numbers (referring to A3 transcript layouts); descriptive coding; interpretive coding; and a column for emerging themes, with parenthetical notes that organised themes into clusters, and detailed a further hermeneutic interpretation afforded by this additional step (the double, or even 'triple' hermeneutic) (figure 3.5).

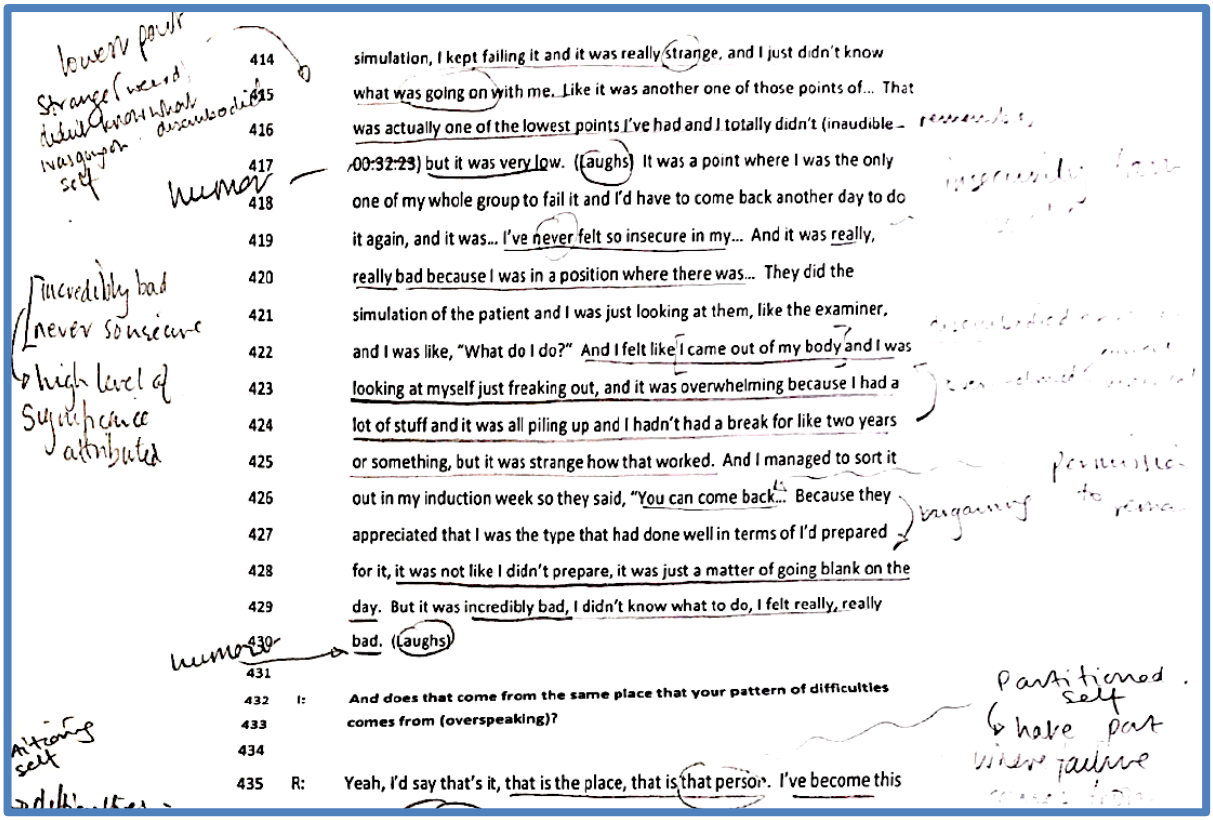
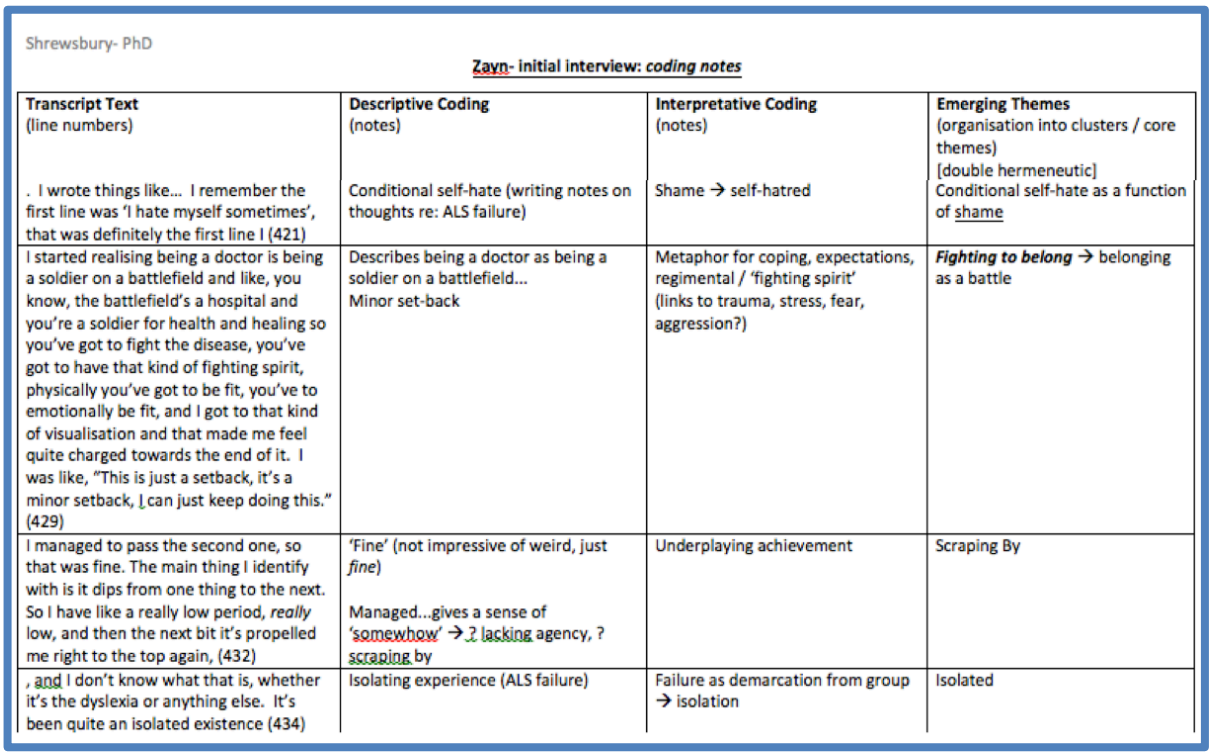


Figure 3.4: Picture of A3 transcript of Zayn's initial interview, with left-hand margin illustrating descriptive coding, the right hand margin illustrating interpretative coding. The text also includes highlights and annotations to augment, signpost and inform the two forms of coding. Listening to interview recordings alongside reading the transcripts enabled me to check, correct and complete transcription (e.g. 'inaudible 00:32:23)' on line 417).



Shrewsbury- PhD

Zayn- initial interview: *coding notes*

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
. I wrote things like… I remember the first line was 'I hate myself sometimes', that was definitely the first line I (421)	Conditional self-hate (writing notes on thoughts re: ALS failure)	Shame → self-hatred	Conditional self-hate as a function of shame
I started realising being a doctor is being a soldier on a battlefield and like, you know, the battlefield's a hospital and you're a soldier for health and healing so you've got to fight the disease, you've got to have that kind of fighting spirit, physically you've got to be fit, you've to emotionally be fit, and I got to that kind of visualisation and that made me feel quite charged towards the end of it. I was like, "This is just a setback, it's a minor setback, I can just keep doing this." (429)	Describes being a doctor as being a soldier on a battlefield… Minor set-back	Metaphor for coping, expectations, regimental / 'fighting spirit' (links to trauma, stress, fear, aggression?)	***Fighting to belong*** → belonging as a battle
I managed to pass the second one, so that was fine. The main thing I identify with is it dips from one thing to the next. So I have like a really low period, *really* low, and then the next bit it's propelled me right to the top again, (432)	'Fine' (not impressive of weird, just *fine*) Managed…gives a sense of 'somewhow' → ? lacking agency, ? scraping by	Underplaying achievement	Scraping By
, and I don't know what that is, whether it's the dyslexia or anything else. It's been quite an isolated existence (434)	Isolating experience (ALS failure)	Failure as demarcation from group → isolation	Isolated

Figure 3.5: Coding notes of Zayn's initial interview, corresponding to the image of the hand-annotated transcript in figure 3.4.

Drawing on Ricoeur (1988), Ezzy (2002; p. 149) argues that in reporting research 'events become meaningful only insofar as they are interpreted within the frame of a narrative, a story that accounts for the reasons and consequences of the described episodes'. In writing up each case study, the analysis underwent a further additional layer of scrutiny and refining. In order to create a coherent account, the analysis underwent further checking with the data, and with what the data conveyed about the participant. In this sense, the double-hermeneutic proposed by Smith, Flowers and Larkin (2009) is open-ended, and revisited at several points. Within the process that I observed, this making-sense-of-participants'-sense-making was re-examined in the process of tabulating the data interpretation, in writing up the case studies, in the group-level cross-case analysis, and then in the write up of this group-level analysis too.

In reporting the data analysis, I have intentionally chosen to include excerpts of the original data. This brings the sensitivity of editing into consideration. I personally felt that very little should be edited or adapted. Images were altered purely to enable them to be made visible in their presentation. No other components of graphical data contributions were changed. Where excerpts of participants' written data (e.g. CIRs) were included, they were unaltered with the exception of truncating, in which I have used ellipses. When including excerpts from transcripts, there was cautious editorial

elision, again indicated by ellipses. Additionally, identifiable information (names of people and places) were changed, indicated by square brackets.

3.7.1. A note on narrative and emergence

Throughout the reporting of the analysis, I draw on the terms narrative, discourse and data interchangeably. This is largely a stylistic choice, to aid readability. However, whilst acknowledging that this project follows IPA methodology, rather than a strictly narrative methodology, it is important to recognise the participants' data as representing their stories. In this sense, the data is narrative.

There is tension in another term encountered in IPA, and my work: *emergence*. The literature pertaining to IPA methodology describes themes as *emerging* from the data in the analytical process. However, using the term emergence could convey a sense of passivity to the researcher that is discordant with the true sense of their role, and is considered problematic (Varpio et al., 2017). I acknowledge that it is through the researcher actively engaging with the data, and drawing on the approaches outlined above, that the meaning in the data (via themes) is *identified*. I draw on the terms identified and emerged interchangeably throughout my write-up, acknowledging this tension whilst aiming to craft an account that is coherent within the methodological traditions of IPA.

3.8 Considering quality in IPA research

When considering the contribution of knowledge that research may offer a field, some evaluation of trustworthiness and quality of the work is usually necessary. The traditional notions of quality and validity relating to sample sizes, representativeness, generalizability and reliability are problematic when considering qualitative psychological methodologies, largely because the criteria informed by such notions are not compatible with the philosophical foundations that underpin the interpretive paradigm (Yardley, 2000). A number of scholars have proposed guidelines for considering the quality of work in IPA, which are summarised in table 3.2.

These criteria will be revisited in the Discussion (section 3), where I will aim to demonstrate how the presentation of my analysis demonstrates 'goodness', meeting

the standards required for validity and acceptance. At this stage, however, it behoves me to expand on the notion of the independent audit in relation to my project. Whilst I aim to present the methodological, analytical and discursive accounts in a sufficiently transparent manner to enable scrutiny of the analysis, I also observed a practical process of independent audit too. After the analysis of the first 2 case studies, Zayn and Rubina, the report and data were submitted to my supervisors (at the time BN and JS), which then informed a discussion that helped clarify and refine the process of analysis and presentation of the case studies. In a sense, this was both a process of scrutiny of the groundedness and plausibility of the data analysis, but also an opportunity to inform further development of my understanding of my approach to IPA and research of this nature.

Sensitivity to context
Sensitivity to the context of the field constructed through theory, extant literature, social conventions, and by the participants themselves. This criterion also includes sensitivity to ethical considerations that are specific to the context the work is situated in.
Commitment and rigour
Commitment demands that there is evidence of prolonged engagement with the topic from multiple perspectives. Commitment also refers to demonstrating the development of methodological competence, and immersion in the data. Rigour refers to the nature of the output from the project: the completeness of the data and their analysis. High-rigour data would provide the information necessary to enable a comprehensive analysis. A rigorous analysis would be grounded, and present an interpretation that addresses the variation and complexity observed.
Transparency and coherence
This criterion refers to the clarity and persuasiveness of the argument presented. Coherence also refers to the alignment between the account presented and the methodological and philosophical frameworks that contextualise the work. Transparency also requires that the way that the project is conducted and reported is sufficiently easy to follow, and the data accessible, to enable a reader to scrutinise the interpretation presented.
Interest, impact and importance
This criterion is reminiscent of the pragmatist principle that meaning is derived from utility: the research needs to exert an influence on beliefs or actions in order to derive usefulness. Impact is determined in the context of the project aims.
Independent Audit
The concept of an independent audit is considered a powerful means of ensuring validity of the research. This is achieved in both a hypothetical sense, by preparing and reporting the data in a way that is transparent and coherent enough, as above. This can also be achieved by having someone independent of the research project to check the plausibility and credibility of the reported analysis.

Table 3.2: Guidance on characteristics of 'good' research in qualitative psychology (Willig, 2013; Yardley, 2000; Smith, 2011a & 2011b; Smith, Flowers & Larkin, 2009)

In the next section, I will present an account of each participant as a case-study. Due to the nuanced, detailed and in-depth nature of each account, I have organised each case study as an individual chapter within a larger analysis section. Following the tradition of IPA, the presentation of the individual case studies will be complemented by a group-level cross-case analysis, before an exploration of implications of the analysis for both the specific research questions guiding the project, and for the wider medical education and dyslexia fields.

Part 2: Analysis

In this part of the thesis, I will present the analysis of the data from the project. In an attempt to make manageable the analysis that is presented here, it has been organised as a part in its entirety, due to the size, and the way in which the following sections called to be structured. To begin, I will introduce each participant and their case study, comprising of an analysis of the data contributed by each of them in turn. This will be presented as individual chapters for clarity.

This section contains:

Chapter 4: Introduction to the analysis

Chapter 5: Zayn

Chapter 6: Rubina

Chapter 7: Amanda

Chapter 8: Brian

Chapter 9: Liz

Chapter 10: Sarah

Chapter 11: Helen

Chapter 12: Gemma

Chapter 13: Paul

Chapter 14: John

Chapter 15: Cross-case analysis

Chapter 4: Introduction to the analysis

In the analysis section, I will present the idiographic analysis of the data provided by each of the participants involved in this study. Conventions of analysis and reporting in IPA vary, but typically involve a cross-case analysis of themes that evolve from the idiographic analysis of each participant's contribution (Smith, Jarman & Osborne, 1999; Smith, Flowers & Larkin, 2009). Indeed, Smith (2011a) suggests that the prevalence of themes across multiple sources of data within a project is considered an indicator of quality. Conversely, Smith (2011c) also draws attention to the 'analytic leverage' gained from the rare gems that are found in the detailed and rich idiographic analysis of each participant. It is in the instances of individualistic, idiographic, interpretation that a unique insight into the meaning and meaning-making process derived from individual experience can be gained. Therefore, this chapter will be structured in a way that introduces each participant, and the independent idiographic analysis of their data, before combining the corpus of data into a cross-case analysis.

In response to the invitations cascaded to doctors in training, 35 trainees within the UK responded, expressing an interest. Of these, 10 went on to complete an initial interview and engage with the project. Of these 10, nine were from England (West Midlands, East Midlands, London and South West), and one was from Wales. Of note, additional responses were received from doctors in training in overseas countries. However, these doctors were not eligible for inclusion in the project as outlined in the approved protocol. The characteristics of each participant and the level of engagement, and variable completion of the different project elements are illustrated in table 4.1 below. Pseudonyms have been used throughout the data analysis and reporting, in order to confer some degree of participant anonymity. Note, here, that the order of appearance in the table, and subsequent analysis, corresponds with the order in which participants were initially interviewed. This was, primarily, based on when they engaged with the project, and our mutual availability.

	1. Zayn	2. Rubina	3. Amanda	4. Brian	5. Liz	6. Sarah	7. Helen	8. Gemma	9. Paul	10. John
Specialty / Grade	FY1 Resp. Md.	FY2 Micro	FY1 Resp. Med.	ST3 Public Health	CT2 Cardio.	ST2 Public Health	FY1 MFTE	FY2 Acute Med.	ST1 GP	CT2 Surgery
Age	27	25	31	46	27	49	25	29	28	28
Phase of project and contribution of data	Int-1	Int-1	Int-1	Int-1	Int-1	Int-1	Int-1	Int-1	Int-1	Int-1
	SCS	SCS	SCS	SCS	SCS	SCS	SCS	SCS	SCS	
				CIR x 12	CIR	CIR			CIR	
					CIR	CIR				
					Int-2	CIR				
	App. 4	App. 5	App. 6	App. 7	App. 8	App. 9	App. 10	App. 11	App. 12	App. 13

Table 4.1: Table illustrating participant characteristics and contribution to the project. Int-1 = Initial Interview; SCS = Self-Characterisation Sketch; CIR = Critical Incident Reflections; Int-2 = second Interview. Grey indicates discontinued response to prompts and invites. App. 4- 13 refers to Appendices 4-13, in which the coding notes for the case studies can be found, with extended transcript excerpts. Resp. Med = respiratory medicine, Micro. = microbiology, MFTE = medicine for the elderly. *Pseudonyms have been used throughout.*

An idiographic account of each participant's case study will be presented, beginning with a brief biography. In presenting the analysis of participant data, I will attempt to illustrate the superordinate themes that emerge from the data, along with the ancillary themes that support the analysis by organising the themes into concept maps, linked to associated data. The 'gems' from each participant will then be summarised for each participant as a concept map (Wilson et al., 2016; Jackson and Trochim, 2002; Novak and Cañas, 2007). I believe this to not only be a helpful means of aiding the analysis, but also conceptualising the analysis of the data. Graphic representation of the analysis also reflects van Manen's call to include an 'artistic dimension in the writing up of phenomenological research so as to "stir our pedagogical, psychological or professional sensibilities"' (van Manen, 2007: p25, in Finlay, 2011: p114). Because of this mode of representation, and due to the emergent and conceptual nature of the themes that arise from the data, the terms concepts and themes are used interchangeably.

In reporting, excerpts from participant's data are used to illustrate how themes were identified, and demonstrate the grounding of the analysis in the data. These excerpts

are identified by parenthetical: participant pseudonym; followed by the element of the project that the data has come from; followed by the line number, corresponding to the A3 layout of the transcripts. For example, an excerpt from Brian's self-characterisation sketch will be identified as (Brian, SCS, 654).

Chapter 5: Zayn

At the time of the initial interview, Zayn was 27 years old. He studied medicine as a postgraduate student, and was diagnosed with dyslexia at the age of 25, during his medical degree. He was working in a hospital rotation in respiratory medicine, and lived at home with his parents and older brother. Zayn participated in the initial interview, and self-characterisation sketch. He responded to follow-up prompt emails, but did not submit any critical incident reflections (CIR). The initial interview took approximately an hour and 20 minutes, taking place in his parent's house, where he lived. He initially appeared friendly and confident, but throughout the interview he shared deep feelings of uncertainty about what his dyslexia meant to him, and at times shared strong negative emotions directed towards himself. This was particularly apparent in his narrative around making sense of experiences of being a doctor with dyslexia.

Three inter-related concepts form an overarching superordinate theme, which were identified from Zayn's case study. These are *Belonging – Coping – Partitioning*, and are supported by a network of ancillary themes, which are summarised in figure 5.1. Of note, his account frequently referred to notions of coping, but in a negative sense either driven by fear, or by 'only just' managing or 'scraping by'. This was intrinsically linked to the sense of establishing a means of belonging to the professional group within which he found himself. The overarching concept that emerged from Zayn's data was that of an interrelated and inseparable notion of belonging – coping – partitioning. Each of the components to this triumvirate emerged bottom-up from the data, and will be explored in more detail individually, below.

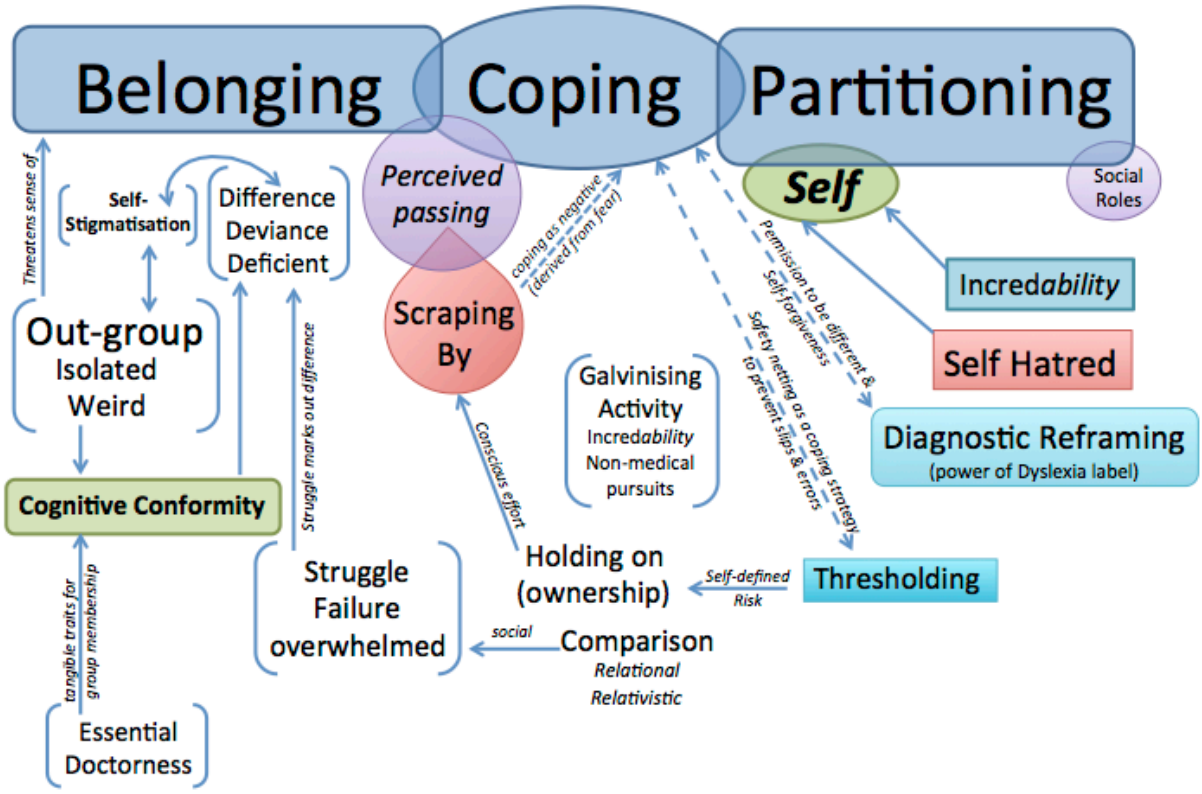


Figure 5.1: Concept map of themes emerging from Zayn's initial interview and self-characterisation sketch. Arrows are to imply associations rather than underlying generative mechanisms. Dashed lines indicate a less certain association, compared to the solid lines. The colour of boxes is to provide a visual aide (Belonging – Coping –Partitioning, all blue to illustrate inter-relatedness). Red was chosen for concepts that were interpreted as being particularly negative.

5.1. Belonging

Zayn's narrative exploration of his educational journey, and his dyslexia, gives a strong sense of struggle with gaining an authentic sense of belonging to the professional group into which he has graduated. Within *Belonging-Coping-Partitioning*, the component of *Belonging* encompassing concepts of: difference and deviance; isolation and group membership; a notion of essential 'doctorness' and related cognitive conformity. There is also a relationship between the experience of difference, and social comparisons that make apparent his sense of struggle and failure. This, in-turn, appears to contribute to the sense of struggle with negotiating a personal sense of professional group membership. In the discussion that follows, supportive quotes are taken from Zayn's initial interview, with numbers in brackets referring to the line from the transcript from which they were taken. A table illustrating this coding process, with corresponding notes, can be found in appendix 4.

From the beginning of the first interview, and the outset of his educational journey, Zayn makes it clear that he felt *different*:

'well from primary school, I guess. I've always kind of not fitted in and that's been a common theme through the entire educational journey really...'
(Zayn, int-1, 16)

The language that he uses in reference to this sense of difference is often negative, or self-derogatory. In the below quote, Zayn refers to the way he does things as *weird*, which is a word he uses on several occasions in a similar way throughout his narrative:

'And I just remember feeling quite isolated but I'd do things that were quite weird'
(Zayn, int-1, 28)

This brings about a sense of not only being outwith the norm, but also a self-stigmatising interpretation of a quality of his work, practice or cognition in relation to learning. This self-stigmatisation draws parallels with the expressed self-hatred that appears throughout Zayn's narrative, in relation to perceived difficulty or failure. This illustrates the complex inter-relatedness of the ancillary themes that feed into the superordinate theme, and why it is not possible to neatly separate the concept of belonging from *Belonging-Coping-Partitioning*. The language that Zayn uses in these instances (e.g. self-loathing) appears to be directed at a particular 'part' of himself, rather than him as a whole. This 'part' also appears to be where he locates his dyslexia:

'then there's other moments where I just have a complete mind blank and that builds a very deep sense of hatred towards yourself ...So there's two sides of it, don't know if it's a psychiatric problem… (Laughs) But there's two sides of my mind; one is exceptionally impressive, even to myself, and the other's just… and it's kind of self-sabotaging, the other side of it.'
(Zayn, int-1, 113)

The process of curating incidents of difference, which threaten membership to the professional group and imply membership to the corresponding out-group, appears to be contingent upon a context-dependent social frame of reference. For example, in Zayn's reflection on primary school, the comparison is with other children, where at

medical school, the context in which the comparison is made is different, yet the manner in which it is made has similarities.

A related concept that was identified in Zayn's narrative was that of *cognitive conformity*. In explaining how he approached exam situations, he describes:

> *'I think it matters a lot more now but it's easier now because you've got a physical person in front of you, so you've got a patient and that is what it's all about, whereas before it was a question and then it'd just blow up in my head so I would totally not understand what the question was asking'*
>
> (Zayn, int-1, 151)

There is a sense that thinking the right way 'matters a lot more now' that he is a doctor. There is a sense here of having to conform to the expectations placed upon him by the professional group, and by not doing so, or not having always done so, his membership is threatened. He later makes this link more explicit:

> *'By not thinking like a doctor, I don't know what I mean by that. I guess it's just compared to other people, I feel like I just still don't fit in. Like some people just seem to know how to do everything and I always think, "How is that possible?"'*
>
> (Zayn, int-1, 450)

Here, 'thinking like a doctor' becomes a tangible identity trait that affords group membership. By not cognitively conforming, he does not fit in, and therefore is outwith the immediate professional group of 'others' who do conform to the cognitive template of 'doctorness'. This brings us to another related theme, of an essentialist trait that conveys a sense of both being a doctor, and belonging to the group: *essential doctorness.* This concept emerges at several points in Zayn's narrative. During the Self-Characterisation Sketch (SCS) exercise, he drew a representation of how he saw himself, which comprised several separate images (figure 5.2). One of these images was a stick-man that he described as 'insubstantial' (highlighted). This evokes a sense of negativity, disdain, and lacking in substance. The substance that this implies is an innate quality of others, against which he compares himself, and contributes to *essence* of being a doctor*,* or *essential doctorness*. The negativity, and implications of separateness within this image, and accompanying narrative, will be explored in more detail in the following sections.

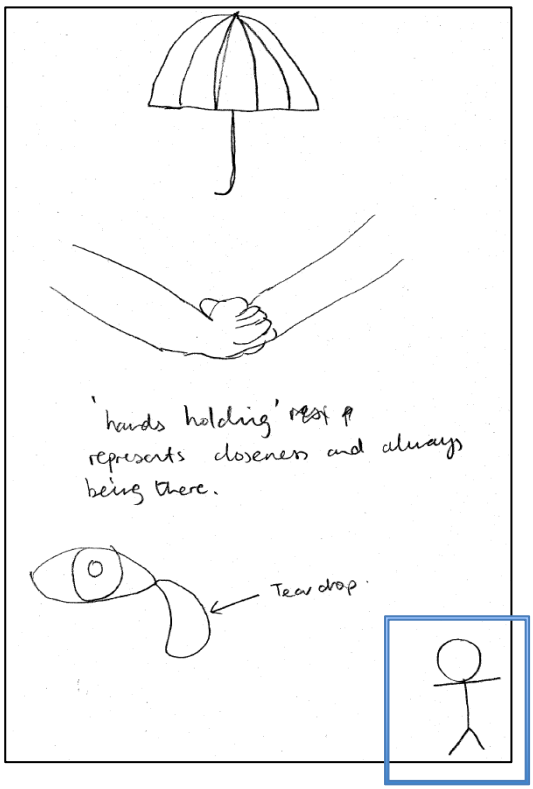


Figure 5.2: Self-Characterisation Sketch representation of how Zayn sees himself, drawn by Zayn during the initial interview. All four images form part of this single representation, comprising an umbrella, holding hands (text: '"holding hands" represents closeness and always being there'), an eye with a teardrop (text: teardrop), and a stick-man in the bottom left (blue box highlight added).

Further to this, in the context of failing an Advanced Life Support skills course (a mandatory requirement to be put on the rota to work in emergency situations in hospital), Zayn reflects:

> *'I just feel like they've been through medical school and then how they know how to be a doctor, or at least they've got that kind of confidence, whereas me, I've been through all of that and yet I'm starting from square one again'*
>
> (Zayn, int-1, 456)

In this example, *essential doctorness* manifests in the notion that equivalent experiences interact with a quality that an individual possesses to result in readiness for clinical work and conveys group membership. This is distinct from cognitive conformity, in that this implies there is an essence within certain individuals that imbues an innate capacity to transform into a doctor. This is in contrast to Zayn's experience, where he has undergone an equivalent level of training, and has put in, what he perceives as, more effort, yet is unable to make the transition or attain a sense of authentic group membership. Effort and success relate to a concept that bridges the components of *belonging* and *coping*: *scraping by,* and *perceived passing.* Here, I will explore the aspects of these concepts that link them to *belonging*, and will follow in the next section, onto how they relate to coping.

Zayn makes repeated reference to putting in a great deal of effort into his studies and exams. This occurs throughout his educational journey, before and after his diagnosis of dyslexia. He frames much of his educational progress as 'just passing' or 'scraping through'. By 'just' achieving and 'scraping through' his educational journey, he 'gets by' and maintains some form of membership, and sense of belonging, within the community (e.g. of medical students). However, this does not appear to afford him an authentic sense of membership to the professional group of doctors. This is illustrated by narrative around having to re-sit a year of medical school:

> *'The way I'd learn, I'd developed a method of repetition, so I'd have to go through all of the notes with the system, so I'd read it then I'd go through it in pencil then I'd go through it with red pen and then I'd go through with a highlighter, so by the end of it I'd gone through everything four times. And then through that I've learnt enough to get 50% which is kind of strange...'*
>
> (Zayn, int-1, 56)

In referring to attaining a score of 50% (the pass mark) in an assessment, Zayn relates this achievement to scraping by, and in doing so, 'just' securing continued membership to the community of medical students, and 'just' passing in that membership. I use the term *passing* intentionally, although in this sense it does not align fully to the conventional sociological term (e.g. Ginsberg, 1996). What Zayn's experience appears to illustrate, is a sense of *perceived passing* that is a further evolution of the concept of Renfrow's 'everyday passing' (2004). Traditionally, passing is the conscious assumption, adoption, or imitation of traits of another identity group, in order to pass as a valid group member (Goffman, 1963; Ginsberg, 1996). Renfrow (2004) introduces the notion of unconscious, or passive, passing, whereby someone will not actively correct a miscategorisation of identity (*ibid.*). Everyday passing involves the transgression of more peripheral, and less threatening boundaries of society and identity (*ibid.*). In Zayn's case, he describes this sense of passing as a result of his conscious effort to retain group membership, but it would not externally appear to be a miscategorisation (because he achieved the necessary qualifications to legitimately enter and remain in that group). Therefore, the concept of *perceived passing* emerges, as it is due to a sense of illegitimacy and doubt that Zayn refers to his sustained group association, that his achievement is undermined, and membership threatened:

'...then somehow I managed to get through it and even…the written exams I passed with 51%, 52% so I just about scraped a pass, but I passed and that was the main thing and now I'm here'

(Zayn, int-1, 219)

'I had the re-sit and I went straight into fourth year and my mum got sick between fourth year and fifth year, and then fifth year was just crazy and the moment you finish that you go into FY1, so I've not actually had time to process it. It's always been, "Okay, that's the situation, how do I deal with it now and how do I make sure I don't fail again?" I've somehow managed it the past two years.'

(Zayn, int-1, 360)

In saying 'I've *somehow* managed it the past two years', Zayn appears to be simultaneously abdicating agency and distancing himself from, or refusing to acknowledge his significant achievement, thus undermining his progression and legitimate qualification. In his eyes, his *scraping by* doesn't fully legitimise his participation, and as such, he feels as if he is trespassing in one of Goffman's 'forbidden places' (1963: 102).

5.2. Coping

Within the domain of *Coping*, both *scraping by* and *perceived passing* carry a different significance. Here, rather than seen as contributing to a negative sense of undermining authentic belonging, scraping by and perceived passing are contextualised, and seen as, a strategy for maintaining a sense of professional belonging, enabling Zayn to continue along his journey in medical education and practice. Additionally, *scraping by* implies a property of action, of holding on. It has agency and ownership. In this regard, whilst the concept may have negative connotations, there is an element of positivity here, in that Zayn is able to exert control. In the below example, Zayn describes a strategy he developed for 'overlearning' in order to 'get through' and get 'enough' in his exams. The language used, and reference to a bare-pass (50%) reflects the notion of *scraping* through the exams, and therefore *scraping by* as a medical student:

'I'd developed a method of repetition, so I'd have to go through all of the notes with the system, so I'd read it then I'd go through it in pencil then I'd go through it with red pen and then I'd go through with a highlighter, so by the end of it I'd gone through

everything four times. And then through that I've learnt enough to get 50% which is kind of strange'

(Zayn, int-1, 56)

Coping also has negative connotations, in that it is a behaviour driven by fear. There are examples throughout Zayn's narrative, where the fear of failure (actual or perceived), or the fear of patients coming to harm appears to drive specific checking behaviours, and the development of other effort-intensive coping strategies:

'there's no support and you are chucked in at the deep end with very sick people. But when I was in that situation I became quite resourceful, as I have been over the last six or seven years, I've had to figure out ways of getting things done. So, you know, even staying 'til late, getting there really, that's a huge thing to do, and writing everything down and having a clear tick box kind of list and not getting distracted by things, not letting the organisation part of it go at all; I'm never losing concentration on my organisational skills at work'

(Zayn, int-1, 93)

The 'deep end' analogy used by Zayn indicates struggle, the implication being that he would sink in the 'deep end' if he failed to swim (manage the workload) effectively. The implication of struggle at this point is two-fold: struggle or failure in his role as part of the team, jeopardising his group membership; and in his duty towards his patients, jeopardising their well-being. The sense of pressure and reactivity is emphasised through Zayn's choice of language: 'I've had to figure out ways'. Further supporting the notion of fear-driven coping, Zayn specifically links the development of strategies to fear:

'Yeah, I've never really spoken up about things that go wrong with me, I can never tell anyone, and so I've developed these mechanisms of handling it.'

(Zayn, int-1, 244)

In this regard, *coping* appears to be reactive, and therefore lack the sense of ownership or agency that more active notions of coping imply. This is in contrast to the concept of *thresholding* that emerges at other points in Zayn's narrative. The issue around disclosure that presents in this excerpt will be revisited in more detail under the heading of *partitioning*. However, it also relates to *coping*, in the sense that protecting that aspect of his identity from his peers, and through non-disclosure contributes to his

perceived passing. Returning to *thresholding*, in these instances Zayn appears to actively make a decision based on a threshold that he determines himself. In doing so, he draws on self-awareness and taking ownership of that decision:

'The moment somebody calls I won't do it unless I've got a pen and paper ready to take down a message and I know everything for that day, where it is. And I think it's just because I'm scared'

(Zayn, int-1, 98)

However, it is difficult to link this sense of choice and agency, as there remains an explicit link to fear. *Thresholding* can work in another way too, whereby others contrive a threshold, the crossing of which raises a question of ability. Although this particular aspect of the concept only emerged in reference to the circumstances around being diagnosed with dyslexia, there is potential for this type of thresholding to also relate to questions of legitimate group membership. Below, Zayn reflects on how the manner in which he failed his exams triggered a suspicion:

'they referred me to Study Skills because they said like, "There must have been something that made you do that wrong"'

(Zayn, int-1, 196)

This single passage also speaks of underlying assumptions operating in educators: that failure is unacceptable, it must be explained, a cause must be operating and be found. This in turn may reflect wider societal attitudes and pressures towards education in the context of medical professionals (failure being an unacceptable trait), or education in a more general sense. Whilst practices in student support are motivated by a variety of other factors, Zayn's meaning-making alludes to a sense of him and his performance being deviant within this context.

The process of being diagnosed with dyslexia resulted in reframing of subsequent, and prior experience, which is represented in several different ways throughout Zayn's narrative account. Firstly, Zayn recalls how the difference, isolation and loneliness that he had felt throughout his life was reframed and suddenly took on new meaning:

'Like actually when I had this assessment done my whole life changed so everything that I felt in terms of loneliness became positive. Because I think there was a label that was put on it or there was an explanation put on why I felt so isolated and I think

that's where the whole meaning changed and it became more of a strength than a weakness…'

(Zayn, int-1, 47)

In this short excerpt, Zayn makes a profound statement. The application of a label, to something he knew he had (he recognised his difficulties and difference) had the *power* to *reframe* and ascribe a new sense of meaning to the feelings that his experiences throughout education had resulted in. What is more, Zayn makes an explicit link that this *diagnostic reframing* changed the meaning of his difference from a weakness into a strength. The positive impact of this potential is profound enough to counter some incidents where he would ordinarily direct hate and shame inwardly:

'When they said to me, "Oh you're dyslexic" it just eased the pressure from my mind of… I used to feel quite badly about myself in kind of a self-hatred kind of way because I really wouldn't get where I wanted to go'

(Zayn, int-1,102)

It would appear that this was mediated through a process of diminished expectation, easing the pressure that Zayn felt. This appears to be an operation of an internalised assumption, corresponding with the notion that dyslexia implies a differential level of performance or ability. This, in turn, gives rise to the idea of implied *forgiveness* as a consequence of the diagnostic reframing, a concept illustrated more specifically when Zayn relates to the diagnosis affording him confidence, and making it 'okay' to be different:

'I think the main thing I've got from it is it's given me the confidence to be myself, right, to be not like everybody else, and that's okay'

(Zayn, int-1, 365)

Another example where the *reframing* afforded by the diagnostic label of dyslexia had a positive impact on Zayn's trajectory was the catastrophic event of failing his Advanced Life Support. In the following excerpt, Zayn recalls how failing this course led to him considering leaving medicine altogether. However, on this occasion, he reflects that the diagnostic label of dyslexia afforded him enough sympathy to continue:

'If it wasn't for having a diagnosis or having a starting point I probably would've just said, "I'll take this as a sign that I'm not meant to be doing this," and just leave it, yeah.'

(Zayn, Int-1, 459)

In this instance, *diagnostic reframing* confers not only forgiveness, but a *second chance* to legitimate on-going participation in the professional group. These examples of the *power of the dyslexia label* have a positive influence on Zayn and the process by which he reconciles his difficulties and differences, with the tensions associated with negotiating legitimate group membership. However, the *power* of this label has complexities, intrinsically linked to the process of *perceived passing* and *self-stigmatisation* that reinforce the internalised sense of difference that undermines Zayn's perception of authentic belonging, as illustrated by the conflict in the concepts that have emerged from his narrative. The label acting as a tangible reminder of difference, for Zayn, appears linked to strong feelings of *self-hatred,* which he directs at a particular aspect of his sense of self. The emergence of these concepts link strongly to the third element of the triumvirate superordinate theme: *Partitioning.*

5.3. Partitioning

Throughout Zayn's narrative, there are repeated references to 'parts' of himself in opposing contexts: there are parts of himself to which he refers to positively; and those to which he refers to negatively, associated with failure and his dyslexia-related difficulties. In identifying different facets of his identity and self-concept, Zayn creates discrete 'parts' or 'sides' to which he can attribute his perceived successes, difficulties and failures. Reflecting the specific language that Zayn uses, this process emerges as the concept of *Partitioning*. Primarily, *partitioning* relates to *partitioning of self*, whereby Zayn actively describes 'parts' of himself as having different capabilities, or being responsible for successes:

'So the moments where I'm quite incredible, like I can play the piano just like that, and I wouldn't understand it, how I can just sit on the grand piano and play in a way that people think that I can play piano, or play guitar and it's… It makes me feel incredible, the way I can play, and then other moments when I can't do it at all. And it's the same in medicine.'

(Zayn, int-1,106)

Or failures:

'it comes from a different part of my thinking. So when I'm with a person I'm speaking from a different part, whereas when it's just you and yourself and there's an exam it's slightly different, no actually it's very different. It's coming from a different place. I don't know why I feel like that but I do feel like that. And that might be why I did so badly in exams.'

(Zayn, int-1, 163)

But there are examples where Zayn refers to the process of partitioning in a very physical, biological sense too in referring to 'two sides' of his mind (int-1, 112). Zayn further crystallises the notion of discrete components of his *self* by directing strong emotions of 'very deep' *self-hatred*:

'So there's been moments where I've known everything and I've been teaching my friend and then there's other moments where I just have a complete mind blank and that builds a very deep sense of hatred towards yourself'

(Zayn, int-1, 107)

From one these different 'parts' of his self, Zayn draws on an 'incredible' personal resource, which he associates with music and creativity. In his narrative, Zayn explains how this provides an emotional outlet for him, but also gives him a sense of capability, skill and achievement. This 'part' of his *self* therefore emerges with the label of 'incred*ability'* synthesising his sense of the achievements of that 'part' being incredible, and that this part contains a discrete ability that is, as yet, inaccessible by his other 'part' (as illustrated by the separated concepts in figure 5.1). The contrasting 'part' to his identity is the component responsible for the 'self-sabotaging' (int-1, 113), and also the part at which he directs his 'deep self-loathing' (int-1, 270). This represents a damage limitation strategy: containing the shame associated with perceived difference, difficulty and failure, within a partitioned element of self.

Partitioning of *self* also relates to the partitioning of *social roles*. Throughout the narrative, and the self-characterisation sketch exercise, the notion of separatedness is evidence in both the way he feels from *other* but also within *self* (as illustrated in figure 5.2). The following example, from Zayn's SCS, illustrates not only how he believes 'sympathetic others' would see him in his role as a doctor (infantile), and as a friend ('rockstar confidence'), but also reflects the different attributes that he ascribes to the contrasting 'parts' of his self (figure 5.3). In explaining the graphical representations, Zayn explains that the 'rockstar confidence' state that he occupies as a musician, as his friends would see him, is how he would 'like to be' as a doctor. The implication here is

that he is not yet able to assume those qualities in the other social role that he plays, reinforced by the contrasting image of him as a 'Baby' with a stethoscope around his neck.

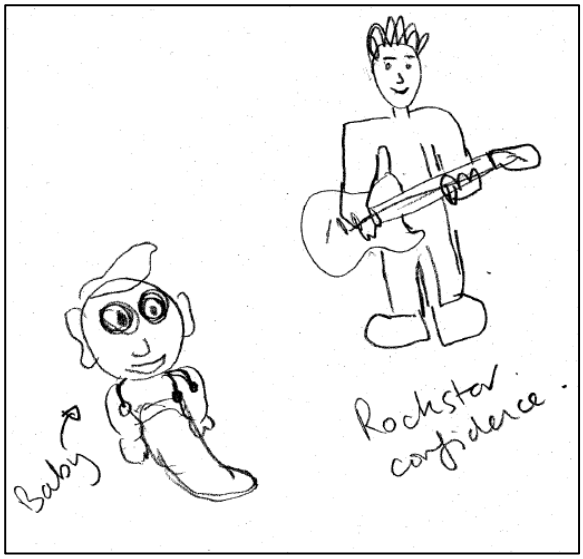


Figure 5.3: Zayn's SCS of how a 'sympathetic friend' would see him. Two *separate* figures represent the partitioned social roles of 'friend' (accompanied by the text 'Rockstar confidence', and doctor (accompanied by the text 'Baby'). Note the recurring symbolic importance of the stethoscope as part of the image and role of a doctor.

The complex inter-connectedness of the concepts that are encompassed by the theme of *Belonging-Coping-Partitioning* give an insight into the value placed on an authentic sense of belonging, where a strong professional group identity (e.g. medicine) is at stake. Dyslexia, in terms of the difficulties that Zayn associates with it, but also the label in itself, appears to both convey a positive ability to cope and negotiate participation (e.g. the 'second chance') and simultaneously undermine his sense of authentic ('whole self') belonging and legitimate participation within the profession. Partitioning, therefore, may also represent a means of coping with the complexity of this dynamic.

The initial interview with Zayn was the only source of data, as he disengaged from the rest of the interview process. I was struck by how sad I felt for and about Zayn, and the profound sense of isolation, self-doubt and self-hatred. The interview process appeared to be cathartic for him, and he acknowledged that it helped him explore what his experience of dyslexia, and being diagnosed meant to him. Disengagement may represent a satisfactory completion of that particular process for him, moving on from catharsis to acceptance. A year after our first meeting, I enquired after his wellbeing, and was relieved to find him to be in a happier state in a new role, as a 'Foundation Year 2' doctor.

Chapter 6: Rubina

Rubina was 25 years old when we met for her interview. She described primary and secondary education as problem-free, having attended a grammar school in the Greater London area. She progressed through secondary and further education straight into medical school. Her specific learning difficulties were diagnosed during her third year of her medical degree, when she experienced difficulties in surgical skills teaching. Rubina was working as a FY2 doctor and was completing a rotation in microbiology. She participated in the initial interview and self-characterisation sketch, and submitted one CIR in response to follow-up prompt emails. The initial interview took approximately an hour and 10 minutes, taking place in a city centre coffee shop. On meeting, Rubina appeared apprehensive and uncomfortable, but seemed to settle after initial introductions. In particular, she appeared to be most reassured through discussing my experiences of dyslexia, and what the aims of the project were.

One high-level overarching superordinate theme of *Self, Other and Coping* was identified, alongside a related, but separate, theme of *Risk*. The theme of *Self and Other* is supported by two intermediate-level themes of *Conflicted Self* and *Coping and Belonging* that, in turn, are supported by several ancillary themes. The theme of *Risk* doesn't quite fit within the superordinate theme, but is related to aspects of the supporting ancillary themes. These are illustrated in figure 6.1. and will be explored in detail in the following sections.

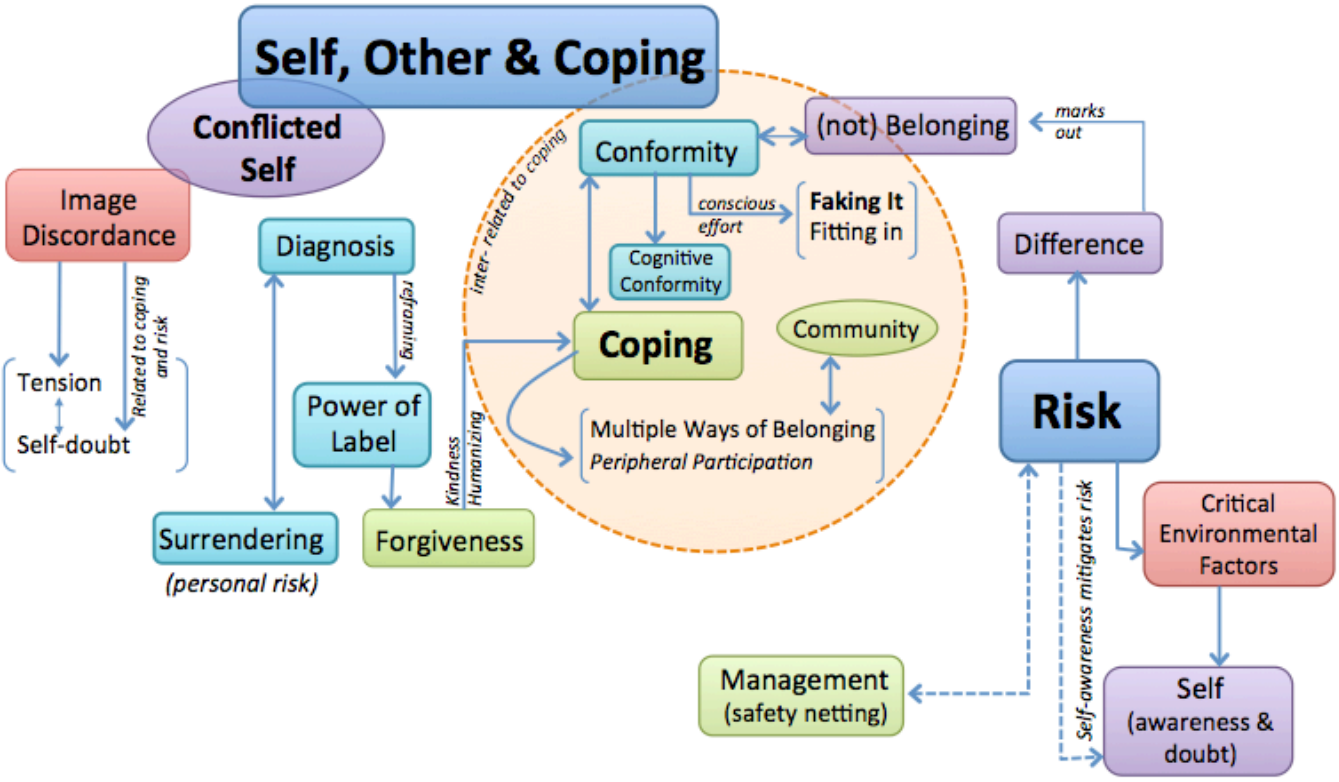


Figure 6.1: Concept map of themes emerging from Rubina's initial interview, self-characterisation sketch, and critical incident reflection. Arrows are to imply associations rather than generative mechanisms. Dashed lines indicate less certain association, compared to solid lines. The colour of shapes is to provide visual contrast (blue illustrating super-ordinate themes). Red was chosen for concepts that were interpreted as being potentially negative.

6.1. Self, Other and Coping

Rubina's narrative account presents references to a conflicting sense of identity, as well as a differential sense of belonging. The super-ordinate theme of *Self, Other and Coping* hosts concepts of her *conflicted self*, and *coping*, which in-turn relate to several ancillary themes. Perhaps the most significant example of *conflicted* sense of *self* emerged early on in the interview:

'Going to medical school in 2008 that's when I kind of started to notice things so just I think the worst thing for me that I can remember it's not dyslexia I have it's dyspraxia I have and it really showed the most when I had a surgical skills test to do.'

(Rubina, int-1, 31)

The realisation that Rubina's underlying SpLD was dyspraxia, rather than dyslexia, was contrasted by her references to dyslexia throughout her interview, and in particular the implied fear of the assessment and diagnosis process:

> *'…if I went to that test then it turned out I didn't have dyslexia then I guess it would just mean that I'm not as clever as my peers'*
>
> (Rubina, int-1, 229)

Whilst this could represent a slip, or misunderstanding, the multiple references to dyslexia, or dyslexia and dyspraxia, creates a sense of confusion and conflict around Rubina's identity construction and sense of self, which extends beyond her learning difficulties to her professional identity and notions of belonging. This conflict and discord appears to arise from comparison with peers, and perceived expectations from 'others'. Rubina's *conflicted self* is further supported by concepts of *image discordance* that came to bear through the self-characterisation sketch exercise. In this, Rubina drew an image of how a 'sympathetic friend' sees her, and combined it with an exploration of how she saw herself too (figure 6.2).

Figure 6.2: Self-Characterisation Sketch representation of how a sympathetic friend sees Rubina, and how she sees herself, drawn by Rubina during the initial interview. The sketch utilises colour to highlight significance (big red smiling lips, and heart) as well as reflect diversity (different coloured friends).

This image conveys a sunny, positive and smiling person floating in a boat on the world, drawing on metaphor to illustrate being on top of the world. The power of this image

is created by what it includes, such as her music, sense of love (heart), and diverse friendship circle. However, what is absent from this image is also significant: there is no reference to work, her professional identity, or her difficulties. In contrast, her subsequent sketch (figure 6.3) brings in a *token of doctorness*: the stethoscope. Through her accompanying narrative, Rubina explores the significance of this, conveying a sense of incompatibility between her professional role and her personal life, and subsequently an *image discordance*. This is also literally illustrated between the contrasting images in figure 6.2 and 6.3:

> *'I've not drawn anything medical or in here because I feel like it's ...I'm I need friends rather than a doctor of medicine. I, I enjoy medicine but I suppose compared to my other peers it's not a passion role in my life'*
>
> (Rubina, SCS, 420)

Rubina's narrative also brings in a sense of tension, in relation to the image of her personal self, and the discordance that this has with her professional self. By referring to her extra-curricular interest as 'odd', 'quirky' or 'strange' (Rubina, SCS, 405 and 411) there is an implied tension between what she sees as part of her identity, and what she perceives as an expectation from her profession or wider society.

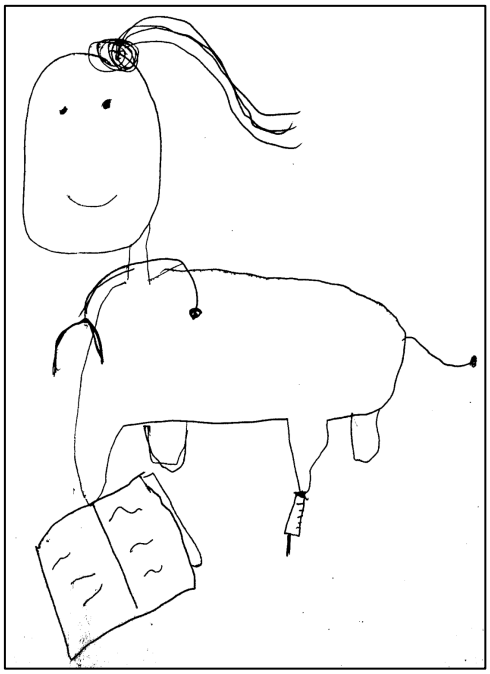


Figure 6.3: Self-Characterisation Sketch representation of how a 'critical other' sees Rubina, drawn by Rubina during the initial interview. Rubina felt this image represented how her clinical supervisor would see her, as explained in her narrative: a donkey forcing a smile. Note the presence of 'tokens' associated with her professional identity: a stethoscope and syringe. Her hair (worn down in the interview) also illustrated as being neatly tied up in a ponytail, which both continues the metaphor and complies with dress codes for clinical workplaces. In contrast to her previous image, this drawing was in monochrome (using a black ballpoint pen), and therefore lacks the vibrancy and diversity conveyed in figure 4.3.2.

When undertaking the SCS exercise from the perspective of a 'critical other', Rubina reflected on how she felt her clinical supervisor might see her. The imagery that she drew on in her sketch and accompanying narrative convey a sense of de-personalised, de-intellectualised servitude and sadness. The use of the imagery of a beast of burden, and the 'smallest smile' as a mask seems particularly significant:

> *'I've done a smile because I'm, I'm always smiling but it's the smallest smile I guess because if, if you're not really enjoying something sometimes medicine's interesting but it's, it's not a passion of mine so you know there's only so much you can smile and I guess this is what they see they don't, like I said they don't see any of the other kind of bits of you as a person it's just medicine, medicine, medicine'*
>
> (Rubina, SCS, 539)

Here, Rubina conveys a sense of obligation, of being expected to appear to be enjoying her medical work, and so *conforms* to this expectation by forcing a smile. The concept of conformity appears elsewhere in Rubina's narrative as well, and will be explored in relation to the theme of *coping,* which emerged from the *Coping* element of the *Self, Other and Coping* superordinate theme. Confirming a diagnosis appears to be an important step in developing coping strategies, but Rubina recounts the process of securing a diagnosis with a sense of fear and personal risk. Before describing the process of being assessed, she recalled how she 'procrastinated...and put that off for a year' despite knowing 'it would be beneficial' to get tested (Rubina, Int-1, 257). The language that Rubina uses in discussing the diagnosis of her SpLD alludes to a passivity, a lack of agency – surrendering this sense of agency to the process:

> *'So I just went to speak, yes so we just had a chat just kind of similar questions, how are you finding school, how did you find primary school, secondary school, what symptoms do you notice and you just sit various writing tests, reading tests, verbal reasoning tests, picture test and that's it and then he just diagnosed me'*
>
> (Rubina, int-1, 270)

Specifically, in saying 'he ***just*** diagnosed me' (emphasis added), Rubina positions herself in a passive role – this was something that was done *to* her. The label, however, has a positive potential to reframe her experience of difference and difficulty. The *power of label* concept centres around the sense of forgiveness. In the following excerpts, the idea that the diagnosis, or label, can somehow assuage shame associated with struggle and being different, and can also function as a tool to bargain for acceptance within her professional group is borne out:

'It doesn't, it doesn't mean you're dumb or anything it just means you're different and you think differently and you have different talents and you have different weaknesses and strengths but I never thought it was anything bad and I thought it was actually good because it gave me an explanation as to why I was having these problems so it provided some sort of clarity so I thought it, in a weird way I thought it was a good thing to have a diagnosis.'

(Rubina, int-1, 288)

'Having this diagnosis makes me feel okay about having to be explained the same thing two or three times over, yes, it, it feels like it's more warranted and acceptable to be told things over and over again because it's not just I'm not listening or anything it's, it's just the different, different, different needs and different strengths and weaknesses.'

(Rubina, int-1, 306)

'I just think the label gave me some clarity and gave me a reason and made me feel not so bad about not understanding things or not being as fast or as quick as other people.'

(Rubina, int-1, 320)

However, examples from Rubina's narrative suggest that in providing a means of forgiveness, the label of her diagnosis also serves as a means of re-attributing her achievements to external factors. In recounting the support she received throughout university, Rubina says:

'I always say if I didn't have the extra time in my written finals I probably wouldn't have passed because like I said I just when I read long texts I just can't clarify thoughts; it's too much'

(Rubina, Int-1, 314)

In suggesting that her success was contingent on a reasonable adjustment received in assessments, Rubina is *dissociating* her *success* from her abilities, attributing them to the adjustment. This *dissociated success* conveys a negative connotation that is counter to the positive, forgiving attributes of the diagnostic label. Whilst the label enabled her to bargain for the adjustments, in this instance it appears to have simultaneously robbed her of her sense of achievement.

The *forgiveness* afforded by the power of the label relates to the concept of *coping*, which is associated with a number of other themes, including: *conformity*, *community* and *(not) belonging*. In the illustrative quotes above, Rubina's sense of clarity, gained from the diagnosis, affords her forgiveness towards her self, but there is also a sense of feeling that the label grants a sense of forgiveness, through acceptance, from peers.

6.2. Coping

The theme of *coping* emerges from the superordinate theme, but is complex in the way it relates to concepts of *conformity*, *community* and *(not) belonging*. At several points in her narrative, Rubina refers to incidents where she has felt like she was, or emulated behaviours to 'fake it' or 'fit in'. This was particularly represented through invoking the metaphor of the donkey and the 'smallest smile' in the SCS (figure 4.3.3). Despite conveying a sense of being passive and disengaged, Rubina responded by 'faking' the smile in order to conform with perceived expectations:

> *'with a not so big smile I think because of I had very kind of dominant powerful colleagues on that, and I was the only kind of passive person so I think that could have been interpreted maybe as not engaging so much or not, not just not caring as much'*
> (Rubina, SCS, 543)

The notion of 'fitting in' is also manifest in the way Rubina engaged in the study. Having dyspraxia, rather than dyslexia (an explicit requirement for inclusion) not only hints at a sense of identity confusion, but also her desire and ability to 'fit in'. This concept is also implied in other ways too, however. When describing a social comparison with peers, she says 'I wasn't ***really*** understanding' (Int-1, 99, emphasis added). The implication here being that she was able to appear as if she was, but felt that didn't translate into an authentic level of understanding. In this sense, there is a private realisation that there is a difference between what image she projects, and how she sees herself. This contrast represents a sense of fitting in through projecting something that is discordant with her inner sense of self (also linking in with the previously explored *conflicted self* and *image discordance* themes). In this context, the discordance represents the idea of 'faking it'. There are examples (e.g. the 'smallest smile') where this is a conscious effort, and others (e.g. the 'not *really* understanding') where this appears to be an unconscious effect, or rather a consequential feeling resulting from circumstance.

The significance of *Faking It* and *Fitting In* is their relationship to their encompassing theme of *conformity*: the perceived expectations and social norms within her environment drive these behaviours that allow her to cope in this environment, by minimising the difference (either that is externally perceived, or that she feels). These differences, which she attributed to her SpLD, are not merely based on externalised

manifestations of difficulties, or on physical attributes, but also on the way Rubina thinks and feels, alluding to the notion of *cognitive conformity*, particularly exemplified in her recollection of needing to ask questions, and take longer to process information, implying that she doesn't think like other doctors would:

> *'I'd say, "Okay how do I do this or what do I have to do?" and then I'd, I'd be explained how, how to do it and then I wouldn't really understand and I'd just be like, "Okay yes" because I didn't, we didn't really have time to kind of just, you know, just keep asking questions and there weren't maybe's I didn't feel so comfortable in asking too many questions so I would just go away quite confused and whereas I thought maybe another person without the dyspraxia would have gotten it.'*
>
> (Rubina, int-1, 205)

The sense of being different expressed within this excerpt carries a feeling of discomfort and unease. These, arguably negative, feelings create a tension and pressure that contribute to a feeling of not belonging in an authentic, legitimate, or native sense. Of note, Rubina particularly links these feelings to the differences that she attributes to her SpLD. Such disparities, between tokens of group membership (e.g. professional qualification, stethoscope) and sense of identity (e.g. of belonging to a different sort of sub-community) add to the *conflicted self*, but also to the notion of *belonging*. In Rubina's case, the theme of *belonging* is complex, and related to a strong sense of *not* belonging.

The theme of *coping* also hosts the concept of *community*, and in relation to this, the idea of *multiple ways of belonging*. In aspects of her narrative, Rubina refers to a professional community (the medical profession), to which she doesn't appear to feel like she fully belongs to. However, she also alludes to feeling like she belongs to another community of peers who share traits of difficulty and difference: 'So I had the assessment and then so ***we*** got the 25% extra time' (Rubina, Int-1, 112, emphasis added). Although subtle, and small, references like this speak of a deeper need to feel a legitimate part of a group. Returning to *multiple ways of belonging*, Rubina's narrative generates interesting concepts around the notion of being able to belong to a sub-group within her professional grouping. This is whilst she simultaneously feels illegitimate as a member of the medical profession, exemplified when referring to belonging to 'that category' of doctors who do not feel able to continue, uninterrupted, in their training:

'interesting I'm in that category. I'm not really sure I want to start with speciality training next year. I feel like I might need a bit of a break before I do it.'
(Rubina, SCS, 455)

Although not explicitly relating to her SpLD, the notion of a 'category' of people *within* a group builds on the concept of a sub-community within the *community* theme. Another facet of *multiple ways of belonging*, though, refers to the way in which Rubina felt she was being, or acting, within the group. Rather than feeling a fully legitimate member of the team, Rubina's narrative describes times where she felt that her participation was *peripheral* or somehow only *partial.* This is alluded to in the 'categorisation' that Rubina suggests above, but also more explicitly when recounting her experiences as a 'supernumerary' member of the team. Of note, this sense of being peripheral does not appear to have a specific relationship to the sense of difference borne out of her identifying as having an SpLD. Her *peripheral participation* is, however, intertwined with her undermined, or incomplete, sense of belonging within her professional group. In the following excerpt, Rubina's account gives a sense of her status as a doctor being compromised by the tangible sense of being 'supernumerary' and peripheral:

'So I think I've had a very different F1 I think to most people because I feel like my job's some kind of supernumerary. So my first job was ITU so I felt like a medical student in ITU; I didn't really touch anything or do anything. I don't have to put central lines or arterial lines but there wasn't too many kind of organisational or practical skills needed there and I did a psych job again for F1 so again there wasn't many practical skills or organisation skills and reading required for that.'

(Rubina, int-1, 160)

6.3. Belonging and (not)Belonging

The concept of belonging has emerged in relation to Rubina's sense of *Self,* and *Coping.* However, there is a distinct theme that encompasses a complex sense of belonging, and simultaneously not belonging, thus represented as *(not)belonging.* This specific concept arises from narrative alluding to participating in team activities, and possessing or displaying *tokens of doctorness* (e.g. stethoscope, and undertaking practical tasks identified with the role), but also not feeling like an authentic, full, or legitimate

member of the team. The latter sense of not feeling a full member is represented by a strong sense of being different, in a way that is not compatible with authentic membership. Some elements of difference are represented as almost tangible *tokens of difference*, such as 'messy handwriting' (Rubina, Int-1, 165), or *tokenism* whereby her membership of a team is contingent on her being the focus of a joke. The following excerpt draws on a sense of deviating from *cognitive conformity*, and how this, being established within her team, is a source of amusement, in exchange for belonging (but at the same time, not fully belonging):

'There is an ongoing joke where about my bad memory because every day we go into the lab and we have the bench run and every day it's the same thing. They, they'll be like, "Oh so there's patient X X X that you spoke on the phone to" and it will just, I, I feel very embarrassed because they're working on them. So it can be embarrassing then I've accepted it myself and they're kind of used to it in micro.

(Rubina, int-1, 229)

Another example of Rubina's group membership being challenged more directly is found in a confrontation with a senior colleague, when she explained why she did not want to have the seasonal influenza vaccination. In response to saying that she wanted 'her body to try and just fight it off' (Rubina, Int-1, 336) her registrar said 'Are you sure you're a doctor? Did you go to medical school?' (Rubina, Int-1, 339). Here, a colleague undermines the very qualification that grants her entry to the medical profession. Elsewhere, a sense of legitimate membership being undermined is manifest in Rubina's narrative surrounding her SCS. By drawing comparisons between how a sympathetic friend may perceive her, and how she thinks she ought to be in order to fit in with the vocational ideal of the medical professional:

'I've not drawn anything medical or in here because I feel like it's ...I'm I need friends rather than a doctor of medicine. I, I enjoy medicine but I suppose compared to my other peers it's not a passion role in my life; I don't like to go home and watch 24 Hours in A&E and Casualty. I, I hate; I actually don't like medicine outside of work. <u>It doesn't really feature in, in my life ultimately and I'm not ... do you want to know ... nothing to do with my dyspraxia …</u>

I know it, it's not sort of the best at this stage in my career I shouldn't ... not that I hate medicine but it's, it's a job for me at the moment'

(Rubina, SCS, 432, emphasis added).

Here, Rubina's reflection alludes to social comparisons, and a perceived perceptive difference that marks her outwith the group, therefore undermining her sense of

belonging within the medical profession. In saying 'I know it, it's not sort of the best at this stage' Rubina's reflection introduces a sense of remorse, or guilt. She feels that to belong authentically, she needs to want medicine to be all encompassing. However, she does not, and reflects that this could be perceived as being unusual within the profession. This sense of having group membership being undermined by interests and traits inherent to her personality, in this instance at least, has been specifically delineated from the difficulties that she experiences due to her SpLD. However, the notion of not fully belonging is inseparable from the sense of *difference* that Rubina feels, much of which appears related to her experience of her difficulties.

6.4. Risk

Risk emerges from Rubina's narrative as a high-level theme that, whilst being related to ancillary concepts, is separate from the themes within *Self, Other and Coping*. Throughout Rubina's interview, SCS, and the CIT reflection, she refers to notions that relate to risk: the *critical environmental factors* that interact with her strengths and weaknesses, and contribute to her perception of risk; the *management* of risk, though *safety netting*; and *self-awareness* of her pattern of difficulties, and strengths, and *self-doubt* which triggers her to employ risk-management strategies. However, the idea of risk, as a concept, is not discrete within Rubina's narrative. Indeed, it is pervasive. There are notions of personal risk involved in the process of seeking a diagnosis for her SpLD, there is a sense of minimising risk of exposure or rejection expressed through conformity to perceived expectations, and there is a risk of isolation and rejection implied by the narrative alluding to *(not)belonging*. Specific examples of risks identified by Rubina tend to centre on the management and recall of patient-related information (names, investigation results), in the context of a heavy workload, chaotic environment, and factors that she attributes to her difficulties (chaotic or slow processing of information). In the following extended excerpt, Rubina recalls an incident where she was asked to recall the results of one particular patient, under pressure. She later drew on her checking strategies, and realised that she had recalled the details of a different patient and immediately corrected this. Her error resulted in what could be termed a

'near-miss'. A patient's care was changed on the basis of the correct information. As a result, Rubina recalls feeling embarrassed, and her narrative conveys a sense of shame:

'On a recent micro lab round I was asked to discuss a positive blood culture result for a patient I had discussed over the phone. I was scattered in my thoughts and had a dozen histories in my head, but was unable to match the history with the generic sounding name on the form. The clinical box stating 'sepsis' was also unhelpful at prompting me. I was 75% sure the history in my head was the one for this positive blood culture and subsequently relayed the history. Based on this information we decided what antibiotics to give and to give the medical team a call back. Luckily I recognise I have issues with clearly organising information in my head and write everything down. I reviewed my notes and saw that I had actually given the clinical history for an entirely different patient. I discussed this with the consultant and, I had not yet called the team and we decided on a different antibiotic plan. Fortunately there was no impact on patient care, however if I had not realised… I feel this was more than a simple case of the SHO forgetting some details. I frequently encounter this type of problem when I have collected large amounts/ variable sources of information in a short time period. I feel like the information is confused, so for example histories for 2 different patients may become mixed together. I find the best way to help me segregate this information is to have an identifiable or visual piece of information associated with the patient e.g. a 55-year-old Farmer, the guy from Mexico etc. I have learnt throughout med school that once I have this initial piece of identifiable information then I can reel out the whole history, however if I cannot remember this initial snippet then I will not be able to recall the history… Initially at the lab round I felt very embarrassed that I could not recall this information, as this happens to me very frequently. However at the same time, it has been beneficial for me in terms of training as I have now gotten into the habit of reading the previous days documentation just before we enter the lab. This is time consuming, but I feel it will avoid me making potentially fatal errors in the future.

(Rubina, CIR-1, 43)

This CIR has been included in its entirety, as it illustrates the high-level theme or risk, as well as the constituent concepts of *critical environmental factors, management*, and *self-awareness and self-doubt.* The *critical environmental factors* that Rubina suggests in her accounts include: large amounts of information, numerous sources of the information, anonymity of patients in the clinical setting, dealing with information in an abstract (e.g. verbal) rather than concrete (e.g. written) sense. Rubina's narrative demonstrates *self-doubt* on a number of occasions, and this is often paired with a *self-awareness* of her difficulties, as in the excerpt above. This *self-doubt* carries negative connotations, but serves as a trigger to institute a coping strategy that results in a positive outcome, as was illustrated above. *Management* strategies to mitigate the risks posed by the interaction of the environmental factors and Rubina's difficulties,

include *safety netting* through double-checking, and strategies to humanize patients and their information.

During her initial interview, Rubina became tearful, and we paused on two occasions, corresponding to feelings of embarrassment and shame regarding her difficulties. She was well, and keen to continue. About two months after the initial interview, she submitted one CIR debrief, and then disengaged from the project, and didn't respond to further email prompts.

Chapter 7: Amanda

Amanda was 31 years old when she participated in the first interview. She invited me to the flat she rented in the city she now worked as an FY1, initially in emergency medicine, then intensive care, and (at the time of the interview) in respiratory medicine. From the beginning of her interview, she drew on language with strong connotations of difference and negativity. The educational journey had been challenging, and she required additional help from her older sister and mother, who was a teacher at her primary school. After her primary and secondary schooling, Amanda progressed through her education into an undergraduate degree in biochemistry, before studying medicine on a graduate entry (4 year, accelerated) programme. It was during her medical degree that she was diagnosed with dyslexia. I met Amanda only once, during which she completed the initial interview and the SCS. Together, these took approximately 1 hour and 22 minutes. Although Amanda responded to email prompts regarding the CIR debriefs, and the interim interview, she found the demands of her day-to-day job, the requirements of training, and a series of chaotic events in her life (including her flat being flooded) too challenging to balance alongside further active participation.

Amanda's narrative began with the invocation of the English idiom of the 'Black Sheep' and continued with a strong sense of negativity towards herself. This metaphor developed significance throughout her account, as emerging themes repeatedly related to the concept of her being different, deficient, and of bringing some form of disrepute to her family or team. *Black Sheep* therefore serves as the single superordinate theme from the interview with Amanda. This theme is accompanied with a high-order theme of *Coping.* Both of these themes are supported by a complex network of lower-order themes, or constructs, which is summarised in figure 7.1.

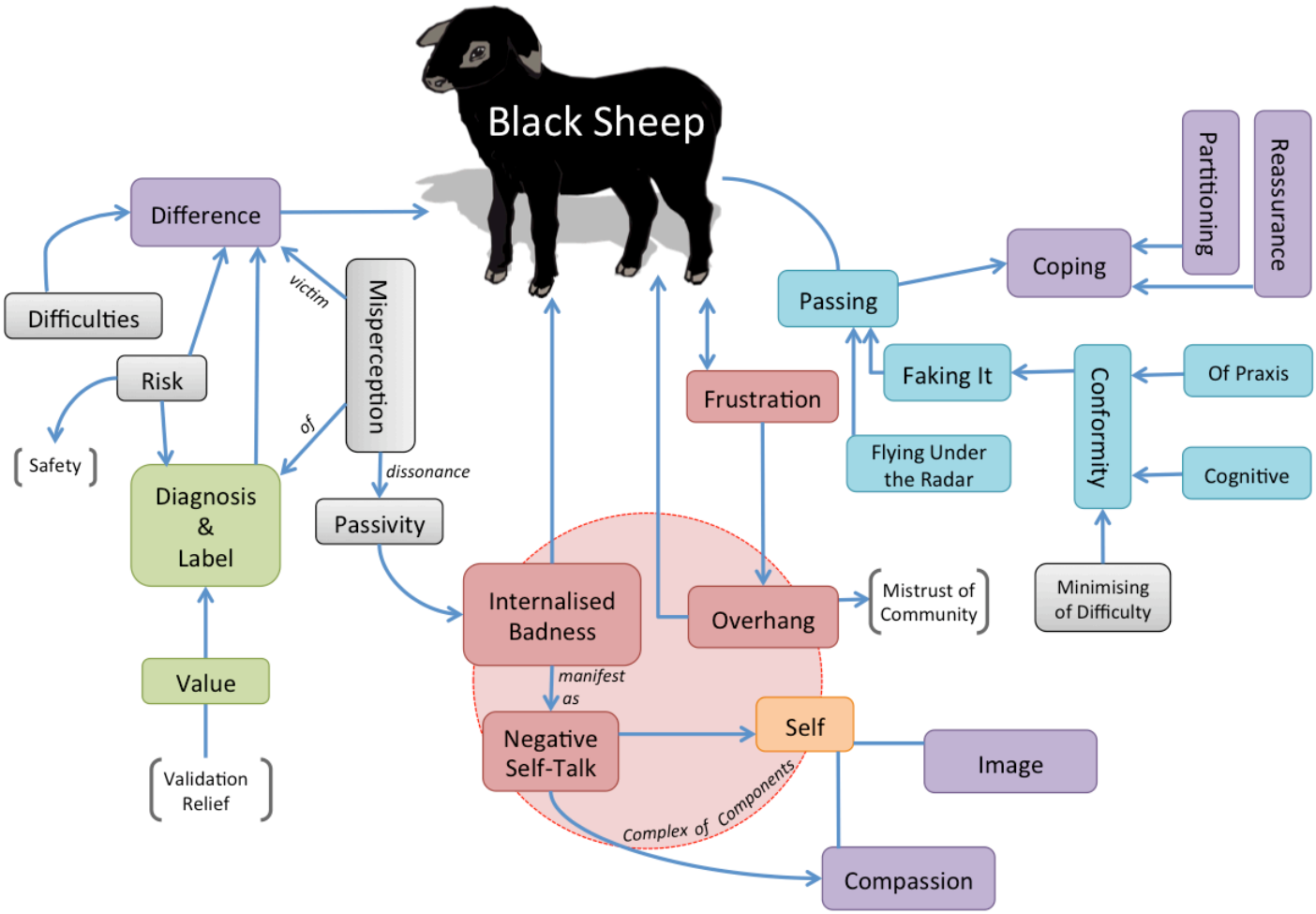


Figure 7.1: Concept map of themes emerging from Amanda's initial interview (int-1) and self-characterisation-sketch (SCS). Arrows are to imply associations rather than generative mechanisms. Lines indicate a link without certain causality. The colours used with the shapes are to provide visual contrast and to aid clustering of related themes. Red was chosen for concepts that were interpreted as being potentially negative. The Black Sheep image was sourced from: https://pixabay.com/en/sheep-black-lamb-shadow-cute-307568/ (cc0 license) (user: Clker-Free-Vector-Images) (16/5/14).

7.1. Black Sheep

From the outset, Amanda constructs herself as *different* within her narrative account. This difference is couched in terms of negative connotations, which is borne out through her use of the *Black Sheep* metaphor:

> *'I was always, as it were, the black sheep of the family because I wasn't very academic.'*
>
> (Amanda, Int-1, 17)

The strength of this metaphor, in terms of the imagery, and dominance within the relationship to themes emerging throughout Amanda's narrative is why the image in

figure 7.1 was chosen, breaking away from the convention of using coloured shapes. The use of the *Black Sheep* implies membership of the group (initially represented by family, but later alluded to in terms of peer and professional groups), but not of the same value or legitimacy. Additionally, there is a sense of bringing disrepute – by being a burden, and a 'sub-par' (int-1, 565) that contributes to the metaphor of *Black Sheep*. Amanda articulated this sense of differential value within her professional group during the SCS exercise, when she explained:

'I feel I can contribute and I am of more value to them when I'm outside. I feel like I almost have a negative effect at work. I would say that this has got 1000 times worse since my mid-placement appraisal because of the feedback I got. I wasn't happy with my performance'

(Amanda, SCS, 578)

The sense of *difference* that contributes to Amanda's view of herself as the *Black Sheep* appears to be created by the difficulties that she experiences, social-comparison (e.g. with her sister or peers), and by the very diagnosis that represents a legitimisation of her difficulties. Social comparison appears to contribute to a great deal of frustration, which is a subtheme that will be explored in detail individually, later.

7.2. Diagnosis & Label, Difference, Value and Risk

The concept of *value* appears in Amanda's narrative to be related to her SpLD, and interacts with her acquisition and use of the *diagnosis and label*. This supporting theme exists in a network interacting with *difference, risk, and misperception*. *Value* emerges from Amanda's account as a concept of feeling relatively value-less within her team, because of her differences:

Interviewer (me): As a doctor?
Amanda:
'Yes, I feel like a deflated balloon, if I don't block it out and I almost kind of like…I don't feel like a proper person, because I feel like if I can't do my job properly I've always wanted to help people and I've always wanted to be of value and if I can't be of value and I can't help people then I'm not a proper member of society'

(Amanda, SCS, 609)

In describing her perception of value, she invokes strong imagery of a deflated balloon, and refers to not feeling 'like a proper person' because of her sense of being different from her peers. However, as she alludes to attempts to mitigate her difficulties (which will be revisited in *faking it*) this difference is something that she appears to be particularly heightened to. This gives salience to the labels associated with her SpLD, which is also reflected in the way she jargonises throughout her discourse, appearing to legitimise her difficulties through the use of diagnostic labels, giving a sense of seeking *validation* of her experience of difference and difficulty (emphasis added):

'It's just hard with motor planning and that kind of thing, and I find it very difficult in medicine'

(Amanda, int-1, 209)

The theme of *value* also refers to the value that the label itself can carry. In a situated context, the label of dyslexia affords Amanda a sense of forgiveness that enables her to create a sense of distance between the frustration caused (to herself, and perceived in others) by her difficulties, and her sense of self. Moreover, this forgiveness confers permission to continue to try, and to persist in her chosen career path:

'I don't think I would have carried on with my medicine degree if I hadn't had the diagnosis, purely because I'm probably being completely skewed in my perspective'

(Amanda, int-1, 341)

Within this notion of *forgiveness*, however, there is a conflict with Amanda's reluctance to make 'excuses' for herself:

'Apparently I'm quite hard on myself so I don't accept excuses for myself or my behaviour or my work, so I needed someone externally to…it's terrible but I needed someone externally to give me a label and say look this is not your fault, it's a biological thing'

(Amanda, int-1, 371)

Excuses are couched in terms of negativity and as being incompatible with legitimate full participation within the profession. In fact, Amanda explicitly states 'I've had four years at medical school, and you can't make excuses' (int-1, 186) reinforcing the notion of the medical profession being intolerant to imperfection and excuses. The conflict between *forgiveness* and *excuse* highlights the complexity of her sense of self, and the

conditionality under which forgiveness may be granted. It was unclear, from the data she provided for this project, if there was a particular pattern to the contexts in which she would allow herself to be forgiven, or would consider it an excuse. There was a relationship between this conflict and the way in which she appears to have *internalised badness* from feedback throughout her life. This theme, and the complex in which it exists (with *overhang* and *negative self-talk*) will be explored in more detail later.

Securing a diagnosis of dyslexia is not a neutral activity, however, and Amanda's narrative refers to notions of *Risk* in approaching a diagnostic assessment, and *difference* reinforced by it. In the following excerpt, Amanda reflects on how 'awful' it would be if her difficulties were 'just her' (int-1, 263) and that she may be perceived as seeking an 'excuse'. This speaks of the personal risk to self involved in approaching a formal assessment for dyslexia, as well as the fear surrounding being discovered as being somehow defective (referring to 'defect in doctoring skills': SCS, 564) without an identifiable cause that can assuage her sense of personal responsibility and guilt:

'I just think it would have been the most awful thing if I'd gone for the assessment and they'd said no, you don't have anything and she would have been like you're just trying to make excuses as usual.'

(Amanda, int-1, 408)

In relation to the concept of risk, Amanda talked about *safety* with regards to the process of accessing an assessment for, and support with, her SpLD. The sense of safety was in reference to a geographical distance, and separation from the medical school, representing the establishment and her peers. This implies an element of secrecy, on her part, and the perception of fear – which could relate to fear of stigma, consequence or discovery. It also implies a mistrust of her community, which will be explored in relation to *overhang* later:

'so it was away from the med school so I felt quite safe and he said that I had really quite profound dyslexia, a significant amount of dyscalculia and some dyspraxia.'

(Amanda, int-1, 311)

Once acquired, the labels and the differences and difficulties they represent can be misunderstood by others. The theme of *misperception* represents a process by which others appear to mislabel Amanda's difficulties as 'behaviour', and attribute her

perceived poor performance to 'laziness' or 'silly mistakes' (Amanda, int-1, 20). *Passivity* represents a process of accepting, and even weighting others' judgements over her experiences. This process appears to affect Amanda's interpretation fo her experience, understandings, and (later) the diagnosis of SpLDs. In prioritising these judgements, in spite of a sense of dissonance, Amanda appears to have accepted them and internalised them. Amanda specifically articulates this (demonstrated in the following excerpts), but the notion of *passivity* is also represented in the language she uses throughout her narrative, such as: 'I'd apparently…' (int-1, 87) or 'I've always been told…' (int-1, 416). In using these devices, she appears to linguistically shift the focus, and importance, from what she perceived, to what others did. Whilst this appears to dominate her narrative referring to times prior to her diagnosis of dyslexia, there are examples of this occurring afterwards too:

> *'I said I honestly don't see how I can carry on in medicine because I'm just working so hard and I'm just not getting anywhere. She just said, well, it doesn't look like you're trying, it doesn't look like you're interested, and so medicine isn't for everyone, and I just thought I'm trying so hard. I know that there were these little things that are niggling away at me and I think I now know possibly what it might be.'*
>
> (Amanda, int-1, 302)

> *'I kind of felt torn because I took in what everyone kept saying to me that you're lazy, you're not trying, you're not achieving your potential, why don't you just try harder?'*
>
> (Amanda, int-1, 324)

Through this *passivity*, the negative *misperceptions* and misjudgements are assimilated within her internal narrative and sense of self, through being *internalised badness*. This theme exists in a complex with at least two others (*Overhang* and *Negative Self-Talk*), which will be examined in the next section.

7.3. Internalised Badness, Negative Self-Talk, Overhang

Within the theme of *Black Sheep* is a supporting, constituent complex of concepts that operate to create a sense of negativity towards *Self.* This complex comprises the concepts, or ancillary themes, of *internalised badness, negative self-talk,* and *overhang*. *Internalised badness* refers to the negative aspects of observations, feedback and judgements cast by others throughout Amanda's life. She appears to internalise and

assimilate the negativity, so instead of being 'bad at maths' she becomes 'bad' as a person, and 'defective' or 'sub-par'. This is illustrated in the dynamic change between the two following excerpts, where she initially refers to being bad at maths, and then becomes frustrated and stressed with herself, alluding to a sense of inwardly-directed anger and negativity:

'My maths was really, really bad. I've always been really bad at adding, subtracting and just basic things, and I think as I used to…I've always been quite a…not self-conscious but I've also been conscious of other people and I've always been very conscious of knowing that there was something a bit different about the way I learned and the way I operated'

(Amanda, int-1, 39)

The internalisation of badness is also illustrated in the attribution of success to external agents, namely her mother. This alludes to *internalised* badness through the implication that by attributing her success to her mother's efforts, she is denying her own capacity to succeed, suggesting she is unable to do so. The relationship between being bad at something and becoming bad as a person is more explicitly illustrated in the theme of *negative self-talk*, which is inter-related with *internalised badness* as a means by which the latter is manifested, for example:

'I just thought that was just me being kind of stupid, and kind of a birdbrain, like everyone used to say I was.'

(Amanda, int-1, 263)

This example seems pretty strong, with the use of pejorative terms such as 'birdbrain'. However, the link between what others ('everyone') would judge her as, and how she now judges herself ('I thought it was just me') is clear. Other examples throughout her narrative also allude to more subtle ways in which this internalisation is manifest, with the framing of neutral, or even laudable and positive, actions (e.g. persevering with something she is struggling at) as negative through the use of deprecating language such as 'stubborn' (int-1, 61). The subtlety here hints at the insidious and pervasive nature of this process, which links to the third element within this complex: *overhang*. This refers to the persistence of the effects of internalised negative judgement, predominantly from childhood, into her later adult life. This is represented by both the significance with which reflections on such instances in her narrative (through the

emotion conveyed in the narrative, the repetition and frequency of the recollections, and also incongruence with the focus of the questions or overall study):

'I'd be terrified of doing that because everyone would laugh at me because I'd apparently say the words in the wrong order and I'd lose my place, and I was always the last person to finish any text that we had to read. You know when they used to say, like, I'll give you two minutes to read this and then we'll do the question, and everyone would have finished and looking around and I'd still be reading it for another couple of minutes, and it was just terrible and I felt so much pressure.'

(Amanda, int-1, 91)

The above excerpt alludes to terror that she experienced in the childhood educational setting, which in itself hints at beliefs and impressions formed from earlier experiences. This fear appears to have influenced the development of her sense of self, and her confidence, which is represented in the pervasive introduction of uncertainty in the language used in her narrative, such as: 'I kind of' (int-1, 60; 65; 77), or 'you know' (int-1, 85; 88). In support of this notion of uncertainty in her discourse, is the attempt to seek reassurance by means of: 'Tell me if I'm going wrong' (SCS, 554) or 'I don't know, I'm not explaining myself very well, am I?' (int-1, 385).

7.4. Frustration

The concept of *frustration* arose out of Amanda's description of frustration directed internally, by herself, but also at her by others. An additional facet to this subtheme appears to have evolved after her diagnosis, and relates to the forgiving capacity of the label, whereby she is able to redirect some of the frustration she feels towards those who she identifies as occupying roles intended to support her learning, development, and practice:

'so if I transition, like often, say, when a weekend starts, I go from here and I get really angry at myself and also my supervisors, whereas before my diagnosis I would always just get angry at myself and now it's split and some of it is at my supervisors.'

(Amanda, SCS, 661)

The *frustration* she feels towards herself emerges from two sources within her narrative: her performance, and her experience of difficulties:

'I started to get really frustrated with myself and I got really frustrated with myself when I was having to do calculations and they wouldn't work, then my friend would just show me and she'd be like it's simple and just…'

(Amanda, int-1, 128)

Her performance appears to be benchmarked, through social comparison, against perceived expectations. Social comparison is a recurring component within this subtheme, and appears to interact with the way in which Amanda sees herself, and the way in which she treats herself with regards to a sense of forgiveness, or even kindness.

7.5. Self

Self emerges in several guises in Amanda's narrative: through the explicit discussion of 'self-image'; through the way in which Amanda construes herself through her difficulties, actions and 'behaviours'; and through the way in which she appears to regard and treat herself, through the use of deprecating language, the conditional withholding of forgiveness, and inward direction of frustration. These three aspects of *self* correspond with the component subthemes of *self-compassion, self-image, and self-construct*. The significance of *self-compassion* as a dominant component of this subtheme is illustrated through Amanda's apparent lack of compassion towards herself that has been conditioned as a consequence of *Internalised Badness*:

'It also gave other people a kind of reason why I was behaving the way I was and it's very, very rarely that I ever say to someone, oh, sorry, I think that might be my dyslexia. I don't think like that, because I really, really don't like to make excuses and I still feel that some people think of it as an excuse. But I know that that's what is happening inside me and I know that if I ever got into huge trouble in terms of someone saying this girl is just repeatedly being really, really stupid, I could say, hang on, this is what's happening, and then someone from outside would be like you can't do that to her because she's actually got an SpLD, it's not because she's just being slapdash or anything like that'

(Amanda, int-1, 381)

Here, Amanda illustrates an awareness that her difficulties are related to her dyslexia, and articulates that 'I know that's what is happening inside' but still refers to her difficulties as 'behaving' in a certain way, and draws on others' perceived judgements of herself as 'really, really stupid'. This conveys a sense of acceptance and

internalisation of the pejorative terms used by others. In relation to this, and the proximity of this statement to the internalisation of negativity within this excerpt is also illustrative, she continues to refer to 'making excuses'. The reference to the potential for others to perceive her as making excuses merely reflects the internalisation, through passivity, of this into a belief that is now sufficiently integral to influence her thoughts and actions.

7.6. Coping, Partitioning and Passing

Coping emerges as a higher-order theme that still sits within the umbrella of *Black Sheep* by virtue of the interdependent relationship with the constituents therein, such as *difference*, *diagnosis and label*, and the complex of *internalised badness*, *overhang* and *negative self-talk*. The theme of Coping appears to be supported by the ancillary themes, or concepts, of *passing, conformity,* and *partitioning*. These are, in-turn, supported by a network of concepts, which will be explored in the following section.

7.6.1. Passing

From recounting early educational experiences, Amanda alludes to active attempts to mask or mitigate her difficulties, so as to go un-noticed. These active attempts construct *Faking It*, which emerges throughout her narrative into HE and postgraduate training and practice. Active attempts to mitigate her difficulties include 'overcompensation':

> *'So history was really difficult in terms of that, and I tried really, really hard and certainly that was the start of me trying to really overcompensate so I'd stay up all night to try and get my work done, and I got really tired and under the weather and I think I still ended up getting a B, and I used to find it really difficult in exams'*
>
> (Amanda, int-1, 95)

The above excerpt refers to an example of *faking it* during secondary schooling. Where this concept emerges in narrative referring to her time at university, including medical school, and professional life is accompanied by a sense of fear – the fear of exposure and discovery driving her actions:

> *'we used to have to do sessions where we would have to write on the whiteboard during our PBL session for the whole group and I just used to get such a…it's ridiculous*

because I'm a grown woman but I'd just get so panicky when I'd have to do that session for myself because I'd spell things incorrectly and I'd put everything in the wrong place like the sentences and things like that, and people would just kind of sharply point it out or snigger, and I just felt really self-conscious.'

(Amanda, int-1, 179)

In relation to *faking it*, and fear of discovery is the idea of the practice and community of medicine having no room to enable these conscious actions to work, thus there is 'nowhere to hide':

'So it's just been really difficult and in terms of the clinical skills, I found that really horrendously difficult and very embarrassing too, because I feel in medicine, there's nowhere to hide, so when you go for teaching sessions, any knowledge deficits, any differences get immediately picked up on.'

(Amanda, int-1, 201)

A counterpart to the active *faking it* is the passive *flying under the radar,* which emerges through a sense of going unnoticed, or being neglected throughout schooling. This, at times, played to Amanda's advantage (in terms of coping), but left her with a strong sense of being unsupported by the establishment with her struggles, instead turning to her mother and sister for support. In the following excerpt, Amanda recalls a time in primary school where her difficulties meant she couldn't submit her spelling card (so it was not active or intentional, as with *faking it*), which went unnoticed. In the same excerpt, she describes 'pretending to work' with alludes to active attempts at evading exposure through *Faking* It:

'I know that I struggled so badly with all the different work that I could never put my card in the box, so I'd just sit there and no one noticed me, but I literally sat there for two months, apparently, kind of just pretending to work'

(Amanda, int-1, 77)

Amanda reflects on the discussion she had with the person who assessed her for dyslexia, recounting her understanding of the debrief. In this account, she alludes to her 'IQ' as enabling her to compensate and keep pace with peers enough to go unnoticed:

'he said that my IQ was such that if people have these kinds of SpLDs, they find ways to compensate for them and struggle along rather than completely bottoming out academically, and he said also what really, really helped was having my sister and my mum because they'd been crucial in kind of getting me to progress and not give up

and working through things. So that was kind of a real relief but it didn't solve the problem.'

(Amanda, int-1, 319)

Faking it, and *flying under the radar* are both, in essence, to align externally observable behaviour with that of peers, or the expectations placed by others. This alludes to a need to conform. Although related to the notion of *passing*, *conformity* emerged as a separate constituent within *coping*.

7.6.2. Conformity

Conformity emerged throughout Amanda's narrative with reference to conforming to appearances and expectations that would be congruent with her professional group membership, which has been explored within *passing*. Separate from these mechanisms, however, is the notion of non-conformity with specific reference to *praxis* (not doing things like a doctor) and *cognition* (not thinking like a doctor). *Conformity of praxis* is constructed through *doing* or *not doing* things in a way that would be accepted practice within medicine. Interestingly, this construction appears to include both practical tasks, and the dealing of information (cognitive tasks) in a way that conveys a sense of practical demonstration. In the following excerpt, Amanda is referring to the struggle she experiences with generating, maintaining and recalling a task list 'in her head' – and expresses it in terms of a practical action, which probably refers to the external role that such task lists have within teams in medical practice:

'doing things in specific orders is really tricky for me and that's another part of medicine that I found very challenging, because if you don't do it in the right way, then it's almost like there's no point to have done it.'

(Amanda, int-1, 213)

This is distinct from the sense of not processing information or thinking in a way that conforms to perceived expectations of the professional group, that comprises *cognitive conformity*. This latter element has implications that exert their influence internally – it is only Amanda who perceives the difference and struggle. Amanda passed her medical school exams at the same pace as her peers, yet she asserts her 'knowledge base' wasn't as good as theirs. This appears to be an internal (not shared) judgement:

'I could see against my colleagues, as it were, that my knowledge base was just terrible, and it still is compared to everyone else'

(Amanda, int-1, 183)

There appears to be an affective component to the internality of *cognitive conformity* too:

'I feel like I'm a much happier and sunnier person when I'm outside work and I feel that I give more happiness to people'

(Amanda, SCS, 575)

Returning to the deprecating language that Amanda uses in her narrative, there are examples where she appears to minimise her difficulties. There is a sense that this could be an attempt to align her experience or performance with those of her peers, and thus be closer to conforming. An example of this *minimisation of difficulty*:

'I used to make a lot of silly mistakes in terms of grammar and spelling because this was kind of pre-computer time'

(Amanda, int-1, 35)

The use of the device 'silly mistakes' reflects the internalisation of pejorative language used by others in earlier years, and also trivialises her difficulties, thus minimising them.

7.6.3. Partitioning

Amanda's narrative complementing her SCS conveys the sense her, and her life, being partitioned as a means of *coping*. The SCS exercise draws on three questions to explore three different perspectives. Amanda explained that she couldn't separate her thoughts, and drew her response in one all-encompassing graphic representation (figure 7.2).

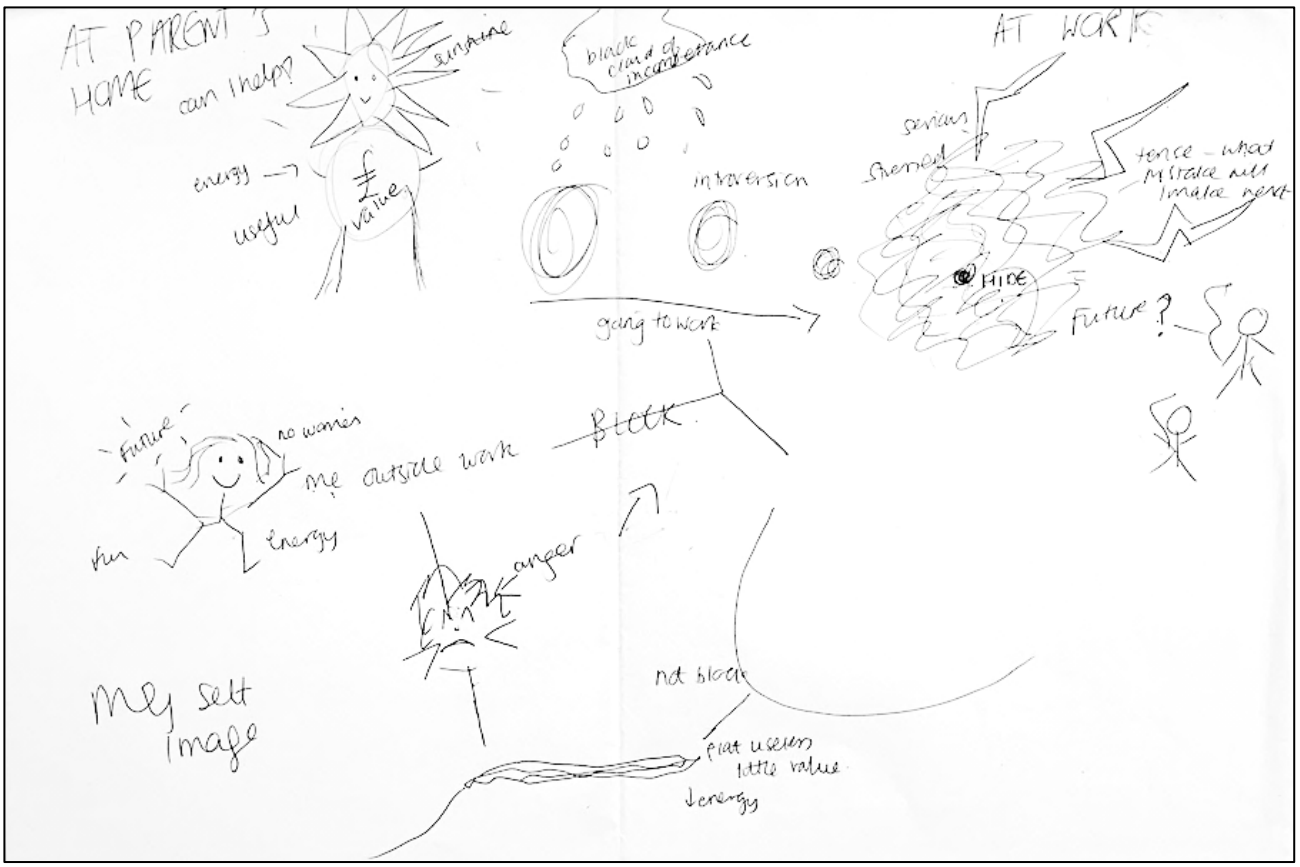


Figure 7.2: Amanda's self-characterisation sketch (SCS) representing how she feels a sympathetic friend would see her, how a critical other would see her, and how she sees herself.

Figure 7.2 shows relationships and tension between Amanda's working life, and life outside of work. Interfacing with work invokes images of 'black cloud of incompetence', and what she describes as a 'mass of fluff and like a dustball because everything's confused and disorganised' (SCS, 566). There is a significant amount of negative affect associated with the 'AT WORK' image, including stress, anger, and uncertainty ('Future ?'). In contrast, the image of herself outside of work bares a smile (note how there is no discernible face within the dustball or on the stick figures drawn around it). The contrast continues with there being 'energy', 'sunshine', 'no worries', 'fun' and a general sense of happiness. This represents a *partitioning* of her life, but also of her sense of self. In the accompanying narrative, Amanda explains how this *partitioning* requires an effort to 'block out' work in order to assume the identity that holds more value, and is a 'proper person':

'my self image kind of has two elements, so if I block out what happens at work, so if I have a weekend off and I just block everything out then I'm a very different person

from if I don't block out what happens at work and how I feel at work and how I feel that people think of me at work'

(Amanda, SCS, 604)

Partitioning represents more than a mere separation of work life and identity, from that outside. In the narrative explored to this point, it is clear that this partitioning also implies a very real sense of two people: one being not a 'proper person', holding lesser value; the other being different, contributing more to others and society. In addition, there is a sense of embodiment with regards to her difficulties and diagnoses. Amanda describes 'parts' of her being 'dippy', and that friends love 'every part' of her (SCS, 625). A more biological sense of embodiment is explored when Amanda describes her father's reaction to her difficulties and diagnoses:

'since being diagnosed, I think that might have slightly changed my self image, so I kind of separated that a little bit. For instance, certainly my dad finds it really hard to understand that that's not me being intentionally like that and it's not possibly part of my personality, it's a biological thing. I think I get slightly more upset when he makes fun when I mispronounce a word because I insert things in the middle of words and stuff.'

(Amanda, SCS, 631)

This excerpt contains narrative that is reminiscent of previously explored themes, but also touches on a sense of conditionality around the notion of embodiment: being a biological thing, it becomes part of her *body* rather than her personality. There is a sense that in becoming embodied, the difficulties or diagnosis would somehow be more accepted.

Much of Amanda's narrative conveys a sense of sadness and uncertainty. She remained enthusiastic throughout the interview, and she did not appear affected by the discussion of experiences that carried significance. She replied to follow up emails, inviting her to submit a CIR, and participate in the interim interview. However, her responses carried a great sense of struggle and chaos, with her balancing the demands of her clinical role, her training commitments, and life events and subsequently disengaged from the project.

Chapter 8: Brian

At the time of the initial interview, Brian was 46 years old and in his final year of training in public health in central England. He was from New Zealand, and completed his primary, secondary and higher education there. After medical school, he undertook junior doctor jobs in New Zealand before applying for, and completing, GP training in the UK. After nearly 10 years of working as a GP, he entered public health training, during which he was diagnosed with dyslexia at the age of 44. He had no brothers or sisters, and his parents remain in New Zealand. He lived with his wife, who found out she was pregnant with their first child during the course of the project. Brian participated in the initial interview and SCS, which lasted 1 hour and 5 minutes, taking place in his office where he worked. He responded to follow-up prompt emails, and sent a total of 12 audio-recorded CIRs, but was unable to participate in the interim interview. One superordinate theme of *Diagnosis and Judgement* emerged from his data. This theme is linked to, and supported by, a network of subthemes, which has been summarised in figure 8.1. and will be explored in detail within the following sections.

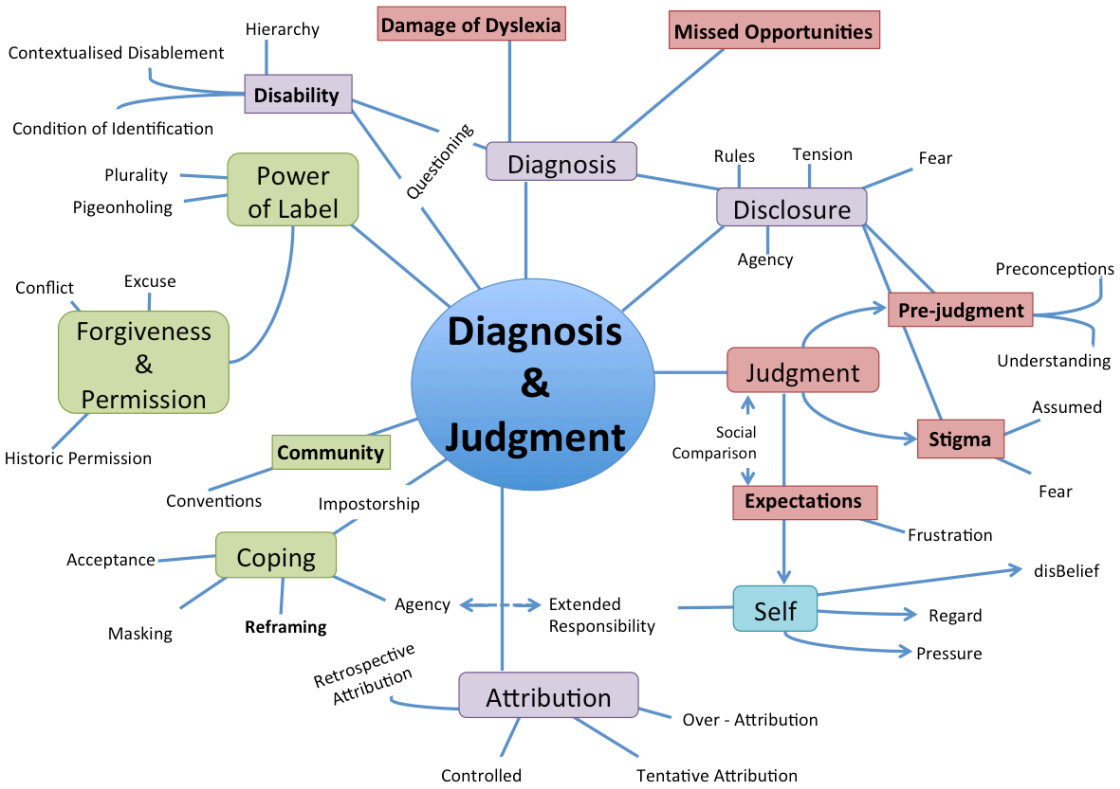


Figure 8.1: Concept map illustrating the superordinate theme (Diagnosis & Judgment) emerging from Brian's data (comprising the initial interview, self-characterisation sketch, and 12 critical incident reflections). Arrows are to imply associations rather than generative mechanisms. Dashed lines indicate less certain association, compared to solid lines. The colour of shapes is to provide visual contrast (blue illustrating the superordinate theme). Red was chosen for concepts that were interpreted as being potentially negative, and green for those with potentially positive or facilitative connotations.

8.1. Diagnosis and judgement

The superordinate theme of *Diagnosis and Judgement* emerged through the strong link with elements of Brian's narrative that represented: the purpose, function and implications of the diagnosis of dyslexia; and the perception and effects of judgement linked to the label and difficulties.

8.1.1. Diagnosis

Diagnosis is constructed from narrative relating to the sense of *missed opportunities*, the fear of *disclosure*, the effects of the *damage of dyslexia,* and the *power of the label* conferred since diagnosis. The sense of regret and questioning surrounding the timing of his diagnosis, made relatively late in life, emerged early in Brian's narrative:

'trying to answer the question for myself, "Why didn't this come up before?"'
(Brian, int-1, 50)

In relation to this, there is reference to searching for information and clues from his memories, and school reports. Neither of his parents had progressed through education beyond secondary schooling, and Brian reflected that he felt they were unable to support him, despite there being a recognised pattern of difficulties (recounting struggles with reading aloud and multiplications tables during primary schooling, in particular). There appear to be a number of factors that emerge from Brian's narrative that could have contributed to the *missed opportunities*, which include the notion of *triggers*: events that could have been interpreted as distinct signs or clues, warranting further investigation. Indeed, one such event (unexpected failure in a postgraduate examination in public health training) led to his eventual diagnosis. Other factors include the environment in which he was in: he characterises his early educational experiences as being in a time where awareness of conditions like dyslexia was poor, and there was little consideration of learning difficulties:

'Dyslexia I think just wasn't recognised when I was at school. I don't remember ever hearing about it.'
(Brian, int-1, 120)

This suggests a temporality to the construction of dyslexia, with reference to social and professional awareness. It also alludes to a visibility: both of the condition within society, and of the condition to those in a position to spot it, indicated by references to both educators and his parents.

Within *missed opportunities* is the notion of *hypothecated alternatives*. Since receiving the diagnosis, Brian reflects on times where his struggles carried a strong emotional component, and considers alternative events if he were to have known his diagnosis at the time, for example:

'You know the only time I got threatened with the strap in school was because I couldn't recite my times table and I can't to this day. I just could not learn them and you know I'd like to go back to that teacher and give them a good shake and say, you know, "This is probably because I don't have the memory span to, you know, to learn these things and can't work with numbers" although I don't have dyscalculia.'
(Brian, int-1, 145)

Instances of *hypothecated alternatives* in Brian's narrative carry a strong sense of resentment at the *missed opportunity.* Another affective link with *missed* opportunities is the conveyed desire for *retribution* towards those who he feels anger, such as teachers who threatened punishment as a consequence of his difficulties, or who got him to read aloud in front of the class, resulting in shame and humiliation.

8.1.2. Disclosure

With the diagnosis, comes the decision regarding whether to share it or not. Brian talked openly about his feelings around disclosure, which related to many of the subthemes within *judgement*, including *stigma* and *pre-judgement*. These will be revisited in more detail later. More immediately, however, *disclosure* emerges from Brian's narrative in the context of *fear*, a sense of conventions or *rules*, *tensions* around disclosure decisions, and a sense of *agency* with regards to exerting control over knowledge conferred via disclosure.

Fear features prominently as a driver of decisions to not disclose. This appears to be related primarily to the fear of resultant stigma. However, there are other concerns alluding to notions of reinforcing a sense of self-believed inadequacy, elements of which appear to be construed from the way in which the diagnostic label is constructed, communicated and understood. Within examples of this, Brian reflects on anecdotes from his community of dyslexic peers. In doing so, he gives weighting to their stories, but also conveys a sense of warning and convention that is unique to that community:

> *'So I think the damage that I fear is that being too open about it might prejudice people against me and I know for a fact from talking to other dyslexics there does seem to be some prejudice certainly in surgical training where I've got a friend who is completely closed off about it and then won't mention it to anyone because of the fear of being looked down upon by her colleagues primarily.'*
>
> (Brian, int-1, 222)

The conventions of the community operate through the perception of *rules*, which appear to be constructed in Brian's narrative through comparison and judgement. In reflecting on dyslexic-peer experiences, he describes one colleague's pattern of disclosure as 'in your face', whilst suggesting he would be 'more modest' about his diagnosis. There is an implied sense of obnoxiousness to being 'in your face' about a diagnosis, suggesting it is not socially acceptable within that community. The reference

to 'modesty' provides a comparison that highlights the different approaches, the latter carrying a sense of being the more socially desirable course of action:

'she's quite sort of in your face with it and it's kind of like she uses it as a label to explain how she comes across as a, you know, I think she, she puts more weight on it that it perhaps deserves. So I tend to be, I suppose a bit more modest about it and if it comes out in the conversation then I'll not deny it and I'll be quite willing to talk about it but I'm not going to meet new people and say…'

(Brian, int-1, 255)

Tension arises around the decision of whether to disclose or not. At several points in Brian's narrative, he describes situations where he felt disclosure might be necessary in order to seek accommodations, but that to do so might threaten his chances of success in that particular endeavour:

'what does this mean in terms of declaring, you know have you got a disability for exams and things and you know I am because I'm coming to the end of my training you know four months to run in the process of applying for things and, you know, do I or don't I tick the box because what if they give me a test to, you know read a guideline and prepare a PowerPoint presentation; well that's going to take me a little bit more time than it might take someone who is much more efficient at reading.'

(Brian, int-1, 211)

This tension is also related to *questioning*, that emerges throughout Brian's narrative, about the nature of the diagnosis of dyslexia, and its relationship to *disability*.

8.1.3. Disability

In discussing his diagnosis, Brian volunteers that dyslexia can be considered a disability. He appears to reject this, finding it unhelpful, whilst simultaneously describing situations where the simple act of ticking a box can confer a consequence of disablement through prejudice. On initially being diagnosed, the idea of having a 'learning disability' was so discordant with Brian, that he sought a second assessment:

'I was floored by the fact that he said I was dyslexic and all I knew about dyslexia was that it's a learning disability (laughter). So I got a second opinion from a dyslexia specialist tutor with a view to doing some work to helping my chances in the exam. It was really her that convinced me that he was right with the assessment.'

(Brian, int-1, 97)

Much of the discourse surrounding the concept of disability is often associated with *fear* of *stigma* and *pre-judgement*. Unique within this subtheme, however, is the concept of *contextualised disablement*. In exploring how Brian considers his dyslexia to affect him, there is tension between denial of any impact, denial of disablement, and acceptance of times where dyslexia 'getting in the way of the day job' (CIR-3, 34) or where it may be disabling:

'you know if someone sees on an application that you've ticked a box that says you've declared a learning disability is that going to lower you, rightly or wrongly, it might mean the difference between being the preferred candidate or not.'

(Brian, int-1, 217)

The idea of contextuality is reinforced by Brian's use of 'mostly' when referring to him not having a learning disability. In the following excerpt, 'mostly' confers a sense that there are times at which Brian has been, or may be, considered as having a learning disability. Thus implying a temporal, or environmental contextual dependence on the function of his dyslexia and potential disablement, as also illustrated in the excerpt above:

'I've had to adapt and had to look for different ways to do things and I should feel proud to be able to do all those different things and to have been able to adapted to them rather than feeling apologetic because I've got this label which in my case hasn't been a disability mostly.'

(Brian, int-1, 328)

Within *disability* are the component subthemes of *condition of identification* and *hierarchy. Condition of identification* refers to combination of circumstances required to recognise a difficulty or impairment. Drawing on Brian's reflection on a *missed opportunity* during childhood, he refers to a 'particular' teacher who took an interest in his education. Brian felt this teacher was in the best position to recognise a learning difficulty, yet he didn't. The implication here is that a condition of identification is that the other party requires an orientation to caring (taking a particular interest, being encouraging and nurturing):

'and I had quite a close relationship with one particular teacher who was a form teacher and a biology teacher and he was quite encouraging me, wanted me to become a biologist and at no point did, did anything like that come up with him and he would have been of all my teachers the one that had the most interest in me and

probably in the best position to have identified any particular learning difficulty if it had come to mind.'

(Brian, int-1, 126)

Another condition is the visibility of difficulties, both in terms of how they are externalised, but also how they align to recognised constructs. The lack of social and professional awareness of dyslexia, alluded to earlier, would undermine the visibility component. Brian refers to his well-developed coping strategies in his narrative, and there is potential that these could effectively *mask* some of his difficulties, effectively reducing their external visibility too. This will be returned to in the exploration of *coping*.

The notion of a *hierarchy* in relationship to *disability*, and *diagnosis* emerges through points in Brian's narrative where he comments on the perceived legitimacy of certain SpLDs:

'I don't paint them quite with the same brush in that, you know, my own view is that certainly some ADHD is an excuse for misbehaving children and I'm a bit dubious about the existence of adult ADHD but, you know, the jury's out.'

(Brian, int-1, 116)

Here, Brian draws on the metaphor of the 'jury' illustrating that he is casting a judgement on the validity of the construct. This creates a sense of comparative validity to the diagnosis of dyslexia.

The final component of the subtheme of *diagnosis* is the *damage of dyslexia*. This is represented in literal terms, where Brian attributes consequential events in his life to dyslexia, and categorises them as damaging, e.g.:

'So dyslexia's no doubt caused damage but it's also my best friend in that it's responsible for all of the things that I'm really good at, you know, people want to mind map, people want something creative out of the box thinking, joining dots that other people haven't joined…
….I guess you all have, we all have a self-image and I didn't like the thought that my self-image included having a learning disability because to me my academic ability was quite core to who I am and being told that you're dyslexic my initial reaction was that self-image was undermined by having a learning disability so I was concerned that, I suppose that that might damage my chances of going further in academia as a sort of, you know, gut reaction'

(Brian, int-1, 205)

The *damage of dyslexia* is also represented in the way it has shaped his self-image, and the way in which he judges himself. In the excerpt above, Brian's narrative illustrates a historical approach that he has taken, holding himself to higher expectations. He also links the relationship with the label of learning disability with an incompatibility of self-image. This 'gut reaction' represents an internalisation of social expectations and norms, that imbue the notion of disability with a sense of inferiority and negativity.

8.2. Power of the label

The narrative surrounding elements of diagnosis also allude to the implications that having that diagnosis has. There are negative connotations associated with the label, which will be explored more within the subtheme of *judgment* (section 8.5.). The label also confers more positive, facilitative powers too. The subtheme of *power of the label* includes another subtheme of *forgiveness and permission*, and a network of ancillary themes, which will be explored in this section.

8.2.1. Forgiveness and permission

Emerging with significance from Brian's narrative is the power of the dyslexic label to confer *forgiveness and permission.* After receiving the diagnosis, Brian describes a process of reconstructing the narrative around incidents of difficulty, and applying a *historic permission* to having struggled. This conveys a sense of assuaging guilt around not meeting expectations, either perceived from others, or self-imposed:

> *'I think the main thing that is done for me is given the historic permission to have struggled and that's the most important thing. To a lesser extent it takes the pressure off me going forward in that if I can't get something done by a deadline I hope I won't beat myself up about it as much as I might have previously'*
>
> (Brian, int-1, 284)

In this excerpt, Brian also alludes to anterograde permission, with the effect of potentially relieving some pressure. Narrative from elsewhere in Brian's data would suggest that, whilst there is potential for granting permission, this does not lessen the pressure he places on himself, which operates through dominating self-imposed expectations. Additionally, the notion of permission here implies that to struggle

without permission is somehow transgressing and disobeying conventions operating within the reference community.

The sense of transgression is reinforced by the further need for *forgiveness* implied through the negative affect expressed in Brian's narrative surrounding pressures and expectations:

> *'if the fact that I need an extra bit of time to do it, you know should I feel bad about that, well probably not but you know, me being me I'll still bust a gut to try to meet the deadline.'*
>
> (Brian, int-1, 292)

There are a number of examples, throughout Brian's corpus of data that alludes to *forgiveness*, including instances that support the emergence of *retrospective attribution.* This process, which will be explored in more detail within *attribution* (section 8.4.), but there are connotations for the notion of *forgiveness*: by retrospectively attributing experiences of difficulty to his dyslexia, Brian creates a sense of a case for forgiveness being built.

8.2.2. Excuse

Excuse was identified in two different forms within Brian's narrative. Firstly, the notion of making *excuses* for his difficulties, by drawing on the *power of the label*. Secondly, *excusing* himself, relating to the sense of *forgiveness* that can be afforded by the label. The discourse in relation to function of the dyslexia label as an excuse for performance below the perceived, or actual, expectation illustrates conflict between the attempt of justification being seen as either seeking to *explain* (couched in positive terms) or seeking to *excuse* (which is constructed as a negative motive). Where the latter function features in Brian's narrative, there is an accompanying sense of fear that being seen as an *excuse* would devalue the diagnostic label. This appears to be related to the uncertainty that underpins *tentative attribution* of a difficulty to dyslexia. *Tentative attribution* will be explored fully in section 8.4.

8.2.3. Plurality and pigeonholing

Located within the *power of the label* are the components of pigeonholing and plurality. *Plurality* relates to *pigeonholing*, in that there are various and multiple ways in which

dyslexia can be defined, understood and taken to mean. Brian's narrative refers to seeing it as a disability, as a difficulty and as a difference. In the excerpt above, Brian alludes to a sense of choice in which version of the meaning to use. However, elsewhere he recognises the potential for this plurality to have consequences, potentially contributing to some of the confusion that underlies the poor understanding of, and prejudgment in relation to the label of dyslexia:

'So I think for some people it's because it … the difficulty with it is it can mean many things, you know, it's a spectrum and that some people it means that they have minor difficulties that they can fully compensate for which is typically my case and for other people it's much more what I thought it was all about which is, you know, word salad (laughter) and you know people that are illiterate or come across as being illiterate even if they're not'

(Brian, int-1, 234)

Pigeonholing refers to the way in which dyslexia can be 'lump[ed] together' (int-1, 242) in a category with another construct, assuming a similar identity. In his narrative, Brian specifically refers to this in relation to the construction of dyslexia as a disability. However, there are other examples where Brian draws on dyslexia as a difference, as opposed to a difficulty. He found doing this helpful both in terms of how he came to understand his dyslexia, but also in terms of how he saw himself. In doing so, Brian is exercising agency in the choice of which assignation he gives weight to:

'lumping it in with learning disabilities is not a good thing but then I read an essay, I can't remember the name and the title of it but it basically said dyslexia is a learning difference rather than a learning difficulty and more than anything else, more than any other information that I had that's what sort of made the difference for me in terms of being able to accept it and see it as a, as something that had pros and cons rather than just all negative; rather than just a potentially damaging label'

(Brian, int-1, 247)

The exercise of agency in this setting could be seen as a means of coping with the potentially negative connotations of being labelled with a SpLD. Agency will be explored in more detail in the next section.

8.3. Coping

Coping emerges as a subtheme from *Diagnosis and Judgment* through both the active discussion of mechanisms and strategies that Brian has developed over the years, as

well as: the action of *reframing* evident in his narrative; the sense of *acceptance* conveyed through granting *historic permission*; and through exerting *agency* as alluded to in relation to *plurality* and *pigeonholing*. Distinct from *coping*, yet aligned and related, is the concept of *community*, which will also be explored within this section.

Brian refers to his ways of coping in several ways. Firstly, he speaks directly of mechanisms by which he has 'compensated' for his difficulties. These comprise investing additional time and effort, compared to the investment he perceives his peers to make, a process of re-reading and double-checking (usually in reference to his written work), and the use of assistive interventions (e.g. computer software). These appear to be driven by a sense of meeting expectations. *Expectations* emerge as a subtheme on their own, but in brief arise from him, from social comparison, and a sense of what is a norm within the reference community (e.g. medical profession). In discussing his coping strategies, Brian suggests that they may have enabled him to *mask* his difficulties. This is framed in negative terms, as contributing to *missed opportunities*, but he indirectly refers to being able to participate in certain settings without affordances made for his diagnosis, on the basis of being able to compensate. In relation to this, is the notion of employing compensating strategies so successful that one can pass for being non-dyslexic. Brian articulates this in aspirational terms:

> *'while accepting that there are issues, I'm still aspiring to be non-dyslexic in terms of my performance. And I guess that's probably understandable, but you don't want to blame everything for dyslexia and you don't want to it to be your excuse for everything, but it doesn't seem to be quite right to pretend that it doesn't exist either'*
> (Brian, CIR-6, 103)

This is the only example of such sentiments emerging from his corpus of data. However, notions of being able to avoid disclosure of his diagnosis in formal settings (e.g. job interviews) in order to evade potential stigma supports the notion of *aspiring to be non-dyslexic* as representing a conscious attempt to influence other's perception of him and his abilities. This conveys a sense of not feeling like he fully belongs to the particular reference community (in this case, medical professionals), and a desire to not fully belong to another group (in this case, of doctors with dyslexia). The concept of *community* is aligned to the theme *coping*, in that membership confers a sense of security and belonging, which is helpful. However, there is a tension, as illustrated

above, whereby this membership compromises the legitimacy of membership to other groups.

8.3.1. Reframing

A key component of *coping* that emerges from Brian's data is that of *reframing*. This component subtheme is illustrated in instances where Brian directly refers to potentially negative experiences related to his dyslexia, as having had a positive impact on his life. An example of this is the experience of exam failure in his public health training. Brian reflects that failing the exam was the *trigger* that resulted in his diagnosis being made:

> *'you know, the Public Health exam that I had trouble with yes I hated that; it's a good thing that it came up. Had I not had that, had I not … of course you always want to pass an exam but if I had passed that exam on the first sitting we wouldn't be having this conversation because nobody would know that I had this dyslexic aspect to me. I certainly wouldn't know and I'd probably be, you know, as hard as I was before on myself without that knowledge.'*
>
> (Brian, int-1, 335)

However, there are deeper factors to *reframing* that are prevalent in Brian's narrative as well. *Reframing* can be employed for both positive, and negative means. An example of a potentially negative use of *reframing* includes where Brian makes a deliberate attempt to shift or accept blame. In the following excerpt, Brian constructs his dyslexia as a discrete part, and reflects how he resists 'blaming' it, but in doing so, takes on the responsibility of that 'blame':

> *'Is it a part of who I am, yes I mean it's not something you could carve off and it probably does, you know, shape a lot of what I do and what I think but in a pretty subtle way so I actually deliberately try to resist blaming dyslexia for everything and instead of looking at what it might have not given me or the extra challenges that it's given me I try to focus on the more positive aspects and, you know, the things I mentioned about, you know, creative, being creative and visual manipulation and stuff like that.'*
>
> (Brian, int-1, 316)

The act of *reframing* appears to require *attribution* of the focus of the activity to his dyslexia. *Attribution*, and the component subthemes will be explored in more detail in section 8.4.

8.3.2. Community

The subtheme of *community* refers to the sense of belonging to a particular group. In Brian's narrative, there are two distinct reference communities, borne out through discussion of friends and colleagues who have dyslexia (the dyslexic-peer community) and others within the medical profession. Another concept that contributes to the subtheme of community is the notion of particular *conventions* that govern membership to the group. In reference to the two communities emerging in Brian's narrative (dyslexic-peers, and the medical profession), these conventions exist as a set of internalised expectations: through socialisation into the community, social mores and expectations have been internalised, and become a force for self-governance. This will be explored in more detail under *expectations* (within section 8.5.). Brian's sense of belonging to these communities (group membership) appears to be in a tension with each other.

An element of the subtheme *coping* that also relates to *community* is the idea of *impostorship*. This emerged from a single, but powerful section of Brian's narrative, but which is reinforced by the sense of uncertainty and fear that imbues much of his reflections:

'whatever it is and you know if you can't do that, if you seem less than above average to have less than above average literary skills that somehow you're getting into medicine was a mistake'

(Brian, int-1, 274)

In this sentence, the focus of uncertainty and apprehension is crystallised: that Brian is, in fact, not 'good enough' to be a member of the community of medicine. Here, he fears that his membership of the group will be discovered to be based on a fallacy, misunderstanding, or mistake, resulting in his expulsion and exclusion. This fear implies a sense of value to being a member of that group which extends beyond the professional implications (rights to practice, or even earn a salary in that role), to something more fundamentally affirming to his sense of *self*.

Another component of *community* is the expressed desire for a *champion*, which emerges through direct discussion of public role models with dyslexia:

'so I think it's good to have role models like, I don't know, isn't Tom Cruise is supposed to be dyslexic and various other people that, that people, the general public can say,

"Oh they're dyslexic, oh I, you know I didn't realise you could be successful, you know and be dyslexic" or whether that's justified I don't know but my perception is that there are probably certainly people out there that think of dyslexia in the same way that I did when I got the diagnosis and didn't really know anything about it'

(Brian, int-1, 241)

This illustrates an example of tension between membership of the dyslexic-peer community, being perceived as incompatible with a successful future within the community of the medical profession. However, there is also an expressed desire to challenge that view, combined with a sense of vulnerability, requiring a public role model to trail-blaze and *champion* their abilities over their perceived difficulties and incompatibility. The action of championing people with dyslexia, however, draws on the act of attribution – attributing qualities (both positive and negative) to dyslexia.

8.4. Attribution

The discrete subtheme of *attribution* emerges from Brian's data in relation to the way he responds to acquiring the diagnosis of dyslexia through a process of *retrospective attribution*. There is also a significant amount of discourse that refers to *tentative attribution*, and cautions, and speaks of fear about *over-attribution*. Another significant component to *attribution* is that of *agency,* which has also been identified in relation to the choice of disclosure, and orientation of reframing. In Brian's *attribution*, agency appears to be *present* throughout.

A sense of *controlled attribution* emerges in the process of attribution from Brian's narrative in relation to a reflection on a discussion regarding traits of dyslexia:

'There was a bit of discussion about behavioural responses to dyslexia and the suggestion that we tend to be a bit disorganised. I certainly don't think that's applicable to myself, as that's one of my strengths, it's one of my main mitigation strategies is to be organised.'

(Brian, CIR-10, 171)

Here, Brian exerts *agency* through the process of *controlling* the *attribution* by means of denial with reference to whether he shares that experience. Brian's 10th CIR yields other examples of this sense of taking control over what can, and cannot be attributed to his dyslexia. This is related to, but distinct from the theme of *over-attribution*,

whereby Brian describes being cautious of over-attributing a particular difficulty (often referred to as a 'behaviour') to dyslexia:

> *'I guess I was looking for things to explain actively as sort of a part of a drive for self-awareness but that didn't last for terribly long because I think I quickly realised that hang on a minute, you know, you're in danger of attributing too much to dyslexia here'*
>
> (Brian, int-1, 342)

There are also examples of where he expresses his discomfort with others within his dyslexic-peer community doing so, conveying a sense of disapproval. This disapproval may arise from the same place as Brian's concern for the 'danger' in over-attributing: fear of the label becoming devalued, or externally viewed as an 'excuse'. This fear may also underlie the drive to be *tentative* in the process of *attribution*. *Tentative attribution* emerges as distinct from *over-attribution*, and is represented differently within Brian's narrative. At instances of attribution, Brian often employs language of uncertainty, such as: 'I think' (CIR-4, 51); 'probably' (CIR-8, 121); or at the extreme: 'whether that's dyslexia or not, I don't know' (CIR-1). In doing so, he loosens the certainty behind the attribution. This creates a sense of space in which error would be granted passage with a minimised impact on consequential guilt, should the attribution be disproven externally. The notion of guilt brings us to the partner component of the superordinate theme: *Judgement*.

8.5. Judgment

Judgement emerges from Brian's data in several different ways: the fear of *pre-judgement* in relation to the diagnosis of dyslexia; the fear of the related concept of *stigma*; how judgment operates through *expectations* that Brian places on himself, or perceives to be placed on him; and through the way he conceptualises his *self*.

8.5.1. Self

Brian's sense of *self* emerges through a range of discourse that refers to the way he sees himself, and the way he perceives his performance to be, as benchmarked by expectations. The subtheme of *self* is constructed of the elements of *disbelief*, *self-regard*, and *pressure. DisBelief* is represented throughout Brian's narrative, often in

terms of conflict with his sense of self-image. The first example is found in his discussion of the process of being diagnosed with dyslexia. Inclusion of language such as 'actually' introduces an element of doubt, reinforced by the overt efforts to seek a 'second opinion'. Here, the sense of disbelief is targeted at the notion of disability, as this is discordant with his self-image, but also with his beliefs about compatibility with his role as an academic. However, belief in himself is also represented through struggle in accepting tokens of positive regard:

> *'I do know a lot, I've had a lot of experience and I know people look to me when, you know, they want advice or they think, you know "[Brian] will know this, [Brian] will know that" so they have a completely different self-view of me whereas my view is that I'm not as good as these guys.'*
>
> (Brian, int-1, 432)

This example highlights the fact that Brian is held in high regard, that his colleagues would not necessarily agree with his generalising self-judgment of inadequacy. This alludes to a deeper mistrust of his sense of self, and his abilities that has possibly resulted from the repeated struggles, and internalised judgement from others. This is also reflected in the concerns expressed around prejudice and *pre-judgment*.

8.5.2. Pre-judgment

Notions of, and fear of pre-judgment emerge from Brian's narrative in association with supposed *pre-conceptions* regarding dyslexia, and fear of *stigma*. There were no examples of direct stigma, or witnessed prejudice in any of Brian's data. However, there was reference to anecdote from colleagues, and fear of the potential for poor understanding, and preconceptions to inform pre-judgement before he had the chance to inform a hypothetical 'them' of the true nature of his dyslexia, or his abilities. There is evidence in Brian's reflection on his diagnosis, that he has internalised these notions to the extent that he held a belief, and fear, that having a SpLD would be incompatible with future in the medical profession:

> *'that had been the case for so long that I didn't even recognise that that's what was happening until you know it was pointed out. In fact I, I didn't even, I didn't expect the diagnosis, I was … when I got told because I wasn't expecting that as an outcome of the assessment, as an academic trainee I was supposed to be smart'*
>
> (Brian, int-1, 82)

The specific reference to his status as an academic trainee highlights the perceived tension between having a learning difficulty, and being in a position where you are perceived as 'supposed to be smart'. The means by which the conventions of the reference community (e.g. medical profession) are internalised to this extent may be informed by *social comparison* which is illustrated in the language that Brian uses throughout his narrative. Examples include his reference to 'everyone else' (int-1, 269), and generalisations, such as 'we're all high fliers' (int-1, 270). In alluding to social comparisons, Brian also refers to *expectations*.

8.5.3. Expectations

The notion of *expectations* has arisen at several points in this analysis so far. This subtheme emerges from judgement in relation to Brian's judgement of *self* as being inadequate. This is represented in the inference to proving himself to his medical school sub-Dean (int-1, 34 and 414). *Expectations* are also perceived as externally placed, with some tangible examples of the threat of consequences should they not be met, during his early educational experiences (int-1, 140). There are positive and negative examples of *expectations* relating directly to his diagnosis of dyslexia. Firstly, it was the *unexpected* failure of part of his public health exams that triggered a referral for assessment. He subsequently reframes this failure as positive, as he has benefitted from the assessment process. Once the diagnosis was secured, however, Brian struggled to access the available support:

> *'it was difficult to apply for an extra 25% time to take my exam when I thought I should be capable, as capable as anybody else; I didn't feel disabled but the public health part A exam was a two day handwritten exam which requires you to be very linear and, you know, answer in order and make your points in order. I don't write that way, I don't think that way. My thinking's all over the place.'*
>
> (Brian, int-1, 170)

The barrier to him accessing support was his own expectation of being 'as capable as anybody else'. This relates to the pressure he places on himself, and is represented within Brian's SCS, where he draws how he feels friends would perceive him (figure 8.2). In this image, and accompanying narrative, Brian illustrates how he holds himself to higher expectations than he does others. His 'summit' (his 100%) would be seen as

120% by his friends, their summit would be his 80%. He reflects on how his friends encourage him to be 'Mr 80%':

> 'I'm constantly being told to pull back and do less as a result of this, tried largely unsuccessfully to be Mr 80% (laughter) and that Mr 80% is supposed to get me to where my friend's expectations are rather than, you know, where my expectations are. So that's probably a fairly apt analogy in terms of how I think people that know me see me in medicine in terms of what I'm trying to do and the effort that I put in to get there.'
>
> (Brian, SCS, 645)

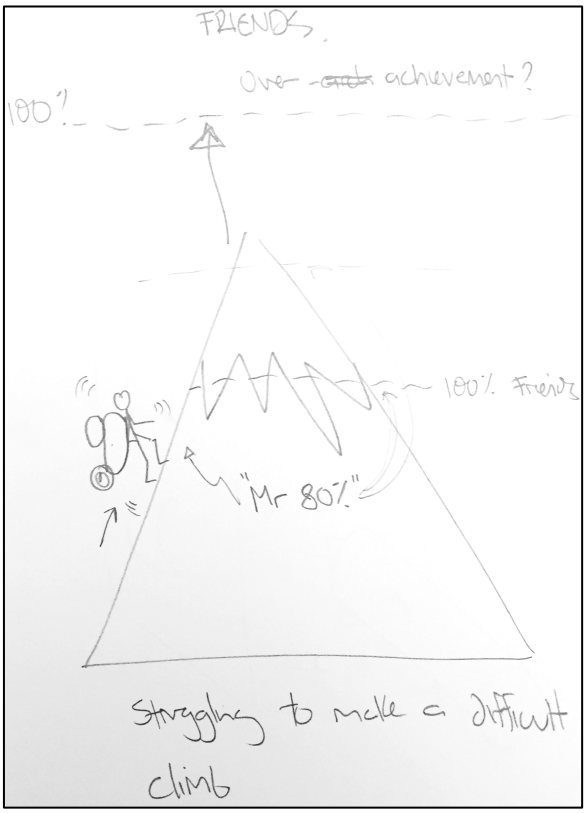


Figure 8.2: Brian's self-characterisation sketch of how he feels a sympathetic friend would see him. The image depicts him climbing up a mountain. There is uncertainty (wobble represented by concentric lines) and a heavy burden (back-pack). He is depicted as attempting to reach *his* summit (which would equate to his friend's '120% level', but he recognises he should accept, and try to be 'Mr 80%'.

From this, it is clear that Brian continues to hold higher expectations for himself, that will contribute to the pressure under which he works. This may serve as a driving force for his coping strategies (e.g. putting in extra time and effort). He does hypothetically reflect that historically 'excusing' himself may have resulted in him achieving less, by not pushing himself.

Brian continued engagement with the project until such time that the pressures of his job made it difficult for him to manage. At this point, he disengaged from onward participation. He went on to successfully complete his training, and secure a consultant job.

Chapter 9: Liz

I first met Liz whilst she was in her second year of Core Medical Training (CMT2). Her jobs in that year had consisted of 4-monthly rotations in neurology, respiratory medicine, and cardiology. Previously, she had spent a year out of training, working as a hospice doctor in New Zealand. Liz invited me to interview her at her home one evening after work. At the time of the initial interview, she was 27, and lived with her fiancé. She has one younger, and two older siblings – all of whom have a diagnosis of dyslexia. Both of her parents, and two of her siblings are teachers. Liz received private tuition to support spelling during primary and secondary school. Whilst studying for her A-levels, Liz also had subject-specific private tuition. She was diagnosed with dyslexia at the age of 17, and received additional time in examinations in her A-level exams and throughout medical school, where she was also in receipt of the Disabled Students Allowance (DSA). She had attended a medical school in the North East of England, but returned to the Midlands to be closer to her family upon qualifying in medicine. Liz participated in the initial interview (1 hour, 2 minutes) and SCS, submitted two CIRs in response to follow-up prompt emails, and undertook the interim interview (25 minutes) with me. Of note, Liz chose to type her responses to the CIRs, rather than use the audio-recorders provided. The excerpts taken from her CIRs are, therefore, unedited.

The combined analysis of Liz's data generated a highly complex array of themes that were distinct, yet inter-related. Due to their complexity, a clear hierarchy within the themes was not apparent. However, themes could be broadly clustered as relating more to *Coping*, becoming one super-ordinate theme, or *Belonging*. An additional high-level theme was identified as *The Dyslexic Way*. These are summarised in figure 9.1. which will be explored in more detail herein.

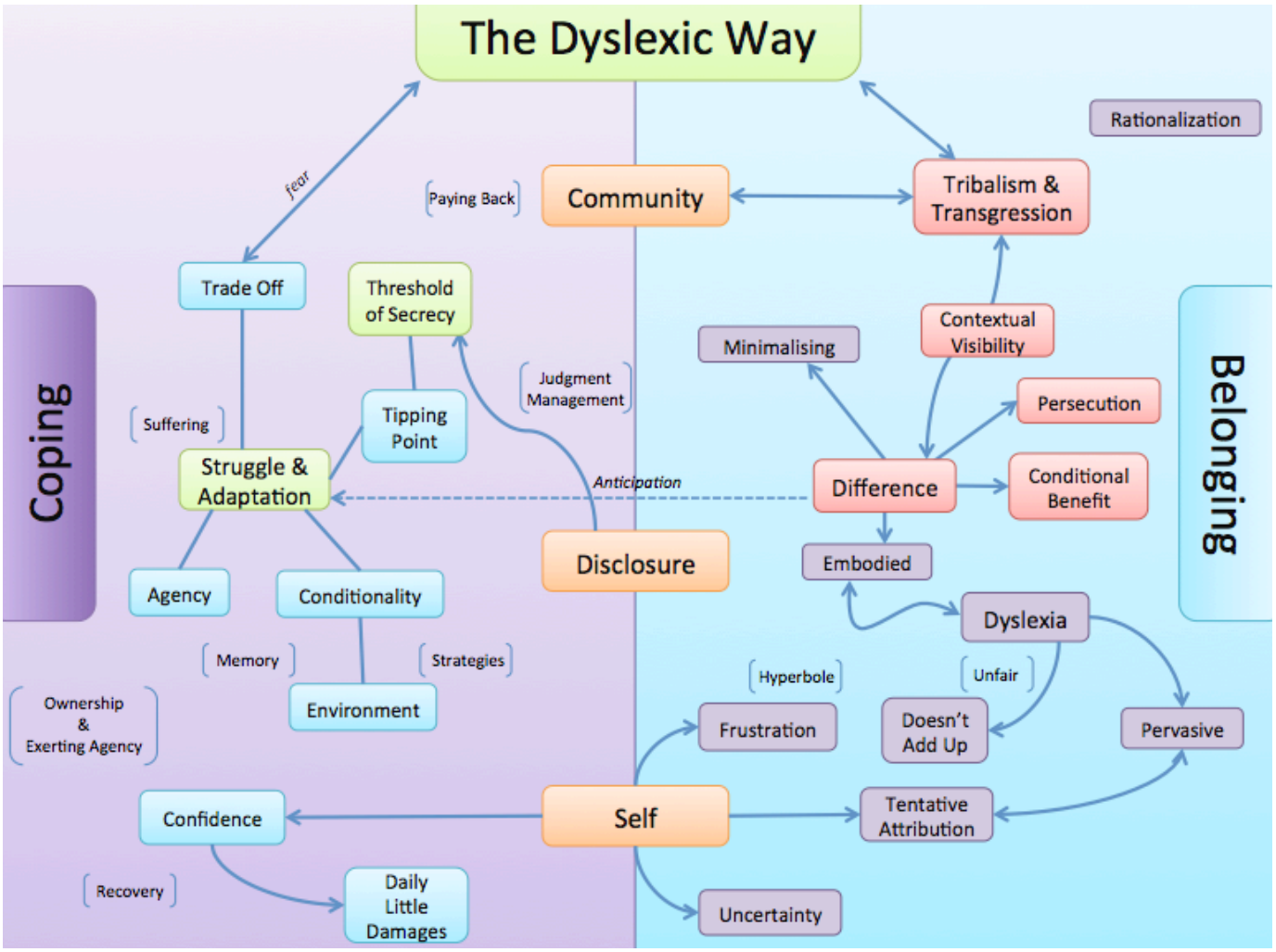


Figure 9.1: Concept map of themes emerging from the data from Liz's initial interview, self-characterisation sketch, critical incident reflections, and interim interview. Colours have been chosen largely to visually aide clustering of related themes, but red was chosen to indicate themes that were interpreted as having potentially negative connotations. Arrows are to imply associations rather than generative mechanisms. The thematic hierarchy, or level of order, is *not* implied by spatial arrangement (e.g. towards the top of the diagram does not imply higher order). In order to simplify the diagram, subordinate themes that cluster *more* towards *Coping* are arranged on the left (within the purple half), with those clustering *more* under *Belonging* on the right. Themes that bridge the two straddle the divide. *The Dyslexic Way* is not a superordinate theme in the same way that *Coping* and *Belonging* are, but is a high-level theme that is separate from, but related to, the two superordinate themes.

9.1. Belonging

From the beginning of Liz's narrative is a strong sense of *belonging* to a *community*. This community initially comprises her family (int-1, 25), but extends beyond this to include learners with dyslexia more generally. Later in her narrative this sense of *community* begins to be shaped by conventions and rules. This refers to the creation of

the professional community (peers and senior colleagues within medicine), and conventions surrounding practice within dyslexic community. This is related to the theme of *the dyslexic way*, but more specifically operates through concepts that emerged within *tribalism and transgression*.

9.1.1. Tribalism and transgression

Within the theme of *tribalism and transgression* Liz explores a sense of a "code", a way of doing things that is "right". This links with *the dyslexic way*, which alludes to a specific path for dyslexic learners, but the focus of that theme is more oriented towards learning. *Tribalism and transgression*, however, appears to relate to a set of codes that operate unconsciously at the social level, without explicit codification. This is borne out of a strong sense of wrongdoing by a close friend, who was diagnosed during medical school:

> *'…the thing that really infuriated me at uni though was that when we were kind of in the fourth year doing our fourth year exams we had our finals at the end of fourth year so that's when we were under the massive, massive amount of pressure and all of us in my house, I lived with all medics and we were all working extremely hard and we were all struggling because it's, it's a fourth year medical exams and like everybody struggles whether you're dyslexic or not it's hard to do and because all of, all of us were struggling my entire house then decided that they must be dyslexic too.*
>
> *So they all kind of went and got kind of privately assessed and like most of them were not dyslexic but then one, like my best friend then got diagnosed as being dyslexic but just she hadn't, she hadn't struggled at all up until that point and then she started having kind of extra time as well and it sounds really, really stupid that I find that I have negative feelings towards that because that doesn't really make me any better than the people who are having negative feelings towards me when I was having extra time but I just, I found that a bit odd'*
>
> (Liz, int-1, 234)

Liz recognises that a discomfort with her initial emotional response ('infuriated me') to this, and attempts to *rationalise* it: 'it sounds really, really stupid that I find that I have negative feelings towards that' and identifies this response as being similar to persecution by others: 'because that doesn't really make me any better than the people who are having negative feelings towards me'. This conveys a sense of perceived 'gaming' of the system of diagnosis and resource allocation, which does not conform to *tribal* conventions. There is also a sense of challenge to the legitimacy of the label acquired in this context, as if it hasn't been earned in the same way as hers,

and is less justified. The clear sense of transgression of conventions within the *tribe* is illustrated further when a fellow junior doctor discloses his diagnosis of dyslexia to work colleagues, in the context of perceived struggle in the clinical setting:

> *'So I'd already been kind of a doctor with dyslexia for a year and when he started his FY one he was really struggling and I think he was really struggling because it is really hard to become to an FY one doctor but he blamed his dyslexia for the reason why he was struggling and he made the decision to tell his consultant and his team that he was dyslexic and that he thought that this was interfering with his ability to be a doctor and so they started kind of double checking all his work and everything and it infuriated ... I was so angry with him when he told me because that is such the wrong impression to give of people with dyslexia and to have, to encourage this belief that doctors with dyslexia are less capable than doctors without dyslexia is just rubbish because every doctor has difficulties; it might not be a named learning difficulty but everybody has difficulties and if he can't cope with his dyslexia then that's actually a reflection on him as opposed to his, as opposed to people with dyslexia, their capabilities'*
>
> (Liz, int-1, 343)

In this excerpt, a different set of conventions appears to have been transgressed: moving beyond those surrounding the acquisition of the label, to the use of the label once (legitimately) acquired. In this example 'the wrong impression to give of people with dyslexia' is suggestive of a moral code within this community, or tribe. In this instance, membership of the tribe is not denied, but feelings of support towards him are annulled by shifting the locus of his difficulties from dyslexia (as he attributes) to him: 'if he can't cope with his dyslexia then that's actually a reflection on him', implying a conditionality around the accepted forms of attribution of difficulty and success within the tribe. Moreover, this statement appears to represent blame from within the community, or tribe, of doctors with dyslexia. The term *tribe* emerges as an appropriate representation of these concepts in Liz's narrative due to the closed nature of the community; the implicit conventions that characterise membership; the implied conflicts the community face to secure recognition, support and resources; and the hostility (implied through blame, as alluded to above) shown towards those who transgress their conventions.

9.1.2. Difference

Markers of belonging to a *tribe* include both the internal experience of difficulty, and personal knowledge of a diagnosis or label, and the externalised differences, indicated by disclosure or visible difficulties. There is a *contextual visibility* that emerges, which

alludes to markers of difference, more generally, or dyslexia, specifically. These markers are often only visible to those within knowledge of the community (e.g. of the community of dyslexics, or community of medical professionals):

'at university when I was with, when I was put with other people who were also high achievers like people used to say to me that "I can tell you're dyslexic." So I think it became more obvious when I was more stressed and more pushed that people all around me could tell and so people were kind of a bit kinder about it at university.'
(Liz, int-1, 218)

When markers of difference are externally applied (e.g. through reasonable adjustments, such as extra time within a common examination venue) people outwith the reference communities are able to identify the individual as different. This *contextual visibility* of difference is strongly associated with a sense of *persecution*:

'When I went to college and I started getting extra time then people were, then people were nasty about it and I remember when I did my exams in the first year of college they put all of the people with extra time on the front row of this massive exam hall which is just such a stupid thing to do and then when they started letting the other people go they ... you would literally like I'd have to close my exam paper because people would be stood around me waiting to go and get their bags like literally stood all around me and I was meant to be doing an exam.'
(Liz, int-1, 204)

Within the theme of *contextual visibility* is the notion of punishment, which is distinct from persecution. Here, those perceived as allies to the community act on visible markers of difference, and restrict resource allocation accordingly. An illustration of this, is where Liz reflects on when her initial psychological assessment had 'run out' (int-1, 257), itself alluding to a perverse sense of disposability and external time-limitation on the experience of personal difficulty. She had to be re-assessed in order to qualify for continued provision of extra time in examinations. Because she had demonstrated an ability to cope, her reasonable adjustment had been reduced, from 15 minutes to 10 minutes per hour. The sense of injustice within this scenario was heightened by the contrast with her friend who had recently been diagnosed:

'Like even at college going to two biology lessons every day for like two years, having private tuition, all of this so I think ... and the other thing that happened is at the same time I got my, for some reason I had to have another psychological assessment and I can't remember why, like the other one had run out or something and that psychological assessment found that I was dyslexic but that I was finding ways to cope with my dyslexia so my extra time in the exam was reduced from fifteen minutes every

year to ten minutes every hour and at the same time my friend who had seemed to kind of get through university like easier than me then got fifteen minutes per hour'
(Liz, int-1, 261)

Continuing with the subordinate theme of *difference*, there are linked concepts of *minimalising* and conditional benefit. The latter relates to the theme of *contextual visibility* and *persecution* too. Through difficulties being *visible* and associated with a perceived *benefit*, there is a resultant persecution. This is often associated with a sense of *guilt* on Liz's part, as if she is either somehow undeserving, or that it is unfair:

'in my second year they moved us into a separate room which was so much better and not just because like cheaply it was better because it meant that you got a more comfortable chair and the atmosphere was a lot more relaxed so it was also better because people weren't kicking your chair but I suppose it meant that we had a more pleasant experience than everybody else as well which perhaps shouldn't have happened.'
(Liz, int-1, 214)

This notion of guilt is also reflected in the concept of *minimalising,* whereby Liz appears to normalise her difficulties ('everybody' and 'just like everybody'), although her narrative suggests this particular issue (her confidence) is particularly significant. This does not appear to be in order to go undiscovered, but to minimise an over-focus of sympathy, conveying a sense of avoiding "compassion greed" – which is the notion of appearing to seek or take more compassion than is either initially offered, immediately available, or considered necessary by implicit conventions:

'So I think that's played a part but then again everybody has problems with their confidence who even when they're not dyslexic so it's always kind of, it's always ... because I've never not been dyslexic I don't quite know what it's like to not be dyslexic but I think, so I think there are issues for my confidence just like everybody has issues with confidence but I think I probably do have issues. I think, I think that I'm a more imaginative, colourful person (laughter) for it'
(Liz, int-1, 440)

Within *difficulty* is another emergent subtheme suggesting a *hierarchy of problems*, illustrated by the notion that some difficulties result in more 'real' problems than others. Here the use of 'real' implies other problems aren't 'real', and the inclusion of

'all the time' implies the difficulty is particularly prevalent, the combination resulting in this being a higher-order problem:

> *'this isn't really to do with education but I have a real problem with telling the time. Like I cannot ... like digital watches are fine but telling the time I really struggle with which is ridiculous and quite often I'll, like I'll just turn up late because I think it's like I've thought, I've looked at the clock and I think, "Oh I've got about 45 minutes" and then I just turn up late and that happens like all the time.'*
>
> (Liz, int-1, 124)

9.1.3. Dyslexia

Linked to the subordinate theme of *difficulty* is that of *dyslexia*. This is clearly constructed from the sense of difficulty, but is more than the gestalt of experienced struggles, and represents a sense of something operating in the background *pervasively*, the notion that things *don't quite add up*, creating a disparity within her reference community, and also the notion of *embodiment* to allude to a discrete body with agency. The *doesn't quite add up* component of this subtheme emerges directly from the discourse within Liz's narrative, and alludes to a sense of frustration and questioning regarding the imbalanced equation of effort spend not equating, at least proportionally, to output and results achieved:

> *'then I did my Part Two and I passed by quite a long way but I think the Part Two is more, I don't know if you know much about the exams but the Part Two is very kind of clinical based whereas the Part One is your basic sciences, your A Level stuff and I just couldn't do it whereas the Part Two which is the stuff that you come across in every day and you learn from your experiences like I kind of smashed it (laughter) and that in itself doesn't really quite add up.'*
>
> (Liz, int-1, 104)

There are references to others sharing the suspicion generated by this disparity. When her parents, in combination with previous experience with her older sister, noticed things not 'adding up', they anticipated her difficulties. This led to Liz informally being identified as having dyslexia within her *community* (family), and later seeking a formal diagnosis to satisfy the conditions of resource allocation:

> *'I think it was just always a given that I had it and by the time we got, by the time I got to college like we were all, you know, there was no question about it we just knew that I had it and to be perfectly honest the reason why I got formally diagnosed is*

because we thought I needed the extra time in exams. So it's a completely almost like academic thing just to get the extra support.

(Liz, int-1, 176)

This creates a duality within the diagnostic label: the formal versus informally conferred. From her narrative, it is clear that Liz identified with having dyslexia from an early age, feeling a part of that community.

Within the subtheme of *dyslexia* is the notion of *embodiment* in which there is significant *conflict* highlighting the complexity of this particular concept. Within this component subtheme, *dyslexia* is constructed as a separate part within herself, the distinction drawn by the reflection on difficulties as being 'dyslexia' or 'part of me and my personality' (int-1, 151). There are multiple instances where Liz refers to *dyslexia* as 'it', creating a sense of distance. In doing so, examples emerge where this creates the sense of surrendering power, or bestowing agency to this 'it', which is then enabled to hold her back, or interfere with her daily life. At times this is conflicted with the ownership of 'my' dyslexia, not entirely commensurate with embodiment, but a sense of bringing it closer to self:

*'So I think that's, that's where it's really held me back and that's where I get really frustrated like I feel confident in my abilities as a doctor in terms of my communication skills. My practical skills I think I'm quite good in my practical skills. It is purely my knowledge that I feel immensely under-confident in and I think **my** dyslexia has played a big part in that but that's just, you know that's not a problem that I can't overcome.'*

(Liz, int-1, 409, emphasis added)

9.2. Disclosure

Linked to the label, is the decision of whether to share and disclose the information it refers to. *Disclosure* emerges as a strong theme within Liz's narrative, as she describes a distinct *threshold of secrecy* at which she changes from being open about her diagnosis, to attempts to keep it secret from peers, colleagues, and even those with whom she feels close. Prior to qualifying as a doctor, she shared her diagnosis with her peers. At the point of qualification, however, she makes the active decision not to disclose:

'I've always been really open about it to my friends, open about it until I started working as a doctor and since I've been working as a doctor I have never ever told anybody that I've ever worked with that I had dyslexia and I make a point of kind of keeping it very quiet.'

(Liz, int-1, 183)

This threshold of secrecy appears to coincide with when Liz also describes her difficulties as outpacing her coping strategies, when she feels she begins to struggle. The choice to actively 'keep it very quiet' appears to be driven by a desire to be 'judged' on her abilities, conveying a sense of inevitability of judgement within the newly joined professional community. This may represent an active desire to control aspects of how she is perceived, and *judgement management*, but may also reflect the sense that dyslexia is incompatible within the medical profession, as articulated elsewhere in her narrative:

'the main reason why I don't share it now is because I am sure, positive, that other people have a negative impression of people with dyslexia to the point that they don't think that people with dyslexia should even be doctors'

(Liz, int-1, 326)

From the narrative explored to this point, it appears that there could be implications that *judgement management* may also contribute towards observing the conventions of the *tribe*, as well as avoid *persecution*.

9.3. Struggle and adaptation

Within the domain of *coping* is the subordinate theme of *struggle and adaptation,* which encompasses a network of constituent subthemes relating to the *conditionality* of her difficulties and coping strategies, to the *trade-offs* that must be made in order to adapt and cope, and to the *tipping points* at which her ability to cope is outpaced by the difficulties she encounters.

9.3.1. Struggle and adaptation

The subtheme of *struggle and adaptation* emerges from Liz's narrative through the description of events that highlight the sense of struggle and disparity (reminiscent of

the constituents of *doesn't quite add up*) as well as the work she puts in, and strategies she employs to overcome these difficulties. The struggle around performance in postgraduate exams appears particularly significant, as it dominate the narrative across the initial interview, one of the CIRs, and the interim interview, which may reflect the sense of pressure to achieve in these exams within a specific timeframe, or the sense of identity that passing them would confer. With this latter point in mind, it is important to reflect that the postgraduate exams she refers to are 'membership exams', successful completion of which confers membership to the medical royal college within which she is training. This overt token to membership confers a sense of power over identity formation – to belong, or not, to the professional group (or royal college). The sense of suffering related to *struggle* is implied by Liz's reflection on the emotional response she had to discussing her difficulties with me during her initial interview:

'I think that's why the last time we met I was kind of more emotional about it then because that's when I'd just started first noticing that I was really really struggling to overcome it.'

(Liz, Int-2, 233)

9.3.2. Conditionality

The particular difficulties that Liz struggled with, as well as her ability to adapt, appear to have a *conditionality* of operation. This sense of conditionality includes a large focus on the *environment*: that is, the environment within which she works, as well as the environment created by her reference community. The notion of *community* is implied through both the relationship with the medical profession (professional community), as well as linking to the notion of *the dyslexic way* (dyslexic community). In the following excerpt, Liz reflects that there are conditions under which her strategies (referring to information resources) could be employed in the clinical setting, but some circumstances (dealing with a patient in anaphylaxis) where this wouldn't be possible, conveying a sense that the clinical *environment* influences the conditionality of adaptations in this context:

'Like the only thing, the only things that you can't look up is when a patient's kind of having an anaphylactic reaction pretty much everything else in medicine you can, you can look up like if you have five minutes to look it up on the internet or get out the Oxford Handbook or whatever.'

(Liz, int-1, 413)

9.3.3. Environment

There is a sense that the environment created by the community of medical professionals has the potential to be self-perpetuating, and perpetuates a specific sense of self. In Liz's case, this is sense of self is of low levels of confidence and insecurity with her knowledge:

'And so you could get a team where you get somebody who's less confident and then somebody who's more confident you almost reinforce those roles as time goes on.'

(Liz, int-2, 123)

9.3.4. Ownership

The relationship to *self* will be explored more in the next segment (9.4). Returning to the central subtheme of *struggle and adaptation*, the notion of *ownership* emerges in relation to *exerting agency* in a process that appears to empower Liz to take control and adapt. This sense of ownership appears to be influenced by her understanding of, and attitude towards, her diagnosis of dyslexia – understanding it as a difference, and seeing it as an asset:

'I've always really used my dyslexia to actually learn vast quantities of information at GCSE and A Levels because when you know how to do it with dyslexia it can really be an asset'

(Liz, int-1, 228)

This relates to *the dyslexic way*, which is conceived as a means of both approaching one's dyslexia, and one's work-with-dyslexia. Deviation from this path, through losing sight of the ownership, thus surrendering agency to external forces (in this instance, a sense of fear), results in poor performance:

'In the past the thought of spending all that time re-writing with the exam fast approaching has panicked me, and that's when I've just tried to learn straight from the text book, but Im not capable of doing that so it's wasted time anyway. As always I just need to resign myself to putting in the extra time.'

(Liz, CIR1, 36)

9.3.5. Tipping-point and trade-off

Within the *struggle and adaptation* subtheme, another concept that emerges is that of the *tipping point*. This describes the point at which Liz's coping strategies are outpaced by the environment (work or learning, or both). This is related to the *trade-off* alluded to in reference to putting in additional time and effort, as a means of coping. This *trade-off* becomes increasingly challenging when working full time in a clinical role, therefore

necessitating compromise. This compromise is a *tipping-point* at which her performance suffers due to the strategies used not conforming to the dyslexic way. In the following excerpt, Liz explains how she 'passed [her] degree' on the basis of revision notes (done in *the dyslexic way*), but illustrates how long it takes (the *trade-off*), which is why she cannot employ the same strategy for her postgraduate exams (the *tipping-point*):

'So these were my notes from university and these, this is what I passed my degree on. So nothing else, just like what's contained in here; so as a general rule if I found something really difficult I use an A3 sheet so these are the things I really struggled with and they're all kind of, kind of brainstorms and like pictures as well. It's amazing how long this takes. That's why I can't do it for my exams because it just takes up so much time but I still use these to revise from'

(Liz, int-1, 681)

Conditionality plays a role in the *trade-off* too. There are circumstances in which Liz's strategies do not 'work' for a particular subject (subject-as-condition), which then interferes with the utility of that approach. This would, in turn, devalue that trade-off and alter the threshold of the tipping-point, resulting in alternative strategies being adopted (which may not conform with *the dyslexic way*):

'I tried to like colour in so I tried to colour code the different kind of areas so I still know that my respiratory is blue and I kind of I try to do that where it is still just so much information that I just couldn't do it basically and it just didn't work very well and like the'

(Liz, SCS, 727)

The impact of Liz's performance appears to be more self-oriented. External markers, such as success in her postgraduate exams and reflection on feedback from colleagues, suggest that she is competent and knowledgeable. However, she remains uncertain in her knowledge, and describes feelings of being in a 'downward spiral' (int-2, 111) where her confidence plummets. Liz's confidence is intrinsically linked to her sense of *self*, which will be explored in the following section.

9.4. Self

In the narrative that Liz shares for her interviews, SCS, and CIRs, it is possible to see an emerging sense of *self* that is dominated by issues surrounding her *confidence*, and an element of *uncertainty*. *Self* is also influenced by *frustration*, *tentative attribution* of outcomes and events to *self* or *dyslexia*.

9.4.1. Confidence

Liz's sense of self-confidence has been degraded over time as a consequence of *daily little damages* that constitute small, almost insignificant in isolation, incidents that 'remind' her that she is not meeting expectations of the reference community (this is largely represented as the medical profession). This expectation appears to be one that Liz construes, or one that she has internalised as a consequence of being socialised into the community. Within this frame of reference *social comparison* also operates, illustrated here:

> *'more costly than the time and the frustration is the near daily reminder it proves to be that I have a condition that I feel at times holds me back in my everyday work compared to my peers, and the damage this has on my confidence.'*
>
> (Liz, CIR2, 55)

Within this theme, Liz's narrative explores the notion that her skills and confidence may be comparable to her peers (in saying 'anyone would say that whether they've got dyslexia or not'), but reflects that her experiences with dyslexia have undermined her ability to trust in herself, her memory, her judgement, and subsequently her confidence:

> *'But I don't know if I'm sure anybody would say that whether they've got dyslexia or not, I just feel that it's more safe for me. So I think there's not kind of ever one incident but it's just constantly like people asking, like consultants or registrars, testing me and quizzing me and asking me questions that I know that I've learned over and over and over again and I still can forget'*
>
> (Liz, int-2, 29)

This mistrust in her knowledge is reflected in the SCS exercise that drew on her ideas about how a 'critical other' might see her (figure 9.2). Her narrative explains that there is stress emanating from her head (outwardly radiating lines), and she is balancing medical notes and computer-based work. Her face does not bare a smile, but the faces of her surrounding colleagues do, giving a sense of relative sadness in her position. In the 'background' (top right) there is a graph depicting performance, in terms of knowledge, of trainees – she has circled the 3rd bar, indicating her performance is below average, but not the lowest in the cohort. This image is reminiscent of the *pressure* that was explored within *struggle and adaptation*, as well as reintroducing *tokens of*

doctorness (stethoscope and syringe). However, the overall message resonates with the subtheme of *confidence* through a sense of not being as good (happy or knowledgeable) as those around her.

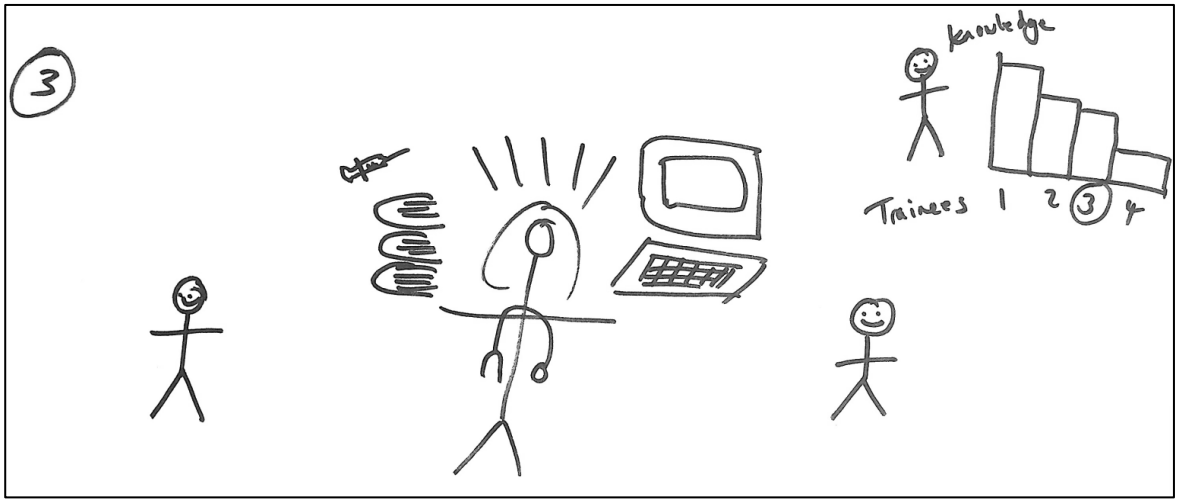


Figure 9.2: Liz's self characterisation sketch depicting how she thinks a 'critical other' may see her. It is focused on her in the clinical setting. There are fewer people in this image compared to the other exercises (where she included family and patients).

There is a sense of recovery in the narrative relating to *confidence*, where Liz exerts agency and takes action to attempt to 'undo' the harm done by the daily little damages:

> *'that's what I'm trying to do so I feel like I've almost halted the downward spiral but I'm not sure if I've managed to get it to the point where it's going up again, I think I'm just kind of static'*
>
> (Liz, int-2, 148)

9.4.2. Uncertainty and tentative attribution

Throughout Liz's narrative, there is evidence of uncertainty. This subtheme has emerged in relation to self, but is as pervasive as her dyslexia, which may reflect a relationship between the two. In the discourse employed in her reflections on events, Liz draws on language that creates a sense of uncertainty, softening the claims, e.g.: 'it's difficult to know' (int-1, 96), 'kind of' (int-1, 101). This relates to not trusting her recall and judgement, but also to a sense of resisting attribution to her dyslexia. *Tentative attribution* appears to be a feature of both positive and negative outcomes and attributes, illustrating the impact of low *confidence*: '*So I think it probably was the dyslexia*' (int-1,106) illustrates the uncertainty that softens the attribution, whereas

further examples hint at a tone of apology, reminiscent of the *minimising* seen in relation to difference:

'It's very difficult to know because people without dyslexia they have different abilities and it's difficult to know if the dyslexia is playing a part or not but I just couldn't see how you could work so hard for six months and then fail and then work so hard again for six months and only just pass'

(Liz, int-1, 99)

In resisting certainty in the attribution, Liz is retaining ownership of her failure, or the unease she feels with 'only just [a] pass'. In reflecting on positive attributes, and coping strategies, Liz retains the uncertainty, but is a little more linguistically directive in attributing the positive focus *on* the dyslexia:

'the dyslexia helps me think outside the box I think and just kind of be creative I think maybe with how I approach problems which again I mean I don't know, I'm, I'm, I don't really know as much about dyslexia as like my sister does'

(Liz, int-1, 150)

In this shift of language, *dyslexia* is the entity that is given agency for her creativity here. There is a sense that by doing this, the end of the path of *the dyslexic way* will never be reached, and is something to continuously strive for. This may, in turn, have an implication for motivating towards this goal: seeing enough progress (through acknowledging the ability to 'think outside the box' and creativity) to remain on-track, but needing to continue towards an endpoint that is held out of reach by the pervasive, discrete entity known as *dyslexia*.

Chapter 10: Sarah

I met Sarah at her home, one evening after work. She was 49 years old when she participated in the initial interview, having been diagnosed with dyslexia a year beforehand. She had extensive experience in education, after struggling through primary and secondary school, securing 5 'O levels' (secondary education exit qualifications) with additional support in the form of classes for reading and spelling throughout. She described failing her 'A levels' (further education). She then went on to study pharmacy, and become a community pharmacist. Her career then took her into management and training, during which she decided to undertake further study, leading to her PhD. After nearly 10 years in this role, she decided to re-train in public health (which is accessible to people with non-medical healthcare backgrounds). She successfully completed her masters in public health, but failed her first attempt at her public health membership (MFPH) exams.

Sarah completed the initial interview and SCS, going on to contribute two CIRs after email prompts. Her reflections were submitted via email as typed responses. Where they have been used herein, they remain unedited. She disengaged from the project, when she no longer replied to emails. From the narrative across her body of data, two superordinate themes were identified: *Self*, and *Power of the Label*. Supporting these is a network of seven subordinate themes, themselves encompassing thematic concepts, summarised in figure 10.1.

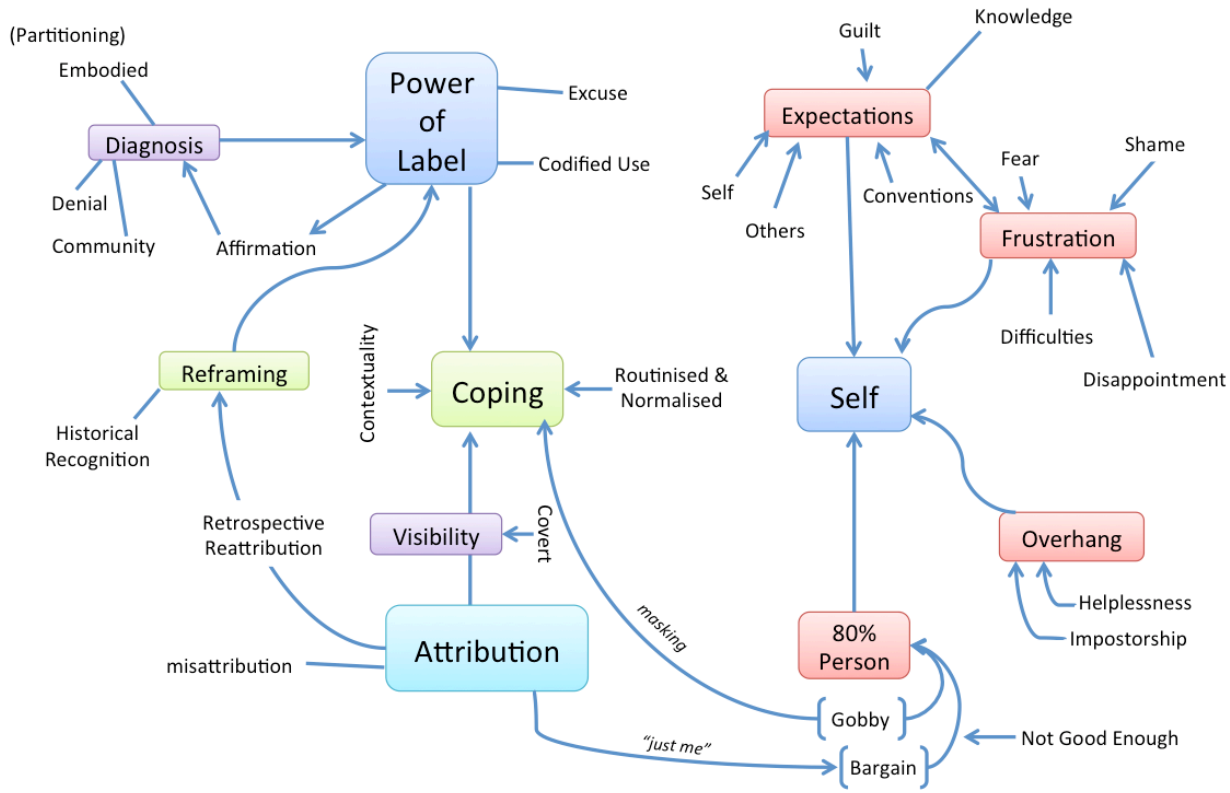


Figure 10.1: Concept map illustrating the superordinate themes: Power of Label, and Self, emerging from Sarah's data (comprising the initial interview, self-characterisation sketch, and 2 critical incident reflections). Arrows are to imply associations rather than generative mechanisms. Dashed lines indicate less certain association, compared to solid lines. The colour of shapes is to provide visual contrast (blue illustrating the superordinate theme). Red was chosen for concepts that were interpreted as being potentially negative, and green for those with potentially positive or facilitative connotations.

10.1 Self

The superordinate theme of *Self* emerges from Sarah's data from four distinct concepts, coming together to influence her sense of identity, and self-regard. The subthemes that contribute to arise from: her perception of, and reaction to *expectations*; a strong affective component represented by talk of, and associated with, *frustration*; how her sense of self has been influenced from the *overhang* from her early life experiences; and the theme of considering herself as an only '*80% person*'.

10.1.1 Overhang and '80% person'

As the youngest child, in a large Jewish family, Sarah talks of growing up in an environment where the cultural expectation was that she would cook, clean, and not have a 'proper career' (int-1, 177). Within her narrative, reinforcement of this notion is represented through experiences, such as her brother described her as having a 'non-

academic PhD' (int-1, 179). Subsequent talk draws on self-deprecating language, such as 'thicko' (int-1, 183), or talk that represents an acceptance, normalisation and internalisation of such beliefs. This process of internalisation appears to have resulted in a pervasive impact on the way she interprets achievement, abilities, expectations, and difficulties in relation to her *self.* It is this impact that is represented by the subtheme of *overhang*. Within this subtheme, there are components of *helplessness* and *impostorship* that emerge. *Helplessness* emerges from the sense of relinquishing agency to external markers of achievement, such as a degree, to confer a sense of personhood. Subsequently, she is represented as having no internal, or inherent, ability to challenge the notion of being a 'thicko':

'so I think having the diagnosis of dyslexia explained to me so much and just gave me the confidence which maybe partly because of my upbringing and also because I did struggle with education. Up until I got my degree I was a thicko. I failed my O levels, I think I took ten of them and I got five. I failed my A levels first time around and I had to retake them and then I still ended up with a B, a C and a D. So I never really thought that I was clever.'

(Sarah, int-1, 186, emphasis added)

Impostorship, in the context of Sarah's *overhang,* is related to the use of external representations of achievement (academic degrees), and other labels (her diagnosis of dyslexia). The sense of *impostorship* is conveyed by drawing on these devices to challenge the notion of luck ('fluke') in relation to securing jobs or training in public health, representing group-membership:

'But having been labelled with dyslexia and having achieved what I have achieved just made me feel, yes clever, and justified in being where I am and I haven't got here by fluke.'

(Sarah, int-1, 188)

This excerpt also illustrates Sarah's tendency to imbue external tokens of success, reinforcing the notion of *helplessness*. The notion of luck appears at several points throughout Sarah's narrative, and she refers to this sense of being an impostor in a variety of ways, often linking to *fear* and *exposure* (e.g. int-1, 361), which will be explored in more detail under section 10.1.2. Sarah's negative sense of self serves a function in relation to *impostorship*, through operating as an active means of *management*: by undermining the projected self, she is able to 'lower' expectations of

others, thus negatively aligning the expectations she anticipates them having, with her self-judged level of competence:

'now when I go to my placements I will make sure that everybody knows very early on that I am dyslexic and I will actually say, "What you hear come out of my mouth may not match the speed at which I will write reports or do a press release or whatever it happens to be. I am capable of doing those things but you have to accept that I am dyslexic." And I actually go in with that now to almost lower people's expectations.'

(Sarah, int-1, 227)

This *management* strategy may contribute to Sarah's *coping* (another subtheme which will be explored later). However, there is the potential that, by drawing on her negative self-view, she is rehearsing her self-judgements and reinforcing the image of herself as an '*80% person*'.

The subtheme of '*80% person'* draws on the language that Sarah uses with reference to her performance, but in discussing this, she refers to herself as 'an 80% person (int-1, 45) which conveys a sense of extending beyond her self-judged performance, to her actual sense of personhood. This could refer to how she perceives herself in comparison to her peers, and therefore how she conceives her sense of professional identity within the medical, or public health, community. This concept is associated with a strong sense of not being 'good enough' in relation to her professional role, which is borne out in her discussion of the third SCS exercise (critical other):

'I have put not thorough enough because I think that probably is something that people consider me as.'

(Sarah, SCS, 351)

The above excerpt illustrates her belief that others perceive her as not being thorough enough. This appears to operate as a surrogate for 'good enough' within her professional context. The following excerpt reinforces this, but also illustrates the sense of *fear* of exposure and discovery, associated with *impostorship*, and her sense of not being good enough (encompassed by the '*80% person*' subtheme):

'Whereas when I was working in the local authority whenever the head man used to come down and sort of say, "Will you do this, will you do that" I would be like, "I can't do it, I can't do it. He is going to see, he is going to tell." So I think...I don't know it is kind of...I suppose really I think confidence is one word or lack of, and sort of understate my capabilities.'

(Sarah, SCS, 384)

Another component of the '*80% person*' subtheme is her self-described *gobby* trait. When describing herself as a 'gobby Jew' (int-1, 22), Sarah alludes to her verbosity and spoken confidence, which is discordant with her sense of self-confidence. She believes that her spoken confidence, informed by her comparatively greater life experience, influences others' perception of her. Specifically, she fears that colleagues may perceive her as being confident and able, thus over-estimating her abilities:

'whether that is because I know that my dyslexia will show up at some point, at some point I will be found out that actually I am just a gobby person who is not really great at writing things, I don't know. And that has definitely...me by my trainer, I am always very wary.'

(Sarah, SCS, 388)

Sarah's 'gobbiness' emerges in her narrative as a potential contributing factor to coping through this sense of projecting capability through her confidence and verbosity. In this regard, being *gobby* may *mask* her difficulties and subsequently enable her to cope with elements of certain environments, such as negotiating entry to a new team or group. The use of minimising language, such as 'just', in this context suggests a sense of falsehood: projected capability being misaligned to performance. By reflecting on her apprehension ('wary') of her dyslexia 'show[ing] up', Sarah also alludes to the fear of exposure and judgement. The prevalence of her self-described 'gobbiness' is illustrative of the pervasiveness and significance of this construct within her sense of self.

Within '*80% person*' resides another thematic concept: that of *bargain*. This concept emerges from Sarah's narrative in several areas relating to achievements. The first instance appears when attributing her degree classification:

'*I was always around a 2:2/2:1, and actually I had a viva and I talked my way into a 2:1 so I was actually on the 2:2/2:1 border and I talked my way into a 2:1'*

(Sarah, int-1, 20)

Through ascribing her success to *bargaining* Sarah implies that she wouldn't have been good enough to achieve the grade otherwise. This sense of not being 'good enough' also resonates through other representations of this theme in Sarah's narrative. The implication of this being that her sense of academic-self appears to be underpinned by the belief that her qualifications, and therefore group-membership, are less legitimate.

This contributes to the fear of discovery, and being found to be unsuitable to hold her position.

10.1.2. Frustration and expectations

Within Sarah's narrative is a strong theme of affect relating to *frustration*. In this sense, frustration serves as the point of convergence of feelings of *shame*, *disappointment*, *fear*, and anger – represented itself as *frustration* in her discourse. This affect appears to arise in relation to *expectation*. Expectations manifest as: those that Sarah perceives others have of her; those that are expressed by others; those that operate as unexpressed conventions, consistent with socialised norms for the reference community, such as medical professionals; and those that Sarah places on her *self*.

Specific examples of *frustration* in Sarah's narrative allude to a sense of anger, shame and disappointment borne out of a disparity between her speed of comprehension (relatively fast) and the speed of her output (such as coherent written work). Such examples emerge throughout Sarah's narrative, and the *frustration* they communicate can be surmised when Sarah states that she 'hate[s] being bloody dyslexic' (int-1, 266) at times. Where frustration emerges, there is also a link to both attribution and coping. An emergent coping strategy appears as Sarah 'blam[ing] the disease' (int-1, 276) instead of herself. There is a sense that this confers the ability to attenuate negative affect (e.g. shame and guilt) associated with performance that is misaligned to expectation. In order to determine the locus of fault necessary to direct blame, however, Sarah must first *attribute* the outcome (e.g. perceived underperformance) to her dyslexia.

The unexpressed conventions of the medical community, emerge in a number of ways throughout Sarah's narrative with reference to job-related performance, such as:

> *'I had had a positive test result for a patient which should they had RSV (Respiratory Syncitial Virus). I could not pronounce 'syntitial' and in the end a nurse colleague wrote it out phonetically in syllables as she heard me struggle so much on the phone. Again I felt foolish.'*
>
> (Sarah, CIR-2, 54)

This can be considered a form of cultural expectation. Having to ask a colleague, especially with the added interplay of asking a colleague from a different discipline

(nursing as appose to medicine or public health), and any level of hierarchy that may imply, creates a sense of disappointment in *self*. This, combined with the affective response (feeling foolish) represents not having met the normative expectation of being able to correctly pronounce medical terminology. Sarah was subject to cultural expectations of another variety, with her being cast in the aforementioned role as the youngest female Jewish child in the family. Expressed expectations were exemplified in Sarah's reflection on the failure of her membership (MFPH) exam, where a senior academic had said:

'So when I went to her for a debrief she was gobsmacked and she said, "I really didn't expect that from you. Everything had pointed to the fact that you would definitely be able to pass."'

(Sarah, int-1, 98)

In contrast to *expressed* expectations, *perceived* expectations appeared to be more subtle, and pervasive in Sarah's narrative. *Perceived expectations* emerged where Sarah implied the perception of an expectation on her through her emotional response to her performance, such as feeling frustrated or foolish in response to struggling or making a minor mistake. She appears to have internalised a sense of being unable to meet the various forms of expectations that she perceives, resulting in her expectations of herself being low:

'It is amazing what poor insight...or maybe not what poor insight, I think a lot of it is upbringing actually. I think my expectations of myself actually have always been quite low'

(Sarah, int-1, 196)

This self-evaluation is revealing, and the significance of the cultural expectation is reflected in her discussion of her SCS, where she discussed how she sees herself. Considering herself unable to draw, she wrote a list of attributes, including 'Confidence (or lack of)' and 'Motherly' (figure 10.2). Motherly may, superficially, be a statement of the importance of her family to her, her role in her daughters' lives, and the relationship she has with her husband (all of which featured positively in her narrative). In bringing that attribute into how she sees herself, though, could also represent an assimilation of the cultural expectations she alluded to, relating to work in the home. It is interesting that she described 'understating [her] capabilities' and being a 'quick thinker' – which would challenge the negative self-evaluations that

emerge from her narrative. She does, however, introduce doubt through the 'or lack of' in relation to 'Confidence', and repeating the 'Duddy / alternative' remark about how she projects herself. The latter being perceived as a potential slur from colleauges.

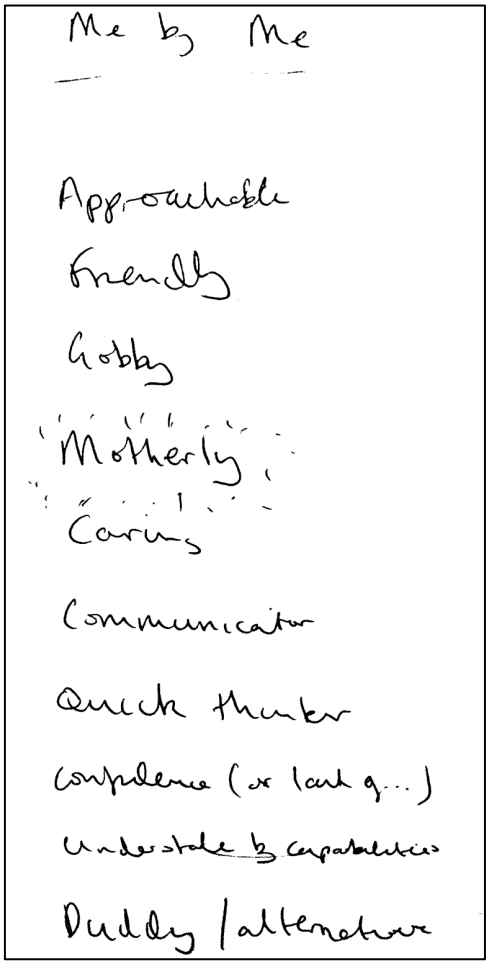


Figure 10.2: A list of attributes drawn-up in response to Sarah's first self-characterisation sketch exercise: how she sees herself, and all the parts of her life coming together. She lists: Approachable; Friendly; Gobby; Motherly (highlighted); Caring; Communication; Quick Thinker; Confidence (or lack of); Understates my Competencies; Duddy / alternative.

10.2 Power of the Label

The second superordinate theme to emerge from Sarah's data is the *power of the label*, which emerges in relation to direct discussion of the way in which Sarah has come to use the label. This superordinate theme is comprised of elements emerging as: the subthemes of *diagnosis;* the recognition of *coping* strategies in relation to her dyslexia; and the process of *attribution* of outcomes to her dyslexia.

10.2.1. Diagnosis

The *power of the label* emerges from Sarah's narrative initially in relation to the *diagnosis* of dyslexia. Sarah initially felt 'gobsmacked' (int-1, 122) at the result of her

assessment. In recounting the event, Sarah introduces language such as 'actually' (int-1, 119), which carries a connotation of challenge, as if the following sentiment ('it does show that there is definitely a tendency towards dyslexia', int-1, 123) is not fully believed. This conveys a sense of doubt or denial, which is reinforced by the disbelief expressed in her being 'gobsmacked'. The diagnosis was, however, accepted by Sarah – as illustrated by her active use of it in a form of reframing and reattribution that will be explored in section 10.2.3.

The subtheme of *diagnosis* is associated with a sense of belonging to a *community*. In Sarah's narrative, this is conveyed in relation to her family, the wider dyslexic community, and the community associated with her professional role. Her two daughters and husband have dyslexia, and she draws on shared experience to identify with difficulties, strengths and potential coping strategies, including those that she has used in bringing up her children:

'So whenever I have taught them how to learn their spellings and things I have always tried to think of rhythms or patterns or word associations that will help. So...what is because? It is big elephant. I can't remember what because is now. But we had little rhymes for all those standard words. So I did it with them because they were dyslexic but I never reflected that that is why I do it.'

(Sarah, int-1, 157)

The sense of their being a 'way' that people with dyslexia do things emerges elsewhere too, and represents the wider dyslexic community:

'I have always been one for really remembering rhymes and associations. So...I can't think of an example at the moment, but you know when you are trying to remember a whole list of notifiable diseases, I would make myself up little rhymes as to which ones were notifiable and which ones weren't. And I didn't know that that was something that dyslexics do. Bizarrely it is always what I have taught my children to do.'

(Sarah, int-1, 153)

This example also speaks of another phenomenon: *visibility*, which will be visited in more detail under section 10.2.3. Here, we see that Sarah's coping strategies (rhyming) only became visible through the knowledge of her diagnosis, attributing the approach to her membership of the dyslexic community.

Examples of discourse referring to dyslexia as a disease emerge from Sarah's narrative at several points. In conjunction with talk that attributes dyslexia-related difficulties to parts of her body (e.g. 'my dyslexic eyes' int-1, 255) this converges on tangible biology:

a disease, a diseased thing (eye). There is a sense that, whilst the disease is contained to a specific organ, or part of the body, it is *embodied*. This notion of embodied, yet partitioned disease, will be revisited in relation to coping strategies in section 10.2.3.

Perhaps the strongest contribution of *diagnosis* to *the power of the label*, at least in terms of the significance with which is appears to emerge from Sarah's narrative, is the *affirmation* that accompanies the diagnostic process, and subsequently revisited in self-talk elsewhere:

'I have got published papers, I have done a PhD, all of these things. And she said, "You have just coped with it and you have never...because you didn't know it you have never used it as an excuse." And it was really lovely having somebody tell me. I don't know [her] from Adam but she told me I was clever. And I came out going, "I am dyslexic and I am not thick, I am clever, [the Dyslexia Specialist] says it."'

(Sarah, int-1, 164)

In this excerpt, the power of a stranger evaluating her strengths and weaknesses, in the context of her difficulties, and concluding that she was 'clever' was powerful for Sarah. She appears to have internalised this message, and re-written the narrative she holds around her achievements, such as entering public health training:

'stupidly aged 49 it made a huge difference and it does now. I feel justified in doing what I am doing whereas when I got into the training I actually thought it was a fluke that I had got in. But now I actually think do you know what I got in because I am a bright person and I have got the ability like everybody else'

(Sarah, int-1, 167)

This *affirmation* has conferred the power of justifying her difference, and acceptance of her qualities. However, through emerging as a component subtheme, there is also an implication that Sarah needs this affirmation despite her considerable achievements to date, which she acknowledges ('stupidly aged 49 it made a difference'). This is likely to reflect the *overhang* from her upbringing, which largely reflects expectations of a cultural nature, but has been re-contextualised in light of her diagnosis of dyslexia.

10.2.2. Codified use and excuse in the power of the label

Where the power of the label emerges in the data, it is often accompanied by an acknowledgement of the tension between a justified form of use (aligned to the

conventions of the community) and using it as an excuse. This tension is illustrated in a reflection on her use of the label:

> *'now I am much more open and just say, "I am really sorry but I am dyslexic, it will take me a few more minutes longer." So it has been really empowering. God knows what I would have been like if I had have got it earlier in life, probably unbearable'*
>
> (Sarah, int-1, 215)

Here, she alludes to a change in the way she approaches challenge ('now I am much more open') since becoming aware of her diagnosis, and acknowledges how empowering it has been to do so. However, in reflecting on the potential for this pattern of use to make her 'unbearable' illustrates awareness of a tension between the use of this label, and the perception of it as an excuse. The discomfort conveyed by this conveys a sense that Sarah feels as if she shouldn't be using the label, or at least in the manner in which she does, suggesting some sort of *code* applying to the 'correct' way of using the label.

The tension is further identified by Sarah herself, when reflecting on her family's response to her use of the label:

> *'in fact now I find that I blame virtually everything on dyslexia which my family joke about really because they have all been diagnosed.'*
>
> (Sarah, int-1, 61)

Because Sarah's children and husband have dyslexia, this 'family joke' may represent a form of amusement or ridicule borne out of the discomfort around this manner of use of the label – because it breaches the code within their community (either as a family or wider dyslexic community). The blame in this excerpt implies fault, couching her dyslexia in negative terms. By 'blam[ing] virtually everything on dyslexia' Sarah shifts the locus of fault from her, to the 'disease'. Expressed in these terms, this device appears to function as an *excuse*: to avoid, or minimise, the damage to self that the responsibility of the negativity (e.g. discrepant performance) may cause. This illustrates a potential means of coping with her difficulties, which will be unpicked further in the next section (10.2.3).

10.2.3. Coping and attribution

The theme of *coping* emerges as an element that both arises from, and contributes to the superordinate theme of *the power of the label*, and is associated with the sub-theme of *attribution*. This relationship is largely due to the way Sarah attributes difficulties, or strategies, to her dyslexia throughout her narrative.

Within *coping*, we can see that *contextuality* plays a role, as does the notion of *routinised* and *normalised* practice, which interact to necessitate, manifest, or make visible (or invisible) Sarah's ways of *coping* with her dyslexia related difficulties. The idea of her coping strategies operating invisibly, in the background is exemplified in her narrative around her diagnosis:

> *'And then when I went for the five hour sort of trawl through 1001 dyslexic tests that she does it became really obvious that I had developed a whole host of coping mechanisms that I had no idea that is what I had done.'*
>
> (Sarah, int-1, 132)

Here, she reflects on having had 'no idea' that she had worked in a different way, drawing on coping strategies that she had innately developed. This speaks of the context-dependent visibility of her coping strategies, such as in the context of an assessment. In section 10.2.1, the excerpt referring to Sarah's reflection on the development of rhymes to recall notifiable diseases illustrates the *routinisation* and *normalisation* of her coping strategies. She didn't 'know that's what dyslexics do' (int-1, 153) and she had always taught her children to do it. It became normal practice within her immediate community (family), and so became invisible. Normalisation emerges through other means too, however, such as the use of minimising language throughout, such as '*just* coped' (int-1, 161). Sarah draws on several other examples of working with her children to unpick her coping strategies. The sharing of experiences with them, which can now be related to the diagnosis of dyslexia, creates the space for her to bring her ways of working into the foreground.

Attribution has been alluded to in relation to coping before (section 10.2.2), where Sarah shifted 'blame' to dyslexia. When situated in the context of considering dyslexia a 'disease', and a sense of partitioned embodiment, this shifting conveys a sense of containment: by attributing the outcome to the disease, and any potential subsequent body parts (e.g. 'dyslexic eyes') there is a sense that this conveys a limitation on the

acceptance of *fault* and subsequently attenuates the impact that it has on her core sense of self. In this regard, coping strategies extend beyond the immediate difficulties experienced with dyslexia, to the affective component explored above (10.1.2).

The very process of considering a strategy to be related to coping, Sarah must attribute a difficulty or strategy to her experiences with dyslexia. *Attribution* emerges as a significant component to coping through conferring the ability to *reframe*. The first emergence of *attribution* is during Sarah's reflection on being diagnosed with dyslexia, where performs a process of historical, or *retrospective reattribution*, making sense of her experiences in light of her new diagnosis. This relies on a process of *historical recognition*, and contributes to the process of *reframing*:

'I went to [Dyslexia Specialist] and it was just such an illuminating five hours because to me it just kind of explained everything that has gone on in my past. The fact that I can remember sitting in those history and geography lessons and just going I don't understand a word that you are talking about and all the letters are jumbling and all the words are jumbling and languages I can't do languages and all the things that I had struggled with.'

(Sarah, int-1, 127)

The above excerpt illustrates a *historical recognition* of her difficulties as relating to dyslexia, as a consequence of the process of assessment with the dyslexia specialist. Elsewhere in her narrative, Sarah illustrates the progression from recognising to reattributing, whereby she solidifies the relationship between her dyslexia and the historical difficulties she experienced, resulting in a reframe: the difficulty being due to her dyslexia rather than her *self*:

'So actually for me when I did get diagnosed with dyslexia through the Deanery it kind of made me feel okay about myself because I wasn't thick actually who just had to work hard. And my general knowledge is very poor but actually there is a real reason for that.'

(Sarah, int-1, 59)

The impact that this reframing and reattribution has on coping is further illustrated in the management of the affective fallout from performance discrepancies. Sarah reflects on a minor difficulty that was manifest during her work:

'so for a moment today I was going, "I hate being bloody dyslexic, why do I have to be dyslexic?" Because otherwise in my head it would be what I thought in my head would then be on paper whereas I had missed out I's and they's and their's and I had

got one sentence totally back to front and I had to go back and I had to back and I had to click on words and move them. And I was just like oh come on [Sarah] because I also knew that I was working to a 3:30pm deadline for the school so they could get the letter out. And that frustrated me. '

(Sarah, int-1, 271)

This direction of 'hate' at her dyslexia is reminiscent of the shift of blame explored in 10.2.2. By directing this strong negative reaction at her embodied, yet partitioned, 'disease', she appears to be able to limit the impact on her affect and sense of self, illustrated by her realisation:

'Now in my pre-diagnosis days I would have been really angry with myself and saying, "Oh for God's sake [Sarah], less haste more speed. Come on you know this, you are an 80% woman, you have got to slow down and do it properly you can't get away with it anymore."'

(Sarah, int-1, 274)

Her reflection that she 'can't get away with it anymore' resonates with a code to the use of the label: when working in the context of a senior professional in public health, the diagnostic explanation holds less validity, relegating it to the function of an excuse.

The *visibility* of Sarah's strategies has a component of contextuality, emerging from her data in association with difficulties, making her strategies manifest through necessity. They also become visible through supportive interactions, such as the tuition she had in preparation for her public health exams (OSPHE stands for *objective structured public health* exam, which forms part of the MFPH):

'yesterday i went to see a dyspexic support person to help me prepare for my Part B membership exams. I am doing the exam on 20/2/15 and have being panicking a bit aboiut the amount of reading and knowledge assimulation that is needed to perform the OSPHEs. [She] was able to instantlky see my issues and helped me develop a really clear framework which if I stick to should help. Her ability to see my issues and then help develop coping stratgies was just great, all I could do was see the problem which I was very able to articulate but i couldn't have developed the framework without guidance.'

(Sarah, CIR-1, 27)

This excerpt speaks of the visibility of her coping strategies being important to her ability to consciously work with, and continue to develop them. In addition to making her ways of working visible, for developmental purposes, this visibility appears to contribute to reframing. Sarah talks about only being able to 'see the problem', which carries a sense of negativity, almost panic, about it. By creating this 'framework' and

providing perspective, the dyslexia specialist was able to reframe her thinking. In the context of this example, the reframe appears to be from a problem-orientation to a solution-orientation, where Sarah's focus shifts to what she *can* to, and how she *can* work with her and continue to develop her coping strategies. This, in itself, appears to be a meta-coping strategy, with positive potential.

Sarah engaged well with the project, and was forthcoming with two CIRs. However, eventually she stopped responding to follow-up emails, including the invitation to an interim interview, indicating her disengagement from the project. She went on to successfully complete her training, and is now a consultant in public health.

Chapter 11: Helen

Helen agreed to meet after her shift, in the doctors' mess at the hospital in which she worked as a FY1 doctor. She was 25 years old when we met, and was working in elderly care medicine[7], having previously done 4 months in colorectal surgery. She had been diagnosed with dyslexia when she was at secondary school, at the age 13, and has a brother and sister who were also diagnosed with dyslexia around the same time she was. Helen attended a 3-tier comprehensive ('state') school system. She succeeded in all of her exams, although her performance in her formal assessments in secondary school demonstrated struggle in English writing. It was this, in the context of having a sister known to have dyslexia, which triggered her dyslexia assessment. She and her brother were assessed simultaneously, after which she received additional time in exams, but didn't recall any tuition or other forms of additional support. Helen participated in the initial interview and SCS, which lasted approximately 36 minutes. She spoke softly and appeared calm and confident.

Four higher-level themes were identified from Helen's narrative. These appear to be inter-related, but one theme emerges as superordinate because the remaining three themes appear to feed into it in a non-reciprocal manner. This superordinate theme is *Struggle and Attribution*, with the remaining higher-level supporting themes being: *phenotype; coping;* and *self,* each of which comprising of a network of subordinate, or ancillary, themes that are summarised in figure 11.1.

[7] There is contention surrounding the term 'elderly care', and the specialty is often referred to as geriatric medicine. Helen, however, used 'elderly care' to describe her rotation, hence this is the term used here.

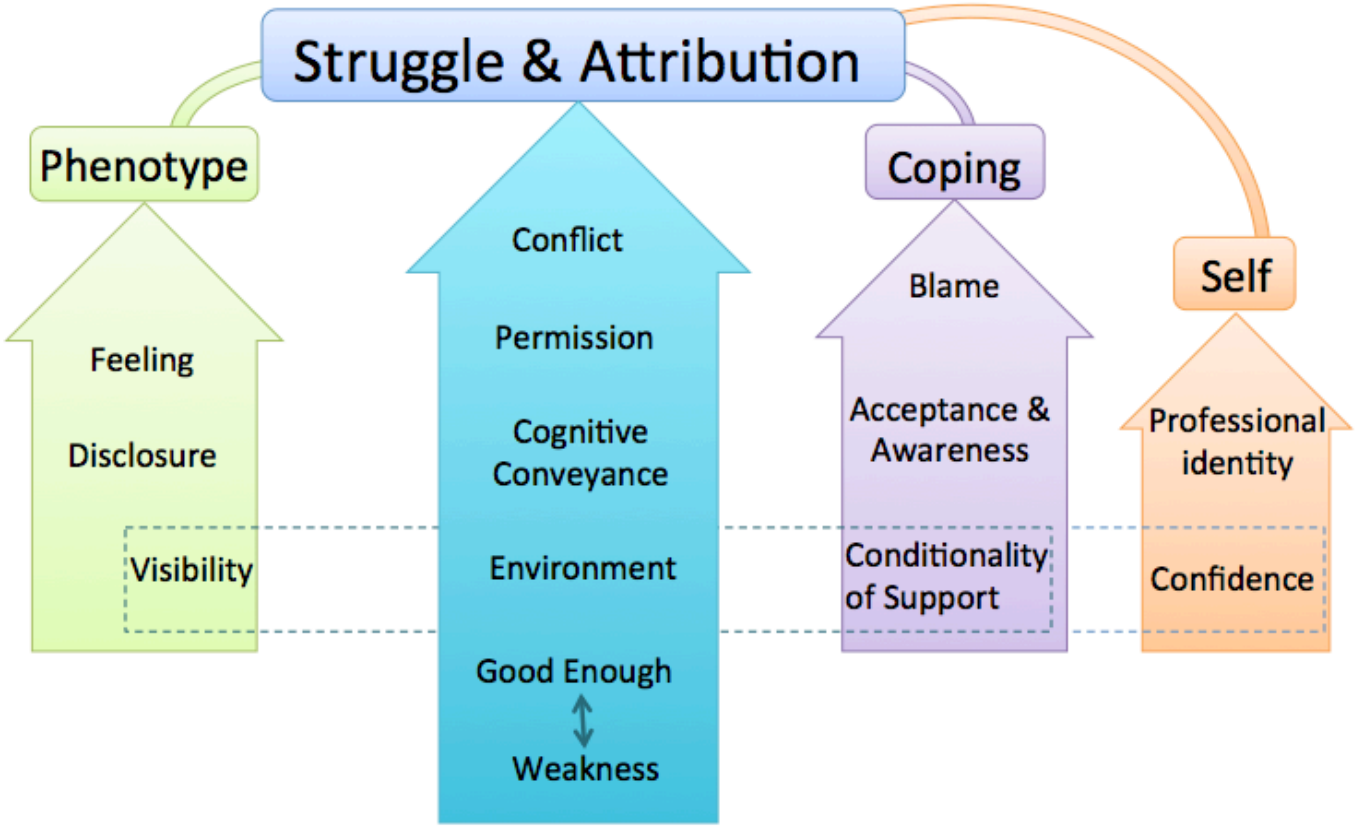


Figure 11.1: Concept map illustrating the superordinate theme: Struggle and Attribution Helen's data (comprising the initial interview and self-characterisation sketch). Arrows are to imply associations rather than generative mechanisms. In this diagram, dashed lines (boxes) are used to illustrate associations across theme groupings. The colour of shapes is to provide visual contrast (blue illustrating the superordinate theme).

11.1. Struggle and Attribution

The theme of *struggle and attribution* emerges from Helen's narrative through instances of talk about practical struggles, as well as how she attributes these struggles to factors, including her dyslexia, the environment, or others. Of note, she stated that she didn't think that her dyslexia affected her, but this was outweighed by reflections on difficulties that she felt may be related to her dyslexia throughout her narrative. This tension is reflected in the sub-theme of *conflict* within *struggle and attribution*: she initially denies her difficulties, which may represent a resistance to acknowledging or attributing her struggles in relation to her SpLD:

'yeah, what was the question? Oh difficulties. I don't think so. I suppose I ... what I was worried about was while I could have extra time in my written papers I could never have extra time in the OSCE, but part of the OSCE was reading, so you have to read what's on the door in a very short amount of time and I used to worry about if I

was going to be able to read the scenario on the door quick enough before you go in because even though apparently they're supposed to have the scenario inside you're actually supposed to read it on the door and then go into the station and complete the station without then thinking, "Right, can I refer back to the scenario?" But actually it was OK. But I used to always worry about that'

(Helen, int-1, 210)

This excerpt also illustrates an element of anxiety borne out of the differential accommodation practices that she experienced. This sense of anxiety appears to be provoked by the differential provision of accommodation (additional time) in assessments, dependent on the format of the assessment. This contributes to a construct within a different theme: *conditionality of support* (within *coping*) that will be revisited in more detail within section 11.3.3. Returning to the notion of *conflict,* Helen's narrative illustrates, this is reinforced by ideas that she can control the impact that her dyslexia has, which is represented in her narrative as *permission*:

'I don't think it's affected my professionalism – if that's what you're asking. But I don't think I've allowed it to'

(Helen, int-1, 246)

Helen suggests that she exerts agency, and in so doing, must also have some level of awareness of her difficulties and ability to *attribute* them to her dyslexia in order to ensure they do not impact on her professional role. This excerpt alludes to more than *permission* and agency, however, and hints at a sense of *fear* – fear that her difficulties could impact on her professional role.

11.1.1. Cognitive Conveyance

In her narrative, Helen draws on examples of difficulties that share a common element, constructing the sub-theme of *cognitive conveyance* (conveying thoughts through communication). This particular type of difficulty arises when she attempts to express her thoughts in writing, or through speaking, and is particularly heightened with work of a reflective, narrative or emotional nature, but suggested she finds fact-based information easier to deal with and communicate:

'I find it hard to kind of ... if I have ... if I want to say something or do something it's taking it from my mind and either writing it down ... so if you're like trying to communicate something with your friend, like if you have a feeling or something, that ... I find that hard and I think ... and I'm sure that's because of dyslexia'

(Helen, int-1, 375)

Within this excerpt, Helen again alludes to the ability to *attribute* this particular type of difficulty to her dyslexia, further supporting the superordinate theme. Other examples in Helen's narrative allude to a difficulty with *cognitive conveyance* and construct the difficulty as a disconnect between her cognition, and her ability to communicate it – this disconnect is in the conveyance of what is being processed and constructed in her thoughts.

Difficulties are represented in Helen's narrative by more than her accounts of specific struggles. Helen also refers to a sense of worry, manifesting as a *fear* of being criticised or seen to be being dyslexic. This constructs difficulty as more than a mere manifestation of difference, or an impairment, but as something that can be self-constructed and imposed through apprehension. Where difficulties and struggle are also represented in Helen's narrative, they involve a strong sense of environmental contextuality.

11.1.2. Environment

Environment emerges from Helen's narrative in the context of struggle, but also in the context of utility and acceptance of support and strategies for coping – these will be explored more in section 11.3. The environmental factor relating to *struggle and attribution,* however, refers to the factors operating around (and outwith) her, that contribute to the manifestation of her difficulties. An example of this is seen in the following excerpt, where the pressure from perceived expectations, and fear of perceived consequences, combined with the pace of the work overwhelm her abilities to cope (e.g. by looking up particular drugs):

> *'the hardest thing in terms of that is writing because of spellings, so when you're ... a lot of medical words, stuff like drugs and stuff, I have to look up ... or I've learnt what they're supposed to be, but when you're under a lot of pressure and ward round's going very quickly sometimes my words are not as great'*
>
> (Helen, int-1, 218)

The environmental forces appear to act in two ways here: one way is through the pressure making her difficulties manifest ('sometimes my words are not as great') due to the pace of work; and another through obviating her coping strategy (looking up 'drugs and stuff'). The notion of *environment* is represented in the context of *attribution* in Helen's narrative too:

'I think I'm quite determined, I want to be as good as I possibly can, I think it's very hard to be as good as you can in the circumstances, not necessarily because of dyslexia, but the current job I have is so busy, you cannot be as good as you want to be which is horrible when you've always ... like sometimes you go away or you go away from a situation and you think, "I didn't ... I wasn't as good as I could have been, I didn't ..." not that I didn't do my best, because I did my best for that situation, but because of what's happening and the constraints and the busy-ness, you couldn't have done what you would have been able to do had you had time and no pressures'

(Helen, int-1, 259)

In the above excerpt, Helen links the *environment* to the manifestation of her difficulties, which resonates with the initial explanation of the sub-theme. However, here, she consciously attributes the manifestation of her difficulties to the environmental factors, which goes beyond the initial construction to more directly link this with the superordinate theme of *struggle and attribution.* Of significance, there appears to be no reference to her dyslexia or own experience of difficulties here: it is an explanatory reflection on how the environment in which one works can undermine and compromise the ability to perform work-related tasks. In doing this, Helen is able to consciously partition the experience of difficulties that are unrelated to her innate abilities, and represents the ability to direct *blame* towards a particular locus. This represents a coping strategy, and will be explored in more detail in section 11.3. Another concept that is represented in this excerpt is illustrated in her self-talk: 'I think I'm quite determined', which alludes to notions of being *good enough*.

11.1.3. Good enough, and weakness

Being *good enough* or *not* good enough is represented through: the introduction of doubting language in self-talk; talk around perfectionism, relating to expectations on self; and in talk around perceived expectations that are embedded within the culture of the medical profession. For instance, in the following excerpt, Helen refers to a desire to 'be good' – in so doing, insinuating that she does not feel good *enough*:

'Helen: I can present the case very well, I know what's happened with the patient, I can talk about the bloods, everything, but then it's after that to then write in the notes a summary of what's happened – I find that really hard and I have to think really hard about what I'm writing and am I writing enough and in enough sense, you know, to encompass exactly what's been decided.

Interviewer (me): And how does that make you feel?

Helen: Stressed. I don't know. I know it's because of that and I do feel stressed about it and I think, you know ... I suppose frustration because you want ... I want to be good'

(Helen, int-1, 229)

This excerpt also alludes to the enculturated expectations of the medical profession, such as: that her work would be of a particular implicit, rather than explicit, standard. The frustration that is present in this example appears to be borne out of Helen's concern about not meeting these standards. In the excerpt above, in section 11.1.2., (Helen, int-1, 259) the concept of not being *good enough* is illustrated by other means: the introduction of doubt in the language she uses in describing herself: 'I think I'm quite determined' – both *think* and *quite* operating here to soften the certainty in the quality of determination that she considers herself to demonstrate or possess. This may represent an element of modesty, but the potential for it to signify doubt seems to align more accurately to the way she presents herself through her narrative. The language of doubt is showcased elsewhere in Helen's narrative, and in the following excerpt is accompanied by the introduction of perfectionism – which carries both self-critical connotations, as well as linking to the notion of *good enough* through an implicit attempt to strive towards perfection:

'I think my friend would say I was messy, but also I think they would also say ... but alongside my family would say I'm a perfectionist, is that how you spell it'

(Helen, SCS, 310)

The self-criticality in perfectionism is conveyed through a sense of apology for not yet having achieved the requisite implied standard or perfection by, for example, being 'messy'. The notion of perfection is reinforced through the concept of *weakness*, which emerges from Helen's narrative as a related sub-theme in the context of her dyslexia, and support she may have received:

'Helen: I was allocated extra time for my exams, but I didn't take any extra time in any of my exams, I think mostly because I was ... it's different when you're at university because you're in a completely separate room, whereas at school you're in the same room and everyone would leave and you'd still be there and I don't know, I think it was just hard to come to terms with ... I didn't want that to kind of be a weakness, I didn't want other people to think that that was ...

Interviewer (me): You mentioned there that you didn't want it to be a weakness.

Helen: More so from other people's perspective. I don't know. I didn't want people to think that I was getting better grades or whatever because I had extra time – if that

makes sense? And ... yeah, I don't know what I was thinking then. It's different because I took all my extra time when I was at university.'

(Helen, int-1, 109)

In this excerpt, Helen reflects on: the difficulty of 'com[ing] to terms' with her dyslexia (as represented as having additional time in exams) and not wanting others to see dyslexia as a weakness. The presupposed premise operating here is that the acceptance of accommodations in exams (additional time) directly implies weakness. Drawing on the idiom 'coming to terms' with reference to her dyslexia, and need for support, suggests this implied weakness as a visible, and stigmatising marker of difference. In the above narrative, Helen also touches on the notion of environmental contextuality of both the differential provision of support, and the differential uptake or utility of this support: practices of exam accommodation varied between school and university, and her use of the additional time varied accordingly. This concept will be revisited in the *conditionality of support* in section 11.3.3.

11.2. Phenotype

A concept that is related to the visibility of difference, and implication of weakness, in relation to her dyslexia is the *phenotype* of the condition. Throughout her narrative, Helen reflects on how she was formally diagnosed, and how other family members were informally recognised as having dyslexia. Additionally, she uses language to suggest that there is both an un-articulated pattern and 'feel' (Helen, SCS, 346 & 360) associated with dyslexia.

11.2.1. Feeling and visibility

The related notion that one can 'feel' dyslexic arises at points in Helen's narrative where she reflects on different ideas of struggle at work and at home. Through this, there is a sense of environmental contextuality to her struggle, and subsequently her 'feeling' dyslexic. Below, Helen illustrates this through reflecting on the difference in the way she feels when she is with her family, compared to when she is at work:

Helen:
'*I think what I mean more is that you're never put in a situation ... well I feel that when I'm with my family I'm never put in a situation that makes me think, "I'm struggling with this because I'm dyslexic." Does that make sense? Whereas that probably would*

happen in other circumstances because when you're with your family you're just watching TV or going shopping. Do you know what I mean? Like it's not ...

Interviewer (me): What are those other circumstances?

Helen:

So if I was at work, say for example as I've said before like trying to summarise notes, writing a ward round ...'

(Helen, SCS, 355)

With reference to the graphic representation of her response to all 3 components of the SCS (see figure 11.2.), Helen specifically reflects on not *feeling* that dyslexia 'becomes part of it' (Helen, SCS, 361). This is contrasted by the distinct lack of representation of dyslexia as a distinct entity in her drawing.

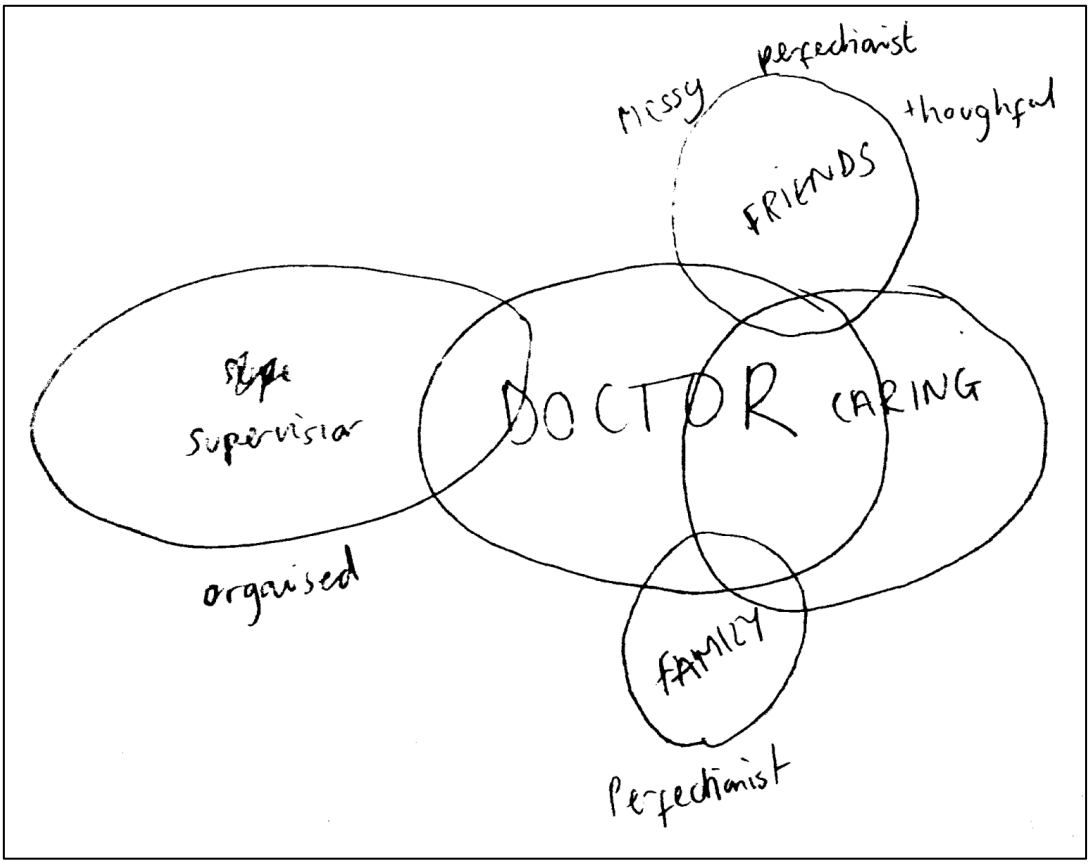


Figure 11.2: Graphic representation that Helen drew, representing her response to all three components of the self-characterisation sketch exercise.

Visibility emerges from Helen's narrative in relation to the strategies she employs to *cope*, which will be revisited in more detail in section 11.3., as well as with regards to specific patterns of difficulty that may become visibly apparent – thus contributing to the notion of a *phenotype* of dyslexia. The concept of a visibly apparent phenotype is exemplified in relation to talk about recognising dyslexic traits in her family:

'I think she probably is dyslexic, like she can't spell, her writing is atrocious, but then it's hard because I haven't like done specific things to work that out and dad's

probably the same, but I suppose it doesn't really come into that because you're never exposed ... you're never exposing your dyslexia – if that makes sense'

(Helen, SCS, 336)

The use of the term 'exposing' in this context conveys a sense of environmental factors revealing the nature of someone's difficulties, but also alludes to a sense of fear through these traits becoming 'exposed'. This may relate to the decision to withhold disclosure, which is explored below.

11.2.2. Disclosure

Feeling is used to represent wider concepts that the notion of "feeling dyslexic" within Helen's narrative, and represents a form of intuition that guides decision making, represented in Helen's narrative in specific reference to the decision to *disclose*:

'I don't tell people, but I don't feel the need to. So I wouldn't like say it. I don't know. I never really say it.'

(Helen, int-1, 148)

In this excerpt, disclosure is represented as a choice, made either because Helen doesn't attribute issues to her dyslexia, thus warranting disclosure, or because her dyslexia does not manifest in a way that threatens to make visible her underlying difficulties. It is through the underlying quality of difference that *disclosure* (of a diagnosed difference) is related to the construction of *phenotype* (a visible manifestation of a difference-pattern). Although Helen does not explicitly discuss disclosure in the context of exposure or fear-related talk in relation to her own diagnosis, in the relatively brief interview data there is a sense of fear conveyed through talk of exposure in the context of the visibility of dyslexia in a wider (i.e. not just her) context. The potential for fear to be a related concept is therefore only tentative, but could relate to Helen's decision to not disclose for fear of the stigmatising consequences. The agency behind the choice that Helen illustrates here also relates to concepts within the sub-theme of *coping*, which will be explored next.

11.3. Coping

Helen refers to ways of *coping* throughout her narrative in a variety of ways. Primarily, *coping* is represented through over-working or over-learning, by working for longer

than she perceives her peers to do. There is also narrative referring to the use of strategies that draw on external mechanisms of support, such as the use of assistive technology. In such examples, Helen alludes to a sense of visibility of her coping strategies, which relates to the *visibility* of her difference, and thus the *phenotype* of dyslexia:

'I think I found lectures very hard because ... I think they were the hardest thing because a lot of the other things I could do in my own time, so even if it took me three hours it didn't matter because it was actually my own time and I did do a lot of work outside of my time in medical school, but lectures I suppose were the hardest because I was kind of ... they would say something and I would think, "God, that's really good the way they've said it," and then I'd be fixating'

(Helen, int-1, 184)

Issues of *visibility* are further illustrated in the tension created by the contrast of doing things in her 'own time' (which 'didn't matter') and the use of strategies, or inability to do so, within a group setting (such as lectures). The above excerpt conveys a sense of fear or desperation to keep pace with the lecture – for fear of missing out, or appearing visibly unable to keep pace with the peer group. Elsewhere, Helen explores barriers to using assistive devices (such as an audio-recording tool):

'…and a Dictaphone to record lectures, although you weren't allowed to do that ... it becomes difficult in something like medical school to record things and extra time ... I think that was the biggest thing that I needed was extra time'

(Helen, int-1, 170)

The difficulty in drawing on these coping strategies, alluded to above, is conveyed through an implied social convention: 'not allowed' and 'becomes difficult'. The absence of specific details would suggest that there was an unchallenged acceptance of circumstance. The difficulties alluded to here suggest a *conditionality* of the support that can be offered, drawn upon and used. The sub-theme of *coping* is also constructed by the emergence of *acceptance and awareness*, which relates to *conditionality of support*, as well as talk around directionality of *blame*.

11.3.1. Conditionality of support, acceptance and awareness

The *conditionality of support* offered emerges as a concept that is contingent on *acceptance and awareness* through Helen's discussion of the difference between support offered to her at school compared to that offered during her time at university:

'I don't know if that's because people are more aware of the fact and there's more things they can suggest and programmes and stuff they can put on your computer, but when I was at school nothing was provided for me in terms of, you know, like coloured paper'

(Helen, int-1, 96)

Although she prefaces her statement with doubt ('I don't know if') she goes on to state her observation in terms of fact: support offered appears to be contingent on the awareness and acceptability of dyslexia in this context. In contrast to the concern alluded to in relation to the visibility of her coping (and phenotype), Helen describes the level of support offered to her at university as greater and in positive terms.

The sub-theme of conditionality of support is constructed in another way, too: through the conditionality of uptake and use of support. This was alluded to earlier, when Helen's narrative touched on issues of barriers and visibility of specific elements of support (e.g. audio recording equipment), and is developed further elsewhere in her narrative. Revisiting the excerpt used in discussing the concepts of *good enough* and *weakness* in 11.1.3, Helen reflects on the use of a form of support (extra time in exams):

'I was allocated extra time for my exams, but I didn't take any extra time in any of my exams, I think mostly because I was ... it's different when you're at university because you're in a completely separate room, whereas at school you're in the same room and everyone would leave and you'd still be there and I don't know, I think it was just hard to come to terms with ... I didn't want that to kind of be a weakness, I didn't want other people to think that that was ...'

(Helen, int-1, 102)

Again, in this example, Helen refers to the potential for this support strategy to confer *visibility* of her condition, and through this expose her difference (as remaining in the examination venue for longer) as a weakness. The potential visibility and exposure described here conveys a sense of fear and shame that acts as a barrier to self-acceptance of her difficulty, and acceptance and uptake of offered support ('hard to come to terms').

11.3.2. Blame

Coping is further supported by the emergence of agency in the direction of *blame* from Helen's narrative:

> *'I didn't get into medicine the first year I applied. I felt that was because ... even though I'd got straight As I felt it was because I had made some bad choices about where I applied. I think I applied to too prestigious places and I think that was because I had bad advice because my school didn't advise me at all practically'*
>
> (Helen, int-1, 46)

Although this excerpt reflects on time before Helen began her medical training, and makes no specific link to her dyslexia, it illustrates the capacity to attribute an outcome to a specific (outward) locus, and choose to direct blame accordingly. By following the initial sentence with an excuse, Helen's reflection conveys a sense of perceived failure. Despite acknowledging that the choices she made were 'bad', the underlying reason for this is situated in the advice she received from those in a position of responsibility around her. This confers a sense of leniency with regards to her self-judgement over the perceived failure - of not getting into medical school the first time she applied.

11.4. Self

Helen's *self* emerges from her narrative through the construction of her *professional identity*, and her sense of *confidence*.

11.4.1. Confidence

The notion of confidence emerges from Helen's narrative in two different ways: lacking confidence, specifically in reference to her self-directed learning; and lacking in confidence, represented through uncertainty in language used throughout her narrative. In the excerpts used above (11.3.2.), a sense of confidence is conveyed through Helen's ability to preserve her sense of self in directing blame at an external locus (Helen, int-1, 46). This contradicts the lack of *confidence* in self conveyed elsewhere in Helen's narrative:

> *'I would think, "God, that's really good the way they've said it," and then I'd be fixating like ... thinking, "Right, I need to write down exactly what they've said like word for word," I find it really hard to like listen to what they've said and then kind of*

put it into shorthand or my own words. I want to write what they've said and then when you're doing that like they're obviously moving on and then you kind of miss the plot a little bit or you're trying to concentrate on the next bit and then, you know, you can't write as quick because obviously they're speaking quicker than you can write'

(Helen, int-1, 190)

Here, Helen surrenders her sense of self-direction and ownership of her learning to the lecturer, prizing and prioritising the specific way they communicate information over her ability to interpret and recall, or augment outside of the lecture. In doing so, Helen illustrates a context-specific lack of confidence in her abilities. Moreover, she specifically relates this to her dyslexia-related difficulties in keeping pace, a visible marker of difference. This concept is therefore related to *visibility* of the *phenotype* of her dyslexia.

11.4.2. Professional identity

At the beginning of the SCS exercise Helen lays out the centrality of her professional role to her sense of identity, which is reinforced through the graphic illustration, above (figure 11.2.):

'so this is me and I'm a doctor which takes up most of my life, so I feel that's probably what represents me the most and especially now because you basically have no life, apart from being a doctor, but then I think I'm caring and I think that other people would see that as me whether it was a critical other or a sympathetic friend.'

(Helen, SCS, 298)

However, through the exploration of how a 'sympathetic other' may see her, Helen illustrates that her professional identity is at least partly constructed by how others see her in her professional role:

'*This is my family and obviously they cross over because they ... the same as friends. Because you're a doctor and although they're supposed to see you first and foremost as a friend they never do and you've always got this title as a doctor and you'll always end up giving some kind of advice or caring for the ill people in your life and even outside of medicine which is why caring crosses over'*

(Helen, SCS, 303)

Her narrative goes on to explore how this co-construction of her professional identity is independent of the level of 'cross-over' between her family, friends and peers: cross-over appears to refer to the degree of overlap that certain qualities, traits or roles (as illustrated in her diagram, figure 11.2.) have with one another – and with the three

different perspectives drawn upon in the SCS exercise. Within her talk relating to her *professional identity*, there is evidence of the aforementioned *perfectionism* driving a fear of criticism:

> *'They'd have to be connected to supervising me and I think they would say I was organised which I think's probably the ... well, I've decided that's definitely what you need to be as an FY1.'*
>
> (Helen, SCS, 322)

This excerpt illustrates a complex tension between feeling criticised (by her supervisor) and the desire to be seen as organised – a trait Helen 'decided' is essential to her professional role. Of note, the language that Helen draws upon here is reminiscent of the language of agency and choice: in deciding that this trait is essential, and reflecting on that is how she may be perceived by a critical other, she is choosing to acknowledge possession of a trait shared by qualified members of the professional group.

Following the initial interview, Helen did not respond to email prompts inviting her to contribute CIRs or engage with an interim interview, thus disengaging from the project.

Chapter 12: Gemma

Gemma came to meet me for her interview in my home one Saturday. She was 29 when we met, and was working as an FY2 doctor in acute medicine in a small rural district general hospital. She had qualified in medicine after initially starting a nursing degree. It was whilst studying her initial degree that she was diagnosed with dyslexia, at the age of 20. Her mother gave her support through secondary school. During her medical degree she intercalated, taking a year out to complete a bachelors degree in psychological medicine. Gemma completed the initial interview and SCS, which took approximately 40 minutes. She did not submit any CIRs in response to email prompts, nor did she reply to an invitation to participate in an interim interview. Throughout the interview, Gemma spoke confidently, without pause. There were times that this confidence was belied by references to self-doubt within her narrative. Two superordinate themes were identified from Gemma's narrative: *Power of the Label*, and *Self*. The sub-themes of *good enough, difference,* and *support* emerged as significant in supporting the superordinate themes, themselves being supported by an interconnected network of ancillary themes, illustrated in figure 12.1.

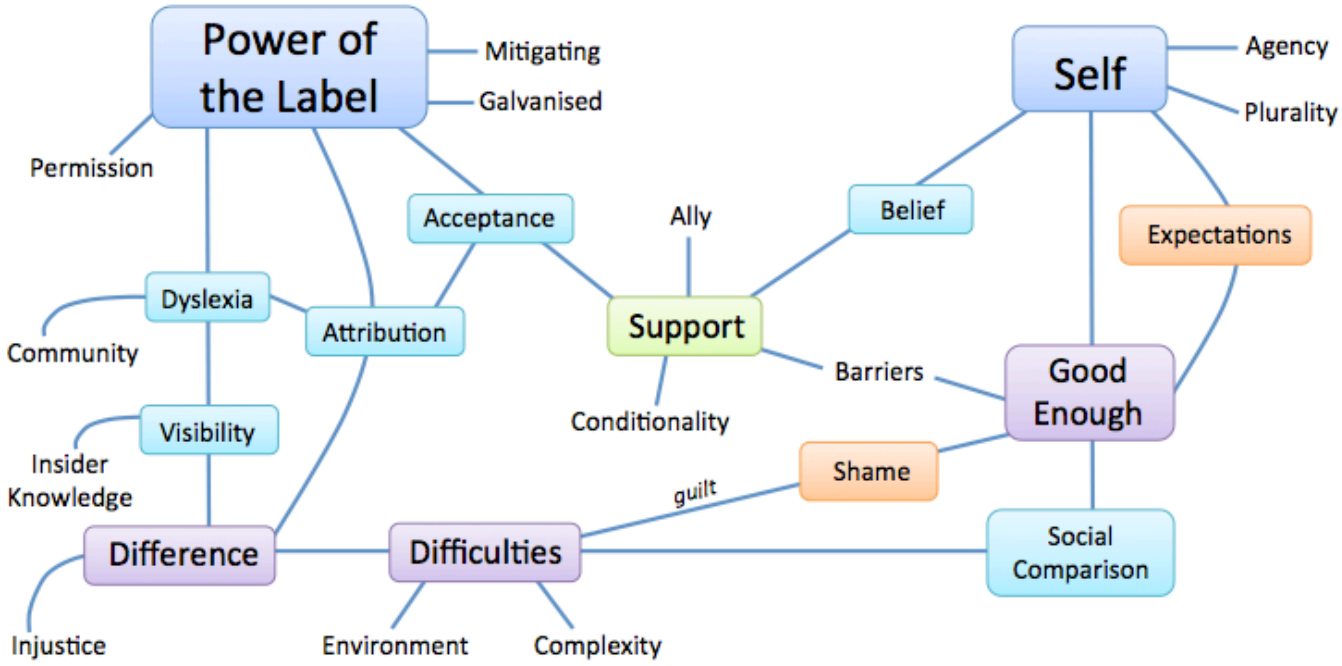


Figure 12.1: Concept map of themes emerging from Gemma's initial interview and self-characterisation sketch. Lines imply associations. The colour of boxes is to provide a visual aide (the superordinate themes of *Power of the Label* and *Self* are all blue) or contrast.

12.1. Power of the label

The superordinate theme of *power of the label* initially emerges from Gemma's exploration her educational journey, and is reinforced by ancillary themes constructed through talk in relation to her experience of *difficulty* and *difference* in other areas of her life, including the professional arena of clinical practice. Power is conferred to the label of dyslexia through diagnosis, and is more immediately represented through the permissive and mitigating properties that Gemma directly attributes to the label. Relief and a sense of forgiveness is seen in her reflection on being diagnosed:

'she turned round and she said, "[Gemma], I haven't looked at...they haven't formally assessed each component yet but I think it is pretty much 100% guaranteed that you are definitely dyslexic." And I was like, "Oh okay." And I walked out and I got back to my room at uni and I just burst into tears and cried for about half an hour because I was just so relieved that that was what it was, that it wasn't because I was an idiot, and that I could actually legitimately be like yes this is difficult for me and that is okay.'

(Gemma, int-1, 73)

The relief expressed here implies a perceived risk of being confirmed as an 'idiot' alluding to a judgement Gemma applied to herself. This subsequently implies an element of shame, a concept that relates to the superordinate theme of *self* (section 12.2). The diagnostic label appears to enable Gemma to apply an element of self-forgiveness by challenging the perception (self or otherwise) of presumed idiocy. Permissive powers of the label are also represented directly in narrative reflecting on her education trajectory:

Interviewer (me): 'do you think that having that diagnosis in...because that was whilst you were still in nursing, did that affect your decision to go on to medical school or having the diagnosis or the dyslexia affect your journey through medical school?

Gemma:

Yes. I think it probably did because I...so I only did a year of nursing because I got partway through and realised I hated it...not hated it, it wasn't what I wanted to do, it wasn't the career I was after. And I realised that I was probably fairly influenced by me being really unsure of how I would cope with the academics of med school. And I think having the dyslexia diagnosis made it easier to then go forward and say actually I probably need to give it a go because it is probably what I want to do with life'

(Gemma, int-1, 119)

The permission alluded to in this excerpt is a permission to struggle and to be different. Through acceptance, this permission also affords Gemma the self-belief required to change her trajectory from a career in nursing to one in medicine. Immediately following this excerpt, Gemma's narrative bears out the subthematic concept of the *mitigating* powers of the label:

> *'I can go to them and say, "Look this is where I struggle, is there anything there that you can offer or support when it comes to exams or what is the set up when it comes to OSCEs that would help me get through. And it probably felt like I had been...not a bargaining, but kind of something to go with, so it would explain why I might struggle, whereas before it would have been oh well I think it might be quite difficult because I am not very good at spelling and I am not very good at reading and I don't remember things easily and I have to work quite hard at stuff.'*

(Gemma, int-1, 126)

Gemma observes that the use of the label alluded to in this excerpt is distinct from bargaining. Whilst there is a sense of pre-emptive apology to the use of the label here, in this case, helps define her difficulties as well as justifying her needs. In defining her difficulties within the bounds of a diagnostic category, there is a protective distance created between her *difficulties* and her *self.* This protection appears to have some prophylactic properties through *galvanising* Gemma in her endeavours. In the following excerpt, this property imbues her with a sense of courage – in essence, galvanising her conviction:

> *'But if I could go forward and say actually yes I struggle with all those things because then it probably was in some ways less daunting.'*

(Gemma, int-1, 128)

12.1.1 Dyslexia, difficulty and difference

Dyslexia is a concept that is integral to the power of the label, not only through acting as the label in name, but also through conferring a different power – the power of belonging to a community both in terms of a wider group of people who have dyslexia, but also to a specific peer group of dyslexic medical students (and later professionals). Another related subtheme within the *power of the label* is that of *attribution*. *Attribution* is constitutive of the superordinate theme through the action of attributing specific traits to the label, thus enabling the *permissive*, *mitigating* and *galvanising*

attributes to act. In the process of attribution, however, Gemma first identifies her *difficulties* and *differences*. These concepts emerge from her narrative in different ways, thus creating two distinct but related concepts.

In Gemma's narrative, *difference* is associated with a sense of injustice and a tension between wanting to be treated differently, and being seen as the same. In reflecting on a 'contract' the her medical school sent out to her regarding the nature of support they would provide to students with dyslexia, Gemma alludes to a sense of threat and therefore the illusion of choice. This creates a significant differential in power, and the powerlessness that creeps into Gemma's narrative speaks of an injustice that recurs in her narrative in relation to institutional support or accommodations:

'and med school weren't very accommodating the first 18 months to two years that we were there. So they kind of...before we all started we had all got this learning agreement that they basically said, "This is what we will offer you. If this doesn't seem enough for you then don't come" kind of thing. And then they kind of didn't do quite a bit of what they said'

(Gemma, int-1, 146)

Of significance, this sense of threat appears to be reinforced through the internalisation of the sentiments expressed by those responsible for her support and education:

'I remember having one meeting with... I can't remember who it was, a male part of the senior team, who when I was speaking to him I was putting forward the general concerns of the group and I remember him turning around and saying, "Look if you think this is such a problem and it is so difficult then maybe you should reconsider medicine as an option."'

(Gemma, int-1, 176)

Difference is also expressed as a tension between the desire to be seen as the same as, or equivalent to, her peers, but treated differently. This emerges in the discussion of reasonable adjustments for assessments:

'So I remember one of our exams that they set up they extended the amount of time for it because the previous year it was an in course assessment. The previous year everyone had struggled to finish it in the time that they had been given so they made it longer. But they didn't give us any longer because they said they had made it longer for everyone so they had increased the time so we didn't need the extra time. And we were a bit like that doesn't make sense, if everybody else needs more time we need

even more time. And that got sorted out right at the last minute. So there was a lot of less than organised chaos around exams and things.'

(Gemma, int-1, 190)

Difficulties appear to be contextualised as environmentally influenced, and highly complex in nature. In the context of clinical practice, the environmental contextuality of difficulty made it difficult to attribute the difficulty to her dyslexia. However, it is notable that this difficulty does not appear to result in a self-blame (as opposed to the direction of blame at a label). Indeed, awareness of the environmental factors contributing to a difficulty appear to be somehow protective, as it reduces the sense of difference from Gemma and her other FY1 peers:

'Being on call on a busy weekend and having like 101 things to do and prioritising them. And it is hard to know whether that was just the fact that I was an FY1 and it is difficult at the beginning for them to prioritise and how much has dyslexia impacted?'

(Gemma, int-1, 199)

Difference is borne out of social comparisons, usually with reference to Gemma's immediate peer group, whereas difficulty is represented through very literal description of cognitive or practical tasks that she recognises as she may get wrong, or finds particularly difficult. Both of these two concepts are represented in the following excerpt, where managing the workload associated with her degree programme is described as difficult, and difference is alluded to through talk of working harder than 'everyone else':

'The first couple of years were really difficult because they were quite intense in terms of workload like written, writing, reading workload. And I probably always felt like I had to work harder than everybody else partly because I felt like I owed it to myself to work hard enough to actually get through and partly because I kind of felt like I had to prove to the medical school that even though I had dyslexia I was still good enough to stay in med school'

(Gemma, int-1, 136)

Through comparisons such as the one above, the personal experience of difficulty is made visible. The concept of visibility is related to the function of the label and appears to operate in both positive and negative ways when represented in Gemma's narrative.

12.1.2. Visibility

The difficulties associated with dyslexia are represented in Gemma's narrative as a very personal experience. However, through a sense of *inside knowledge* certain traits may become visible to informed people, thus alluding to her dyslexia. Gemma alludes to this when reflecting on the unique support she got at school from her physics teacher:

> *'I think he had a son who was dyslexic and he was like, "Yes you know." He never mentioned dyslexia, he never mentioned why but he just said, "Well you know if you need a hand writing it then come along and help out and we will fix it together" essentially which was lovely. And I sent him an...I e-mailed him after I got my actual diagnosis and he e-mailed back 'yes, yes I am not surprised. I am just glad you got to where you want to be'.*

(Gemma, int-1, 43)

Gemma's physics teacher was afforded insight into the nature of difficulties related to dyslexia, through his son's experience. This insider knowledge resulted in a positive visibility: by recognising her difficulties, he was able to offer the sort of help he would have given, or wished for, his son. Visibility emerges elsewhere in Gemma's narrative, couched in the negative terminology of failure and expectation:

> *'then I was like, "Actually the uni offered to pay for it because I completely flunked one of my assignments." And they were like, "This isn't like you, you work hard, we don't really understand what is going on." So they paid for it and I went and had it done.'*

(Gemma, int-1, 62)

Here, Gemma's exam failure was discordant with the expectations that her educators had of her, making visible and underlying difficulty that led to a suspicion of dyslexia. This mismatch alludes to a disappointment and related shame. The negative potential affect is reinforced in the sense of fear that Gemma expressed around the process of being diagnosed with dyslexia, and the resultant relief she felt. In this regard, the expectations and visibility borne out of mismatch in this regard may serve to reinforce her self-beliefs of idiocy alluded to above (section 12.1.).

12.1.3. Support

The power of the label is supported by another subtheme emerging from narrative about the *support* that Gemma sought and received throughout her education and training. Support is represented in Gemma's narrative through talk around supportive

allies, *barriers* to accessing support, and the *conditionality* of provision of support. The conditionality is alluded to in the excerpt used above that alludes to a contract issued by her medical school (section 12.1.1; line 146). This is expanded on in further reflection on the tensions that arose from the medical school neglecting to meet the conditions that they stipulated in this contract:

'we kept going back to them and saying, "Look you said you would do this, you said you would do a print off of handouts from the lecturers who don't normally do handouts. You said in advance that we can scribble all over them so we can actually engage with the lecturer rather than trying to write everything down. And having it afterwards is no good because any notes that we have made we can't put together with the slides afterwards, it just becomes too tricky." So we did quite a lot of work with a couple of the senior welfare people in the medical school.

(Gemma, int-1, 152)

This excerpt illustrates the notion of community ('we') as well as reinforces the sense of desperation and injustice through the need to put in 'quite a lot of work' to ensure the conditions of the contract were seen to be met. This conditionality could be seen as a barrier. However, barriers to accessing support were contrived as internal to Gemma – as something she constructed through the way she felt about her difficulties:

'*I think sometimes I find it difficult to ask for help because I am not sure whether it is something I should be able to do. Yes it is hard to know whether...it is kind of like am I finding this difficult because...and I should be asking for help because I am a junior doctor or do they just expect me just to be getting on with it? So I still find that difficult sometimes.*

Interviewer (me): That is really interesting. Do you wonder if finding it difficult to seek help has anything to do with some of the things that you have mentioned around -?

Gemma:- *Feeling like an idiot*?

Interviewer (me): Well yes things around that and around the feeling that you have got to work harder to earn your place and stuff?

Gemma:*Yes.*'

(Gemma, int-1, 210)

In the narrative presented here, we can see a dynamic interaction between an internalised sense of shame (risk and perception of idiocy), perceived expectation ('I am not sure whether it is something I should be able to do'), and a sense of being *good enough* – a subthematic concept within *self* to be explored later (section 12.2.1).

A related concept that bridges *support* with *self* is the notion of *belief*: by allies offering support, it enabled Gemma to believe in her abilities to achieve. This is exemplified by the relationship that she had with her physics teacher:

> *'I remember my physics teacher when I did my A levels, he was amazing, his name was Mr [Smith], and he was a big guy and you didn't want to cross him because he had a temper. But when you got to sixth form he just suddenly switched. So he was one of these ones that really kind of muddled through the lower years but he really enjoyed teaching the sixth form and he used to teach his third years on a Wednesday afternoon. And when I did my course work he used to come and get me to help him set up his third year classroom and get them going on an experiment. And then he would sit and he would be like, "Right what on earth were you trying to say here?" And he would go through it line by line literally and rewrite what I said and adjust it so that when we actually wrote it and sent it off I actually got the marks he said I deserved.'*
>
> (Gemma, int-1, 38)

Through his words and actions, Gemma's physics teacher taught her that she not only has the ability, but also a right, to achieve. This implies that a lack of belief in self (ability or deserving) may be an internalised barrier for Gemma. The notion of deserving referred to in the excerpt above appears to imbue the actions of the *ally* with the requisite properties to enable *self-belief* which bridges the subtheme of support and the superordinate theme of *self*.

12.2. Self

Self is constructed as a superordinate theme from Gemma's narrative through talk directly concerned with her sense of self, and is supported by the following emergent subthematic concepts: a *plurality* of *self*; *agency*, or lack of; *doubt* and *belief* in *self*; the sense of being *good enough*; and the way in which her sense of *self* is influenced by *social comparisons* and perceived *expectations*.

The significance of the concept of *self* in Gemma's account is illustrated by how it pervades multiple aspects of her narrative, as well as how intricately constituent concepts relate to the themes within the *power of the label*.

Gemma's talk of *self* is evident through the narrative accompanying the SCS (figure 12.2), but there are references to her sense of *self* scattered throughout the narrative of her initial interview too.

Figure 12.2: Gemma's graphic representation of the 3 components of the SCS exercise. The Purple elements referring to how she sees herself; the green elements to how she thinks a sympathetic friend may see her; and red for how she thinks a critical other (in her case, her supervisor) may see her.

Talk of *self* in Gemma's narrative is characterised by negativity and self-deprecation. At times, this appears to be borne out through internalisation of the norms of the medical culture, or of perceived expectations:

> *'the purply stuff is kind of me saying yes okay I take time but I am thorough. But sometimes because it takes me a while to document sometimes someone who is being critical might see that as being lazy or I don't know my patients very well because I find it harder to recall stuff, like the small details.'*
>
> (Gemma, SCS, 302)

The self-deprecating tone in her self-talk conveys a sense of shame, which is underpinned by the belief that she is not *good enough*. The notion of being *good enough* is strongly represented throughout her narrative, and relates to *expectations* that appear to be part of the fabric of the medical culture: perceived rather than explicit.

12.2.1. Good enough, expectations and social comparison

The concept of *good enough* is constructed through Gemma's talk that largely represents the self-perception that she is *not* 'good enough'. This was seen earlier (section 12.1.1) where Gemma articulated the perceived need to 'prove to the medical school that even though [she] had dyslexia [she] was still *good enough* to stay' (int-1, 136). Throughout her narrative, Gemma introduces language of doubt (e.g. 'I guess')

or language that neutralises positivity (e.g. 'fairly') (int-1, 102). In addition to this, the theme of *good enough* is represented through direct talk in relation to how Gemma perceives herself, or thinks others may perceive her. In the following excerpt, despite the focus being on positive attributes, Gemma demonstrates a propensity towards self-doubt ('I don't know') and negative interpretation ('I am not very good'):

> *'strength wise I don't know, I am not very good at talking about good things about me. ...I was always quite practical. So you could give me...I used to build a lot of Lego for my little brothers and sisters. And I could build...they would be like, "I want that" and there would be a picture on the front of the box but not necessarily the instructions, but I could build it anyway, that kind of thing. So my 3D kind of spatial awareness stuff was always quite good.'*

(Gemma, int-1, 99)

The feeling of not being 'good enough' is reinforced by experiences in Gemma's working life, where the culture and implicit expectations is that of hard work, achievement, and completion of tasks. In the face of this, Gemma reflects that it is 'easy to feel inadequate' (int-1, 215). This example, however, incorporates a sense of the environment undermining her sense of self, resulting in unfavourable social comparison.

The influence of the working environment on her experience of difficulty, and therefore sense of achievement, is illustrated elsewhere in Gemma's narrative too. In reflecting on a particular shift, Gemma recalls struggling to work as quickly as she felt she ought to:

> *'after a clerking a lot of people will write whilst they are clerking but I will have a conversation with a patient and their family and then I will come away and write it so it kind of makes some kind of coherent sense rather than being oh I thought about this, oh I thought about this. Even though my questioning might be relatively coherent, if the history isn't then I come away and write it more coherently.'*

(Gemma, SCS, 298)

Here, Gemma alludes to a tacit social comparison suggesting she doesn't work like her colleagues, due to the way her dyslexia influences the way she works. The follow-up justification ('more coherently') feels defensive, and therefore conveys an implied sense of feeling as if she is performing as well as her colleagues (or not *good enough*). Agency is also evident in this excerpt, through the choice that Gemma actively makes.

12.2.2. Agency and plurality of self

Agency emerges in relation to *self* throughout Gemma's narrative through both exercising (and owning) *agency*, and through surrendering (and lacking) it. Agency specifically appears to emerge in relation to experiences of difficulty or failure:

'I will probably get it written on Wednesday evening in all honesty and I will be really stressed about it on Wednesday evening because I won't have done it and I know that. I know that I should start it now but I still won't do it until Wednesday. I can't explain that and they look at me and go 'this is ridiculous, it takes time'. And I go, "I know, I know I need to do it." But I won't which shoots me in the foot.'

(Gemma, SCS, 318)

In this excerpt, we see Gemma exercising *agency* over her action (or inaction) to delay her application to paediatric speciality training. There is discordance between a potentially negative outcome (perceived failure to comply with expectations of timeliness) and a potentially positive (ownership) process. This discordance is recognised by Gemma's use of the idiom 'shoots me in the foot'.

Elsewhere in her narrative, Gemma alludes to the notion of *plurality* of *self. Plurality* is represented in three different ways: through talk of herself within, versus outside of work (SCS, 305); talk of herself 'splitting' to perform multiple tasks (int-1, 228), sometimes simultaneously; and through talk of 'bits' of herself that hold certain beliefs, or cast evaluative judgements of her actions (int-1, 255). In a reflection on a discussion with a consultant about a hostile experience Gemma had with senior colleague, she describes the reassurance regarding her abilities from the consultant. However, there was a 'bit' of herself that actively undermined this and introduced doubt into both the provenance of the constant's view, and her own abilities:

'I didn't really feel like I could speak to the consultant who was on at the weekend but spoke to the consultant who was on this week who I was on with who assured me that it was nonsense as have many of the nurses. But there is still a bit of me that thinks well maybe there is an element of truth in it even though that is really silly'

(Gemma, int-1, 249)

This 'bit' of self is given power over her global sense of self, creating a tangible sense of negative self-judgement ('really silly') in the face of credible evidence to the contrary. The *plurality* of her sense of self is strongly related to the notion of good enough – as it emerges from Gemma's narrative at points where she negatively interprets her abilities (e.g. 'so there is a bit of me that wonders whether actually maybe I am a little

bit shit', int-1, 252). This not only reflects a pervasively negative sense of *self*, but also an element of wilfully re-interpreting information (e.g. feedback from seniors) in a way that reinforces this negative self-judgement, implying that there is agency represented in this process also.

After completing the initial interview and SCS, Gemma disengaged from the research project, and did not reply for further email prompts.

Chapter 13: Paul

When I interviewed Paul, he was 28 years old and at the beginning of his GP training. He had studied medicine after completing secondary education and A-levels in his home town. He had been diagnosed with dyslexia at the age of 12 and received weekly tutorials at the local branch of the Dyslexia Association. After his diagnosis, his mum trained as a SpLD specialist tutor. He was living with his fiancé, and it was at his home that I met Paul, after he had finished a shift in the local Emergency Department. The interview took approximately 45 minutes, completing the initial interview and self-characterisation sketch. Three superordinate themes emerged from Paul's narrative: *Hiccup*, *Coping* and *Self,* which are supported by a network of ancillary themes. These superordinate- and sub-themes are summarised in figure 13.1, and explored in more detail below.

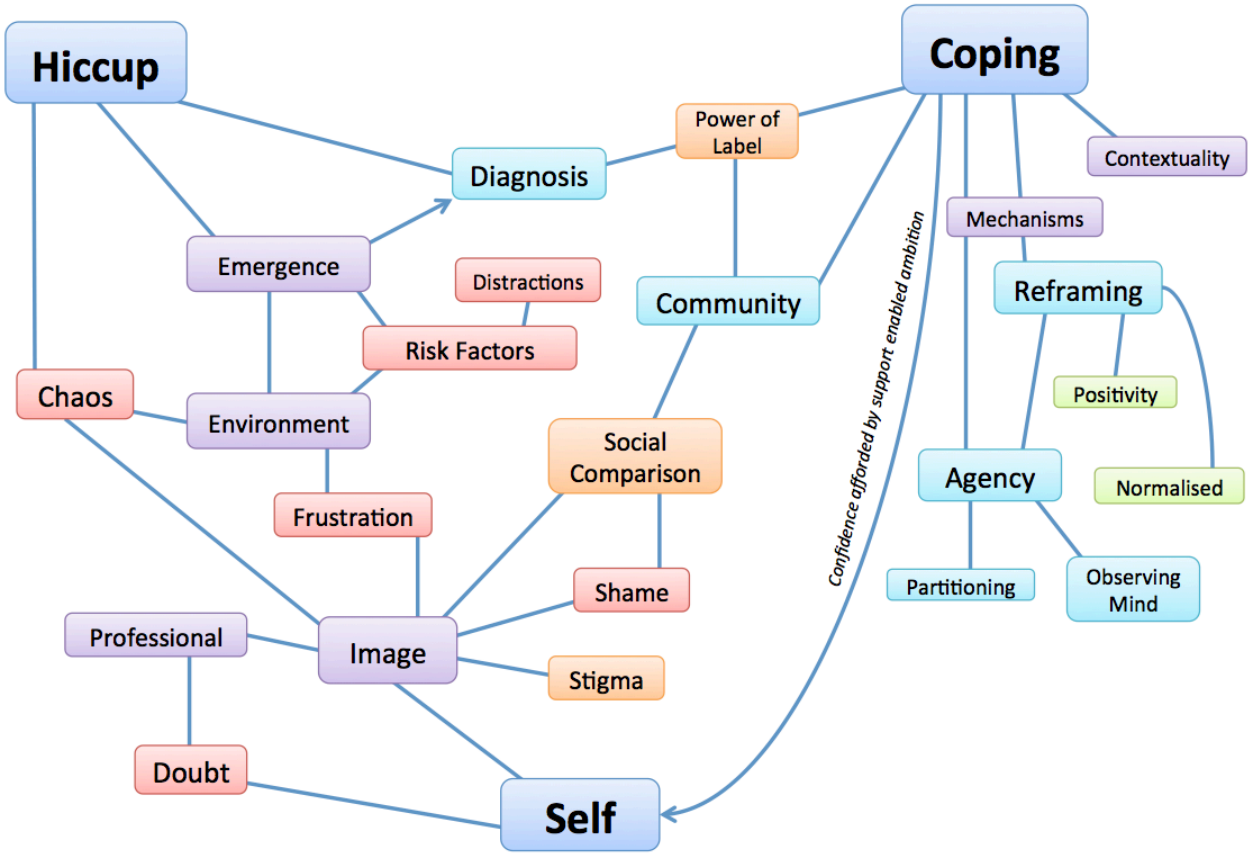


Figure 23.1: Concept map illustrating the superordinate themes: Hiccup, Coping and Self that have emerged from Paul's initial interview and self-characterisation sketch. Arrows are to imply associations and directionality of relationship rather than underlying generative mechanisms. Un-arrowed lines allude to relationships with a less clear directionality. The colour of boxes is to provide a visual aide (superordinate themes all blue). Red was chosen for concepts that were interpreted as being potentially negative.

13.1. Hiccup

Robert first articulated his experience of difficulties in relation to his dyslexia through talk of a 'hiccup' (int-1, 26), which referred to the discrepancy between his abilities as demonstrated through being 'very good at reading and clearly quite articulate' (int-1, 28) and his writing and spelling. The metaphor of a hiccup resonated with narrative throughout Paul's narrative that trivialised or minimised his experience of difficulties, or when his performance did not meet expectations from self or others. This is illustrated in minimising or euphemistic language, such as: 'some issues' (int-1, 51) in his exams during his second year at medical school when referring to significant events like his mother's diagnosis and subsequent illness with a brain tumour. This characterises much of how Paul refers to his difficulties. As such, although 'hiccup' is only used once throughout his narrative, the word encapsulates his approach to understanding and ascribing meaning to his experience of difficulties. Accordingly, there is a relationship between the *hiccup* view of difficulties, and the mechanisms by which Paul appears to cope, such as *reframing*, which will be explored more in 13.2.2.

13.1.1. Hiccup and emergence

Where *hiccups* were represented in Paul's narrative, he often referred to how his difficulties were made manifest, or visible through factors such as the environment, or nature of the task in hand. As such, *hiccups* appeared to *emerge* under specific conditions, and represent a mismatch between expectations that Paul perceived, and his performance. *Emergence* also appeared where Paul's ability to cope, or 'just about keep on top of it' (SCS, 397) were challenged or overwhelmed by the changing dynamics of the circumstances. An example of this is the change in pace of work encountered when starting medical school:

> *'since I've come to university and beyond that it's been more I think things like the organisational issues have come out more. I mean I still think and people joke it's a miracle that I actually manage to turn up on time to work every day with the level of organisation to have remembered my stethoscope, my ID badge, my pen and my stamp and I don't need a lot more than that and actually making it in with all those things is sometimes a little bit of a rarity.'*
>
> (Paul, int-1, 98)

This relates to the self-image that Paul created through the SCS exercise: a 'pleasantly rumpled' visage (figure 13.2), with visible signs of strain – frayed trousers being a

particularly poignant visual metaphor, liable to descending into *chaos* when factors overwhelm his coping:

'I would jokingly consider myself pleasantly rumpled; it's the sort of, you know the friendly, family GP who doesn't iron his shirts type look and I think a lot of my friends would be quite used to me just looking a little bit generally scruffy and disorganised but I think I usually just about keep on top of it and I think my friends would agree but I suppose some might see me turning up, you know with bits of papers and wear a shirt that's a complete mess, shoes fairly dreadful, trousers frayed as usual round the bottom as looking quite scruffy, messy and unprofessional.'

(Paul, SCS, 400)

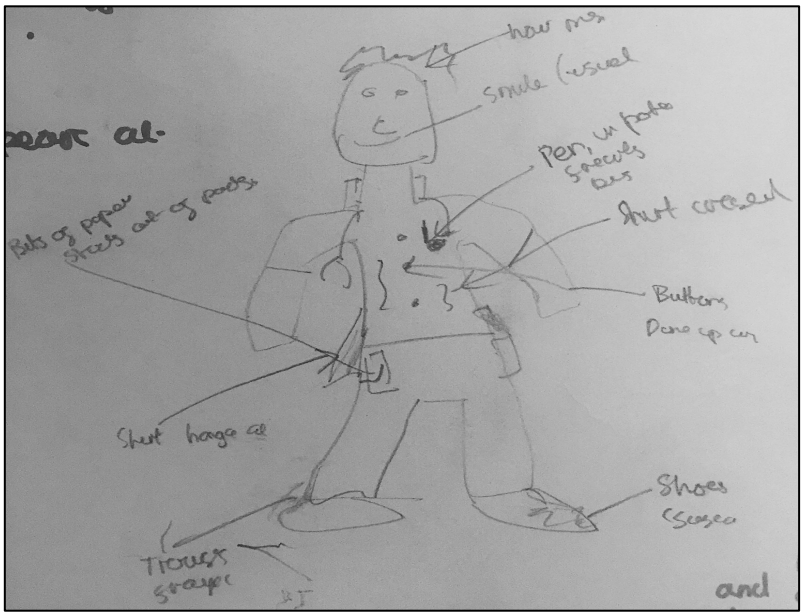


Figure 13.2: Paul's graphic representation of his response to the self-characterisation-sketch exercise. A drawing of himself, with labels confirming illustration of 'shirt creased', with 'bits of paper sheers out of pocket', 'sheet handing out', 'trouser frayed', 'shoe laces', 'buttons done up wrong', 'hair mess', and 'smile usual'.

Emergence is contingent on a dynamic that is sensitive to the context within which a comparison is being made. In this regard, comparisons appear in Paul's narrative to be against peers within a variety of communities: the dyslexic community to which he felt he belonged after being diagnosed; the community of dyslexic medical peers; and the community of medical peers who are not known to have dyslexia. The expectations that Paul perceives appear to vary between these groups, and can be modified. In a short excerpt relating to how his *hiccups* may *emerge,* Paul alludes to a trait that would have formerly been an emergent, or visible, hiccup that has since become 'ignored'. In this excerpt, Paul refers to how he has himself come to ignore this *hiccup* but in doing

so, there is an implicit normalisation within that immediate context that has enabled that internalisation:

'but I think I've just started ignoring that; I can't do synonyms and things like that. I will spell bear as in bear in mind. I will always spell it B-E-A-R and that's just regardless but I think that's become less of an issue and so much stuff is now computerised that the spelling and grammar bit kind of isn't so much of a problem.'

(Paul, int-1, 107)

It was the *emergence* of his *hiccups* with writing and spelling that led to Paul's diagnosis of dyslexia at secondary school.

13.1.2. Diagnosis and the power of the label

The mismatch between perceived expectation, perhaps informed by being articulate and having an advanced reading level, and performance when it came to writing and spelling triggered consideration of, and assessment for dyslexia. Paul reflects on the process of being diagnosed as positive, largely because the subsequent diagnosis had the *power* to explain that he wasn't 'thick' (int-1, 38) or 'stupid' (int-1, 167). This positive explanatory power implies an internalised assumption that not meeting expectations relating to literacy skills has the contra-power to confer stupidity, and had the equivalent stigmatizing effect of such derogatory labels:

'*I think it was at secondary school I got identified as dyslexic which I think was very, very helpful because it gave me an explanation as to why I struggled with some things*'

(Paul, int-1, 36)

The process of diagnosis provided a label onto which a locus of his difficulties could be externally projected. Paul often refers to his experience of difficulties and his dyslexia as being 'part' of him, but this part has the sense of being discrete and dynamic – simultaneously being 'integral' (int-1, 264) to his *self* and something external:

'it wasn't something that was wrong with me, I wasn't stupid, there was a reason for it and with some support we could work round that.'

(Paul, int-1, 168)

In this excerpt, it is apparent that the process of depersonalising his difficulties, through establishing a diagnostic label of cause, appears to change the nature or perception of Paul's difficulties from something that is an immutable trait of his very person, to something that could be amenable to support and work. In this change, the very

process of labelling imbues a sense of potential and capability. By depersonalising the problems of dyslexia, there is also a sense of forgiveness – that it is no longer his fault.

The label of dyslexia appears to hold another form of power in Paul's narrative. Through talk of his difficulties, Paul positively frames his attributes of empathy and communication skills as having developed as a consequence of his experience of adversity:

'sometimes because you've had a problem in one way or another it's easier to identify with other people who you see who have a problem. It doesn't matter what that type of problem but you see, you know the Crohn's patients is just an example off the top of my head who have something that changes how their life works. Well I don't have Crohn's, I'm not equating the two but actually I've grown up with something that changes how my life works so I think that gives me an added empathetic dimension'

(Paul, int-1, 274)

Paul is able to draw on his experience of turbulence to afford him the insight required to empathise with a patient suffering from a debilitating bowel disease. This process represents a strategy for coping, whereby Paul attributes the derivation of qualities that add to his abilities as a doctor by as means of compensation for experiencing a 'problem'. Paul explores the problems, or hiccups, that he experiences through narrative around his work as a doctor, and his professional image. His difficulties with processing and organisation appear to largely manifest as *chaos*, which interacts with factors such as the *environment* in which he is working.

13.1.3. Chaos, risk factors and the environment

Narrative that contributes to the notion of *chaos* is represented in Paul's narrative in relation to his self and his work. The image in figure 13.2 illustrates a 'pleasantly rumpled' (SCS, 394) doctor (note the presence of the stethoscope) with frayed trousers, and papers spilling out of his pockets. This characterises the fine balance that Paul alludes to striking between coping and his difficulties overwhelming his abilities. The narrative representations of chaos represent a dynamic that approaches equilibrium, but does not reach steady-state. Instead, those around him become desensitised to markers of his *chaos*, which becomes normalised:

'I think my friends are all used to the general air of chaos and mess that will surround me but I usually manage to come out of it reasonably okay. I think from an outsider that would start, that's an aspect of breakdown.'

(Paul, SCS, 475)

This process of normalising aspects of *chaos* in Paul's life appears to be dependent on his ability to maintain other markers of esteem – such as friendship, or professionalism. Talk of this specific aspect of *self*, Paul's *professional image*, is seen in relation to *frustration* borne out of chaos that overwhelms his ability to cope, resulting in an outburst that threatens to compromise his professionalism:

> *'the IT infrastructure at my place is appalling and the computer won't turn on again and this is delaying me and I've got five things that need to be done and that job has to be done in the next ten minutes and this bloody computer wouldn't turn on again and there have been incidents where things have gone flying around the ward because I've just got so angry about it, you know the red mist descends and the caution cleaning sign disappears up the hall and that, that has happened.'*
>
> (Paul, SCS, 424)

In this excerpt, factors external to Paul appear to be operating to contribute to this sense of *chaos,* interacting with his coping strategies that appear to already be stretched by his workload. This illustrates an *environmental* contextuality to aspects of Paul's *chaos* – in this case, the working environment providing both the contributing factors (slow IT combined with time pressures associated with high workload) and the risks to his professionalism (the 'caution cleaning sign' to be kicked, and the witnesses implied in the clinical setting – patients and other clinical staff). Other environmental factors that contribute to this sense of chaos in flux include distraction, and limitations on what establish coping strategies he can use (e.g. he is able to use lists that synchronise across his portable devices at home, but not in work due to the restrictions on use of IT). Where distractions and interruptions are explored in Paul's narrative, they are construed as a *risk factor* that interacts with his difficulties, other environmental facts (such as workload), and his coping strategies. These factors appear to pose a risk to overwhelming his coping mechanisms and compromise his professional self:

> *'Sometimes there are things that you forget to do or it's been busy and someone's interrupted you before you'd written it on your list and it hasn't migrated it onto my jobs list and if it's not on the job list it isn't going to happen and actually managing that I found really, really difficult.'*
>
> (Paul, int-1, 233)

This reflection illustrates the dynamic between risk factors (distraction), task factors (complexity), environmental factors (the use of a paper 'job list'), and abilities (memory). These components are in a constant state of flux, contributing to a chaos

that may remain quasi-stable (in a state of coping), or may become unbalanced (compromising performance or professionalism).

13.2. Coping

Coping is represented in two ways in Paul's narrative: the dynamic equilibrium of factors alluded to above; and the specific approaches to managing his experience of difficulty and difference that appear facilitative. Such facilitative approaches can be understood in terms of: perceptive – the way Paul frames his perception of his difficulties; or strategic – the strategies he uses, and the way in which he approaches specific situations and tasks, being mindful of his strengths and weaknesses.

13.2.1. Community

In narrative referring to when Paul's difficulties were attributed to dyslexia through the diagnostic and labelling process, he reflects on a sense of belonging to a *community, o*r several different communities. These appear to consist: of 'dyslexia people' (int-1, 56) who are those who identify as having dyslexia, and their allies; high-achieving role models within the dyslexic community; and his medical student peers who also had dyslexia. Once he began working as a doctor, the notion of community becomes more nuanced to include a reference to his medically qualified peers (with or without dyslexia), and a hypothecated community of dyslexic doctors.

Membership to a community conferred a sense of belonging, but also served to provide a specific normative reference point for within-group and inter-group *social comparisons*. This is illustrated through Paul's reflection on how he has come to see dyslexia as a positive attribute:

'I think that dyslexia's a strength. I think it's a part of what makes you the person that you are and you know you have experiences and things that I think help you relate to people but also I think by the time from my year I can remember there was sort of a discussion about for some of those with dyslexia about when we joined you know what sort of services and support was available and where to get to it and me and friend was just, there's loads of people there, there's loads of people with the same thing as you and they're, they're great people so it doesn't kind of, you know they're just as good if not better than you so it's not a problem'

(Paul, int-1, 208)

Within this excerpt, it is possible to see a reference to a community of students-with-dyslexia ('loads of people there') and their allies (those facilitating the discussion about support). Paul exemplifies a within-group comparison by drawing on the wealth of skill he sees within the group. In doing so, he alludes to a sense of the positive attributes ('great people') negating or mitigating any difficulties they may experience that mark them as different from other groups (e.g. the non-dyslexic community). This mitigating effect appears to neutralise the negative potential of the label for Paul ('so it's not a problem'), and contributes to his positive perception and reframing of dyslexia. The positive perception of dyslexia is also influenced by a sense of *community of capability* through drawing on successful high profile role models:

'I think I've viewed it as such a positive thing. One of the things my mum did in her dyslexia centre was she had a wall with you know the thing of famous dyslexics and I know if you...I don't know how many of them actually are true but you sort of get a list of, you know, all these NASA scientists and you know there's so many very successful people who are dyslexic and I suppose, you know, there's the thought if, if they actually some of them got where they were because they're, because of their dyslexia and not just … also in spite of it but also because of it then I've got that capability too'

(Paul, int-1, 181)

Of note, there is an implicit recognition of the potential for dyslexia to be impeding in its effects through language conveying a sense of surprise ('actually') and contrast ('in spite of'). Paul appears to draw inspiration from the success of people who may have some shared experience of difficulty relating to dyslexia. The label, in this case, functions as a form of currency, affording an interchangeability of capability due to (or 'in spite of') the commonality dyslexia.

Within-community comparisons can serve as a double-edged sword, operating in both positive and negative ways, however. This was illustrated by a further reflection by Paul:

'actually I suppose at times it can work the other way and you think, "Well come on" you know, "I can manage this, sort yourself out"'

(Paul, int-1, 275)

Here, Paul acknowledges that membership to a community can lead to projecting the standards and expectations one develops of themselves to the rest of the group members. This implies that the sense of belonging afforded by group membership over-rides an appreciation of nuanced difference in experience of dyslexia, and

diversity in the profile of strengths and weaknesses individual group members may have. Perception of communities, belonging and how they inform comparisons appear to be unconscious and reflexive, and do not in themselves appear to represent examples where agency is present or exerted. However, there is a sense throughout Paul's narrative that he has somehow chosen to see his dyslexia as positive, and there are mechanisms that emerge from his narrative that allude to how this choice manifests as a strategy that contributes to coping.

13.2.2. Mechanisms of coping, reframing and agency

Coping is represented in Paul's narrative in terms of 'mechanism[s]' (SCS, 402) and 'strategies' (int-1, 56). This language implies a conscious awareness of ways that Paul can mitigate his experience of difficulties, and a sense of agency over the way they are employed. Strategies that Paul appears to employ include the use of techniques to aid his memory (lists in both paper and electronic form), and the reframing of experience to maintain a positive perspective of *self* and his dyslexia. Much of Paul's direct reflection on his experience and perception of dyslexia is framed positively, as alluded to in examples above. Where he has experienced adversity, he appears to consciously reframe the experience, to derive a positive outcome:

> *'I've found that actually looking at education, how and why people learn and how we can help them to learn and to maximise their performance is something that really interests me but I suppose actually part of that is because I had some difficulties in that area myself and that makes it interesting to me and makes me want to do things with others.'*
>
> (Paul, int-1, 71)

In the above excerpt, Paul draws on lessons learned from encountering difficulty, to inspire an interest and passion for helping others. The outcome (interest) is imbued with a sense of positivity and energy, subsequently galvanising his sense of capability.

In addition to positively framed narrative around his dyslexia, Paul creates a sense of joviality around his experience of difficulties in the use of humour and 'joke' (int01, 94; SCS, 394). The examples (seen in excerpts above – SCS, 400, and int-1, 98) of his difficulties being seen as a joke, in the context of the rest of his narrative, do not invoke a sense of ridicule, but convey minimalisation and normalisation of his difficulties. Contrasting with internal, and agency-driven actions, Paul reflects on external support

received, alluding to a mechanistic process of re-calibration of his existing strategies. This example is not devoid of agency, but is contingent on external influence:

'and I had quite a bit of intensive support for probably about a year from the dyslexia people at the university which again I think changed a bit how I worked and you looked at some strategies and since then I've found things have, you know, things progressed very well'

(Paul, int-1, 61)

This excerpt reinforces the mechanistic notion of re/calibration to different demands and expectations when moving into a new learning and working environment. This requires a sensitivity to the differences, and a self-awareness of strengths and weaknesses in order to guide a change in the strategies used to meet the new pace or expectations of work.

13.3. Self

The concept of *self* in Paul's narrative extends beyond awareness of *self* and his strengths and difficulties, to encompass a sense of his identity, his *professional image*, and *doubt*. When referring to his strengths and difficulties, Paul constructs a sense of self that is comprised of 'part[s]' (int-1, 201), or 'side[s]' (int-1, 107). This manner of constructing self appears to relate to coping in Paul's narrative, introducing a conditionality to agency and attribution: agency, as explored above, can be exerted, but other examples allude to where agency may be surrendered:

'It's sometimes more of the organisation side that has been an issue but I have tried to come up with strategies to cope. My phone reminds me every evening of what things I need to pack in my bag for tomorrow morning and I know that if I listen to my phone's reminder I will remember to do it and I try and set routines and things in place and I think I cope with that a lot better than I previously would have done because I've just had to learn how to get the strategy that lets me deal with it'

(Paul, int-1, 113)

Here, 'I know that if…' introduces the conditionality of coping, which is combined with a partitioning of organisational difficulties within a 'side' of his *self*. In the context of Paul's narrative, this process suggests an acknowledgement of the internal factors that make this 'organisational side' prone to error (note the similarity with concepts in the theme of *chaos*) and requiring a strategy to cope (technical support). This description

of a coping strategy, however, lacks the agency that is represented elsewhere in Paul's narrative.

Hitherto, several concepts from Paul's narrative can be seen as contributing to *self*, such as his professional image, both characterised and compromised by *chaos*. When reflecting on his *hiccups* or the *chaos* that contribute to his *self*, Paul's narrative implies a sense of failure to meet expectations, which manifests as disappointment and shame.

13.3.1. Self-image, frustration, stigma, shame and self-doubt

The image in figure 13.2, and accompanying narrative, alludes to a 'rumpled' (SCS, 394) and 'frayed' (SCS, 399) doctor. He said he would 'jokingly consider' (SCS, 394) himself in these terms, and describes 'usually keep[ing] on top of it' (SCS, 397) alluding to an implicit assumption that the traits of being rumpled, frayed, chaotic and disorganised are incompatible with legitimate group membership. This implication changes the meaning of the 'joke' in this context – no longer an attempt at positively reframing, but to diffuse tension created by a sense of embarrassment and shame at not conforming to an accepted image, and the expectations and norms of the medical culture. This notion of shame is reinforced by a sense of desperation with reference to Paul's experience of *hiccups*:

> *'my list's very important but I try to remember to dispose of my lists every day from one day back so I've always got … but I sometimes end up with lists in my pockets and forgetting which one's which and five copies of one and not having of the other'*
>
> (Paul, SCS, 391)

Through inclusion of 'I try to remember…' here, Paul conveys a sense of justifying, excusing or seeking forgiveness for the slip, which is further reinforced by emphasising the effort he puts in. The frustration evident in aspects of the narrative adds to this sense of shame, through an inwardly directed anger at the experience of difficulties in certain situations, and the resulting mismatch between performance and perceived expectation. Accordingly, frustration is represented through literal reference to 'frustrations' (SCS, 486), as well as through his performance failing to meet expectations in given social circumstances (e.g. primary, then secondary school, followed by medical school).

Another way that the superordinate theme *self* is represented and constructed is through the element of *self-doubt* that pervades Paul's narrative. *Doubt* is primarily

represented linguistically, when Paul refers to his capabilities or capacity through language that modifies the strength of his statements, such as 'probably' (SCS, 486), and 'I think' (int-1, 29). In the following excerpt, Paul uses 'I could' to a similarly modifying effect in reflecting on how his professional image may be influenced by his appearance:

'I could appear as not as good at things as I might have given the impression of; that's probably because I've given the wrong impression as to what I actually do and can do'

(Paul, SCS, 446)

In the wider context of this excerpt, and all of Paul's data, there appears to be a significant theme of *self-doubt* that undermines his notion of his professional *self-image*, and associated abilities. This belies the confidence and positivity he presents elsewhere, which may allude to an underlying element of doubt that operates at a continuous, sub-conscious level. This reinforces the notion that positive reframing, even when only hinted at by linguistic subtlety, draws on agency, and a conscious choice or effort.

Paul completed the initial interview and self-characterisation sketch exercise during our first meeting. He replied to subsequent emails inviting him to an interim interview, and to several reminders about submitting critical incident reflections. However, due to workload and difficulties with timing, he was unable to submit any reflections, and did not arrange to meet for a second interview.

Chapter 14: John

John was 28 years old at the time of the interview. He was in a 6-month extension period to his second year of core surgical training (CST2), and about to sit his membership (MRCS) exam for a final time. John had grown up and attended school in Wales, the only child of his mother and father, who was a plumber. He had not got the A-level grades he needed to get into medical school initially, so took a year out to re-sit his exams. He had been diagnosed with dyslexia during his time at medical school, at the age of 'twenty and nine months, to be precise' (int-1, 35). He was living with his wife, whose name has been changed to Jane, and their 10-month-old baby. John was interviewed via Skype, which took approximately 55 minutes. He was only able to complete the initial interview, from which one superordinate theme was identified: *failure*. This was supported by two higher-order themes *crossroads* and *coping*, and relates to a network of inter-related ancillary themes, summarised in figure 14.1.

14.1. Failure

The dominant theme emerging from John's narrative is that of *failure*. This is represented directly through talk of exam failure that he experienced at several points along his educational journey. *Failure* is also constructed by narrative that relates to how his exam failures were *constructed* by himself and the system, through talk of the harsh *brutality* of failure – alluding to a violence of the educational system and the processes it uses. The strong theme of *crossroads* is intertwined with the reality, and recurring threat of failure, and *failure* is represented through narrative exploration of John's *difficulties*, and the ways in which he *copes*. The significance of failure to John is represented by both the way his narrative returns to reflections on instances of high-stakes exam failure, and the emotion he uses in the talk relating to these experiences, which will be explored in more detail with reference to *brutality* (section 14.1.2).

Figure 14.1: Concept map illustrating the superordinate theme: Failure, that has emerged from John's initial interview. Arrows are to imply associations and directionality of relationship rather than underlying generative mechanisms. Un-arrowed lines allude to relationships with a less clear directionality. The colour of boxes is to provide a visual aide (superordinate theme = darker blue, with the higher-order subordinate themes *coping and crossroads* in lighter blue). Red was chosen for concepts that were interpreted as being potentially negative.

14.1.1. Constructed failure

Through talk of *failure,* the concept of *construction of failure* was identified. On several occasions, John reflects on how he was unable to demonstrate his true, or underlying ability through mechanisms associated with the administration of assessments: largely time, as a psychological pressure, but also a logistical limitation on how many questions he was enabled to answer:

> *'Absolutely horrible year but I got through it and it was just a case that I know I needed to finish 80% in them and if I did that I'd get an A. So it wasn't a case that I didn't know what I was doing, it was more the case that I was desperate to finish the exam.'*
>
> (John, int-1, 175)

This concept of failure *construction* was affected by different exam formats, and is associated with a sense of intentionality through the regulations around reasonable adjustments (the utility of which will be explored in 14.3.2):

'my MRCS Part A exam which I am currently revising for me sixth and final attempt. Now, I've put hours and hours of revision, done thousands of past questions, I've reams of notes. I had to have another dyslexia assessment because I wasn't 21 when I had my last assessment, so that cost me another bloody six or seven hundred quid, but the results were exactly the same and I got my, you know, 15 minutes per hour. The shame of that is I have to go down to London because that's the only people that accommodate it so that's a bit of a pain, but, you know, for the longest time I've been trying to get this exam out the way and I'm just… I'm falling short every time; I need 70% to pass and the last three attempts collectively I've only been seven marks away, the last two being one mark away.'

(John, int-1, 258)

This excerpt illustrates the *construction* of two types of failure: the failure of an individual exam-sit, and a final failure when exhausting the number of attempts allowed. This reinforces a notion of *construction*, through an institution of a threshold at which he can be finally failed. When John refers to accessing reasonable adjustments – he refers to having 'had to have another dyslexia assessment' at great personal cost ('another bloody six or seven hundred quid'). He makes sense of this through the rationale that his previous assessment was conducted when he was below a certain age threshold – which implies another institutionalised cut-off. There is frustration present in this reflection, which conveys a sense of hurdles being put in his path unfairly.

Not all *failure* is *constructed* by the system, however. Elsewhere in John's narrative, he reflects on his experienced difficulties, and recalls:

'I said, "But this doesn't make any sense, I've just got this right, I've literally not even two hours ago got this exact question right, and I've read it and I've read it again and I've read it again…," I can read it ten times and I still get it wrong. Reading the question two or three times doesn't make a difference for me; if I've read it incorrectly in the first chance it's usually the case that the next time I read it I read it exactly the same.'

(John, int-1, 282)

Here, his sense of repeated effort *failing* to change his outcome. Here he constructs his failure, owning it as a part of his difficulties that blind him to correct readings of the wording of questions. The exasperation conveyed by 'but this doesn't make any sense' invokes a sense of finding this unfair – which is reminiscent of the concept of *victim* that will be explored within *helplessness* (14.1.3)

14.1.2. The brutality of failure

The talk relating to *failure* is imbued with emotion, conveying a strong sense of brutality of the process. By alluding to a episodes of exam failure as 'horrible' (int-1, 172), or 'dreadful (int-1, 303) periods of his life, associated with feelings of 'being kick[ed] in the teeth' (int-1, 300) John's narrative creates a violence in the act of conferring a failure, and the associated reconfiguration of life events around the failure, and subsequent re-assessment. This violence is apparent in other forms of assessment too:

> *'my ARCP, my annual review, was actually on the date of my January exam so it was in absentia and he looked at my portfolio from November. In November it wasn't really quite up to scratch but I figured, "Well I'll get everything done ready for the actual meeting and they shouldn't have any qualms." So they absolutely destroyed me when I wasn't there to defend myself and had me meeting with one of the clinical directors. So I sits down with him and he basically tells me that if I haven't passed this January exam my career's over. If I do pass it I might get an extra six months, even though they had already told me I was going to get an extra year, and they basically said, you know, "You're unlikely to progress in orthopaedics, have you considered another career?" So "Great, thanks a bunch."'*
>
> (John, int-1, 375)

In this excerpt, John refers to the process of being judged a failure by the educational establishment as absolutely destructive. This violence is reinforced by narrative alluding to misery, and physical injury (kicked in the teeth), and combined with reference to a process that is blind to his efforts and attributes, confers a strong sense of unfair *brutality*. The closing remark 'great, thanks a bunch' conveys a sense of resignation that will be explored in greater detail under the notion of *helplessness* (14.1.3). Overall, this evokes notions of a victim, suffering the violence of a brutal system, which resonates painfully with John's narrative.

Brutality of the system and process of failure for John appeared to be associated with the brute experience of social conventions being enforced: pass according to our rules, or fail and be expelled. In John's narrative, there is a sense of this being a contrary process, whereby hurdles can be introduced, and decisions made without fair justification – reinforcing the notion of brutality (like brute facts, these brute failures appear to have no acceptable explanation).

14.1.3. Not good enough, conformity and helplessness

The concept of *not good enough* is extant in John's narrative and self-talk, and is further constructed through the notions of *conformity* and *helplessness*. John's narrative alludes to him construing himself as *not good enough* through the language he uses to justify his performance, professional group membership and through efforts to prove himself against expectations placed on him by self and others. This is reinforced by he experiences with selection to medical school:

'And I go to [Medical School Y]; they were the only one who really gave me a chance.'

(John, int-1, 176)

This example also alludes to a sense of being an out-cast, and of non-conformity to conventions that would afford him entry elsewhere, the chance created here is one for John to prove himself – to the educational establishment, and to himself. Converse to the notion of not being good enough, there is an example in John's narrative where he reflects on not being 'bad' enough to qualify, in his father's eyes, for educational support earlier in secondary school:

'If, you know, Miss [Smith] had turned round to me and said, "I think you may have a form of dyslexia"… well I didn't know what that meant at the time, all I knew is that I had to go to the special needs class, and my dad was like, "Well you're getting As, why are you going to the special needs class?" And I thought, "Well no, I suppose you're right, why am I going to the special needs class, I am getting As so what's the problem?" So I just ignored it and carried on and just always put it down to, you know, my grades in English, of all things, being poor because I just thought I was crap at English and it was always my worst subject and I hated it.'

(John, int-1, 321)

This specific excerpt alludes to another emergent theme too – that of *crossroads,* which will be explored in 14.2. Throughout John's narrative, there is a sense of 'what if' combined with language that evokes the imagery of his path changing direction or branching off into different options, the trajectory of which will be determined by factors such as *failure*. Returning to the above excerpt – John agreed with his father's sentiment of not qualifying (by not being bad enough) for the special needs class, which confers a sense of resignation to being considered undeserving of support, but also a sense of being not good enough – reinforced by the sentiment of being 'crap at English'. The past tense in 'I just thought' is reflective of the change in perception of these difficulties in light of his diagnosis of dyslexia, which was made when John was in medical school.

14.1.4. Difficulties, visibility and contextuality

Specific talk of two types of *difficulties* was identified when John talked both of *experiencing* difficulties in tasks, or as marked by failure in assessments, and when John referred to others *observing* patterns of difficulties that he was unaware of, giving rise to the notion of *experiential difficulties* and *observed difficulties*. The notion of difficulties being *observed* is construed as being dependent on a form of insight, afforded by interest (such as his teacher – Miss Smith, alluded to above), intimacy (such as his wife – Jane), or qualification (such as the depersonalised 'she' that gave him shape-puzzles and reading to diagnose his dyslexia, int-1, 466):

> *'then she gave me like these shapes to, you know, match the pictures up with the shapes, and literally in seconds I went through the entire set of them with really no problems whatsoever and really didn't appreciate it, and then she showed me on the scale of where it should be for my intelligence level and where actually it was and then when I saw my sort of reading and spelling and stuff it was way down and then my sort of visual spatial awareness sort of skills were way above. I just thought, "Well that kind of makes a bit of sense, actually it says a lot about what's happened"'*
>
> (John, int-1, 483)

Here, John alludes to the tests, used by the 'she' assessing him for dyslexia, making his difficulties visible. Elsewhere in his narrative, John refers to difficulties with his speed of reading and writing, as well as his legibility (e.g. int-1, 235), but also alludes to difficulties that only others were able to observe, and that he had no insight into. One specific example is when his wife observed him switching the initial letters of a celebrity's first and second name (int-1, 209). Inherent with talk of different types of difficulty (*experiential* and *observed*) is the notion of visibility, where difficulties either become manifest (and are therefore experiential and observed), or where the difficulties are observable (by others). Visibility is also conferred by the diagnostic label of dyslexia – whereby a retrospective acknowledgement of some experienced difficulties becomes assimilated into John's dyslexic self, affording a sense of forgiveness:

> *'And, you know, I'd done well in my interviews and I got my place and I just felt like I just wasn't good enough, I'd been found out, "I'm not as intelligent as I thought I was." You know, it's just come to the point it's so complicated that it's too difficult for me and I couldn't do it. And then to be told that this might be a major contributive factor to this, it's not just the fact that I'm not intelligent enough was a massive relief'*
>
> (John, int-01, 501)

In this excerpt, John refers to a fear of being 'found out', which resonates with his expressed belief of not being good enough, and the implication that he was unintelligent, which is met with relief by the explanatory power of the dyslexia label.

John's experience of difficulties, and how visible they may be appears to have a component of environmental *contextuality*. He opened his interview with 'That's where, looking back, was the start of the sort of dyslexia' (int-1, 46) when referring to his initial experience of failure in his A-level exams. This implies a *contextuality* to his dyslexia from the outset – implying it exists at the interface of failure. Elsewhere, he refers to his difficulties as being prominent on 'bad days' (int-1, 337) associated with fatigue or stress. There is a relationship with the clinical environment, where John reflects on adapting to different speciality environments (e.g. medicine) or specific people (e.g. surgeons), which will be explored in more detail in relation to how John's adaptability to the environmental contextuality of his difficulties enables him to cope (14.3.2).

14.2. Crossroads

John drew on the term of being at 'another crossroads' (int-1, 352) in the context of facing his sixth, and final attempt at his membership exam (MRCS). The term resonates with representations throughout his data that allude to a sense of missed or changed opportunities. In the main, this concept is represented in the sense of having his trajectory changed by external factors (such as system-constructed failure), but there is a detailed instance where John explores the role he, and his agency, play in determining his trajectory. When having to re-sit his first year medical school exams, he recalls:

'And, you know, having had to redo my A-Levels and then completely failing first year I genuinely thought my chances were out. I really wasn't interested in anything else and I was very close to just saying, "Oh bollocks to it all, I'll just be a plumber." And my dad always told me I'd be a good plumber – my old man's a plumber – and I was really resigning myself to just giving up on this uni business altogether'

(John, int-1, 513)

In saying 'bollocks to it all', John creates a sense of frustration and choice. At this point, he could have chosen to go down the route of his father's suggestion and become a

plumber. However, he persisted under his own volition. This choice appears to have been borne out of the permission to struggle, and forgiveness of failure afforded by his diagnostic label of dyslexia. Another concept that is identified in this excerpt is that of *risk* and psychological *safety* for John: through the sense of comfort and ease in the option to conform to his family heritage (plumbing), and the decision of a harder path strewn with risk of further brutal failure. Accordingly, the narrative construes training in medicine as being risk-laden for the learner.

14.2.1. Chaos

A theme that emerges as characteristic of instances of failure in John's life is the notion of chaos. This is evoked by a sense of multiple significant, complex, and dynamic events happening, seemingly simultaneously. This is reflected in talk about life-events occurring at home, such as a 'family bereavement' (int-1, 199) during his initial re-sit of his first year medical school exams, where he describes becoming 'a bit of a mess' (int-1, 202). Chaos is present in narrative pertaining to John's clinical role too, where the sense of overwhelming workload associated with the dynamic clinical environment interact with shifting expectations and peer support:

> '*in my first job in hepatology I really, really struggled then, never came home before sort of eight o'clock, mainly because I was still on the ward doing, you know, admin more than sick patients. I had a locum Somalian F2 and a part-time reg who I saw once in a morning and my other F1 quit.'*
>
> (John, int-1, 629)

Here, John's experiential difficulties interact with the challenging clinical context and the additional chaos created by an international medical graduate with English as a second language (implying a difference in the peer-relationship) and partially filled staffing rota, creating a sense of precariousness about the team, its formation, function and support.

14.2.2. Diagnosis

Within the theme of *crossroads* there is narrative that represents the meaning and impact of the diagnostic label to John. As alluded to above, being diagnosed with dyslexia allowed him to retrospectively explain aspects of his experience, making his difficulties visible as dyslexia. The label also affords a sense of forgiveness. There are several instances where John refers to thinking he was just not 'good enough' (int-1, 493), a 'dunce' (int-1, 507), or 'crap' (int-1, 321) and that the label challenges this. The

power the diagnosis has in enabling John to forgive himself is exemplified in the continued trajectory, despite expressing the sentiment of 'bollocks to it all' (int-1, 511). This illustrates the power for the label to influence trajectory at crossroads, and resonates with John's remorse at not having found out sooner:

'to just pick up on those little cues and, you know, if I could've got that sorted earlier on my life would've panned out differently.'

(John, int-1, 136)

The expressed remorse implies a value in the knowledge of the diagnosis, and resonates with notions of the label being empowering and positive for John. The label has value externally too, however. As the 'massive relief' (int-1, 501) afforded by the label through explaining John's *experiential difficulties* adds legitimacy to his experience, and in so doing confers a sense of protected validity with regards to group membership.

14.3. Coping

Coping emerges in the context of the superordinate theme of *failure* throughout John's narrative through representations of coping with struggle, and the threat of or actual failure. *Coping* is conceptualised in both reactive terms, such as 'muddl[ing] through' (int-1, 121) and in terms of active adaptation to task and environment. The notion of muddling through conveys a precarious sense of barely coping, which constructs this representation in a negative manner, reinforced by narrative reflecting a sense of John's coping mechanisms being overwhelmed and failing:

'my coping mechanisms were, you know, pretty good but when the workload increased and the importance of the exam increased then that I think is where I really came unstuck'

(John, int-1, 289)

Becoming 'unstuck' implies failure, creating a very tangible sense of John's ability to cope. The negative connotations of this form of construction of *coping* resonate with representations through use of certain strategies, such as drawing on his wife's ability to proofread for him. In having his wife read 'everything' (int-1, 325) he does, he implies a lack of self-trust. This particular strategy appears to be driven by a fear of being seen

as an 'idiot' (int-1, 329). Beyond this example, however, *coping* is represented in positive terms, imbued with agency and adaptive capability.

14.3.1. Adapting

John represents coping as drawing on his visuospatial strengths, and as adapting to different contexts: specialties (e.g. hepatology, or vascular surgery); colleagues (e.g. consultant surgeon, consultant physician, or medical registrar); and the different environments (the different wards, theatres, or teams in which he works). Accordingly, there is a contextuality to his adaptations and coping strategies:

> *'as far as sort of note-taking and stuff, it's just an adaptation of my revision techniques and my sort of clinical studies. You know, if I'm in a lecture now I very rarely take notes because I realise that it's just word vomit. Occasionally I will… if printouts are available beforehand I'll print them out first, but more often than not what I'll actually do is, if I know what the subject going to… read a little bit about it beforehand, I'll sit there and just listen for the lecture and then I'll go home and write a few things, you know, or highlight a few points which I struggled with understanding'*
>
> (John, int-1, 557)

In this excerpt, John alludes to an adaptability that is transferrable across different settings, an evokes notions of malleability to task and environment. Across different examples of such malleability in John's narrative, it seems evident that adaptability is driven by a perception of needing to keep pace with peers, or expectations placed by self or others, or to prove himself as a clinician. This feels reactive, but John exerts agency and choice, and owns his adaptability, drawing on examples of it to illustrate his strengths and coping.

Contrasting with the agency and positivity in the malleability that John draws on for his adaptability, the utility of externally derived strategies to aid coping was doubtful. Reflecting on the use of a 'recorder' (int-1, 558), or 'bigger font' (int-1, 533) and other adjustments provided in exams, John describes such approaches as 'dreadful' (int-1, 536) and favouring his own approaches to learning and working. Such instances create a sense of a uniform approach to help all learners with dyslexia is not compatible with the development of the nuanced approaches required to cope in dynamic clinical environments, and the parallel educational workload (e.g. exams) associated with clinical training. Instead, the malleability inherent in John's *adaptability* appears to be

crucial to successfully learning to work in different environments with his *experiential difficulties* associated with dyslexia.

14.3.2. Forgiveness and reframing

Once John acquired his diagnosis of dyslexia, he *reframed* his experiences to either derive a more positive outcome, or to forgive himself. Illustrated above, in the excerpt where he describes nearly saying 'bollocks to it all' (int-1, 511) he specifically notes 'really resigning myself to just giving up on this uni business' (int-1, 513) before going on to explain how the knowledge that he has dyslexia, and all that the label meant to him at that time, enabled him to forgive himself, and allow himself to try again:

> *'just to be given this diagnosis was such a massive relief and had such a profound effect and… you know, my pre-exam psychological status, you know, obviously I was worried but not as worried as I was, knowing that I had that few minutes, even 30 seconds on a question extra time, you know, it might make all the difference, and it did.'*
>
> (John, int-1, 518)

The notion of second chances is also represented through John's reflection on one of his 'ARCP' [annual review of competency progression] assessment panels, when he was granted an extension in which he could re-attempt the surgical exam he had failed.

Forgiveness is also represented through the use of the diagnostic label of dyslexia in excusing outcomes or performance. John does this in a very specific way – by minimising the particular elements of the task he struggled with, and attributing this to his *experiential difficulties,* which he contrasts with his clinical knowledge:

> 'looking back on it, there was quite a few instances where I really… the exam from a, you know*, knowledge perspective, it was just a time issue and I was always told just write quicker. Because my handwriting was always really messy'*
>
> (John, int-1, 115)

The minimising the element of the task, demonstrated in 'just write quicker' (emphasis added) and by contrasting this with knowledge, which is prioritised by implication, John effectively creates a sense of failure based on a non-knowledge component (e.g. handwriting, or running out of time to answer questions) as being less important, and therefore less damaging to his identity as a clinician. Another protective or coping strategy illustrated in John's narrative is that of reframing, whereby he draws on strengths and positive outcomes from his *experiential difficulties* that contribute to a positive image of capability:

'And I think I've picked up a bit of a talent for teaching as well and mainly by, you know, sort of… involving surgery, of course, because that's my main area of expertise, but giving them sort of hints and tips via the way I learn as opposed to, you know, just spoon feeding the information'

(John, int-1, 437)

Having learned how to work with his difficulties, John as developed a skill in helping others. Specifically, this relates to clinical knowledge, and therefore contributes to a reframed professional self-image of someone who has additional capabilities, further implied through his use of 'talent' to delineate his abilities as extraordinary.

14.3.3. Community, belonging and acceptance

Another way in which *coping* is represented is through talk that constructs a sense of *community*, and therefore *belonging* and *acceptance*:

'getting the extra time was great. And the other thing I found quite positive as well is, you know, obviously you do your exams separate and then bumping into familiar faces from the years that I've had this diagnosis of dyslexia, before they even came into university, telling me that they never would've passed their exams so they never would've got the grades, so I think, "How the bloody hell did I manage it? Maybe I'm not as much of a dunce as I think I am."'

(John, int-1, 508)

This excerpt illustrates all three components: through 'familiar faces' seen in the separate exam room, a sense of belonging to a community is created. This community, in this specific excerpt, is created as one of a generic extra-time-examinees community, identified through shared use of a separate room. However, elsewhere in his narrative John specifically relates to peers who he knew had dyslexia, and how it 'helped, somewhat, to know I wasn't on my tod in all of this' (int-1, 586). This supportive function of feeling a sense of belonging to a community is augmented by the example of within-community social comparison. In the above excerpt, John reflects on acquiring his diagnosis of dyslexia later than some of his within-community peers. He reflects on his achievements to date and concludes that 'maybe [he's] not as much of a dunce as [he] think[s he is]'. The assumption operating behind this is that he considers himself a 'dunce', which is representative of his *not good enough* narrative. Despite this, however, he is able to draw on this within-community comparison in a way that neither belittles his colleagues, nor over-inflates his sense of self, but merely challenges the negative self-belief.

John completed the initial interview via Skype (a voice over internet-provider application), and was invited to complete a self-characterisation sketch via email afterwards. This invitation, and prompts for critical incident reflections did not elicit a response. About a year after the interview, John told me he did not pass his final attempt at his exam, and was unable to continue training in surgery. However, he is well and enjoying family life, and continues to work clinically as a doctor.

Chapter 15: Cross-Case Analysis

The purpose of this chapter is to provide an analysis of the data from this project at the group level, which will also be followed by a note on reflexivity throughout the process of data collection and analysis. A cross-case analysis of the data from the whole group of study participants provides the opportunity to look for patterns and relationships among the themes emerging from the data corpus.

Through an iterative re-reading of all participant data, as well as the analyses of these data, 3 superordinate themes were identified: *Self*; *Belonging*; and *Coping*. Each supported by a constellation of inter-related sub-themes, which is summarised in figure 15.1, and will be explored in more detail below.

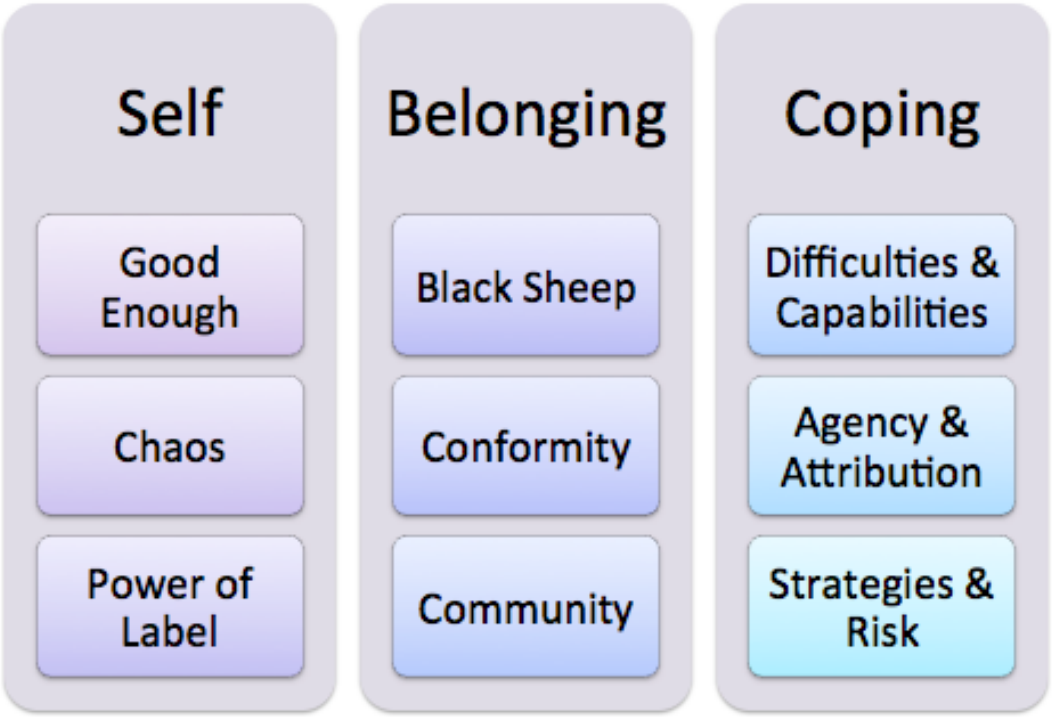


Figure 15.1: The three superordinate themes (Self, Belonging and Coping) with their associated supportive lower-order themes, identified from a cross-case analysis of the data from all 10 participants.

15.1 Self

Narrative representing *self* was identified in the data from all participants, with subordinate themes relating to: the notion of being *good enough*, a lifeworld characterised by *chaos*, and talk relating to how their experience of *dyslexia* shapes

their sense of self. Table 15.1 illustrates how the concepts identified in the cross-case analysis are represented in the individual cases, through linking to the themes encoded in the idiographic analysis.

Self	Good Enough	Chaos	Power of Label
Zayn	• *Self Hatred* • *Perceived Passing*	• Struggle, Failure & Overwhelmed	• Partitioning • Forgiveness
Rubina	• (not) Belonging • Self-Doubt • Faking It	• Conflicted Self • Image Discordance	• Forgiveness
Amanda	• Internalised Badness • Negative Self-Talk • Overhang	• Difficulties	• Diagnosis & Label • Compassion • Value
Brian	• Self • Stigma • Damage of Dyslexia	• Excuse	• Forgiveness & Permission • Plurality • Pigeonholing
Liz	• Daily Little Damages • Confidence	• Struggle & Adaptation • Tipping Point	• The Dyslexic Way
Sarah	• Not Good Enough • Overhang • 80% person	• 80% Person	• Power of Label • Diagnosis
Helen	• Good Enough • Weakness • Confidence	• Conflict	• Blame • Acceptance & Awareness • Permission
Gemma	• Good Enough • Shame	• Difficulties	• Power of Label
Paul	• Self Doubt • Professional Image	• Chaos	• Power of Label
John	• Failure • Not Good Enough	• Chaos	• Crossroads • Diagnosis

Table 15.1: Table illustrating the themes from each individual case that were identified as corresponding with, or supporting the themes from the overall cross-case analysis within the superordinate theme of *Self*.

Standing back from the analysis of individual cases affords two insights relating to the way participants understand their sense of self in relation to *not good enough* and *chaos.*

15.1.1. Not Good Enough

By far the most prominent subtheme within *self* emerging from all participants is resonant with the concept of being *not good enough*. This is represented in different ways, and with different degrees of extremity, or even violence. The nuanced differences between feeling like an '80% person' (Sarah, int-1, 45) and a 'waste of space'

(Brian, int-1, 658) risk going unappreciated in a group-level analysis. However, all 10 participant's narratives represent the core sentiment through reflection on the perception that others have, or may have, of them, and the self-talk representing how they see themselves: they are not legitimately whole or sufficient as a person. This implies a comparison with an internalised notion of the whole, sufficient or ideal person. An ideal that has been informed by each participant's unique sociocultural contexts, such as Sarah's 'young Jewish girl' (Sarah, int-1, 203). Dyslexia appears to be referenced in the construction of deviation from this ideal for many of the participants, but the exact role that the diagnosis plays is complex and dynamic: for some associated with forgiveness and reframing, and for others with frustration and self-doubt.

In considering the extreme nature of the notion of *not good enough,* the emotionality associated with the concept is inescapable. This is particularly exemplified by Zayn's *self-hatred,* but is also represented in the psychological *overhang* that was identified in several other participants' data. Through internalisation of the judgements cast by others throughout their life, participants appeared to develop an image of themselves that is tarnished by remembered notions of idiocy, stupidity and incapability. In some cases, particularly Zayn and Amanda, the manner in which this *overhang* and *self-hatred* is held onto, and applied represents a form of psychological violence against themselves. In some ways, the label of dyslexia confers a capacity to forgive and counteract this violence, alluding to the power that the diagnostic label has. Other emotions that are conveyed through participant narrative include shame, guilt and fear. The guilt appears to be specifically construed from the way they perceive their difficulties to potentially impact on their clinical work, implying a sense of incompatibility between their experience of their difficulties, and their idealised image of their professional identity.

15.1.2 Chaos

There is a sense of chaos that operates in the lives of the dyslexic doctors that participated in this study. This was not represented from encoded themes in the individual analysis of all cases, although there is an undercurrent of narrative operating throughout them all that alludes to a precarious balance between the backgrounding and foregrounding of factors of chaos in their personal and professional lives. Talk representing chaos was particularly prominent when participants referred to examples

of potential failure, such as the discussion of bereavements, illness, house flooding, and multiple converging deadlines. This narrative extended beyond the bounds of the interviews and critical incident reflections, to the communications outside the ethical remit to be reported in this study. Whilst such events do not represent experiences unique to junior doctors with dyslexia, the potential for mechanisms of coping, or self-critique may be overwhelmed or reinforced by the factors of chaos in operation.

The theme of *chaos* also relates to the volatile, complex and dynamic way in which multiple factors influence the experience of difficulties. This includes life events, and is also represented by environmental factors encountered in the workplace, disruption through interruptions at work or events related to training, and implied through the sense of needing to constantly adapt to different conventions that operate within changing teams. Furthermore, in Rubina's narrative, we can see how internal conflict can also contribute to the notion of chaos: through blurring the boundaries of her identity as someone with dyslexia/dyspraxia, and as someone whose works as a doctor as a less important part of their worldview. The implied insecurity associated with this conceptualisation of chaos is reminiscent of notions of not quite being good enough, which returns us to the other insight afforded from the group analysis.

15.1.3. The power of the label

The process of diagnosis confers the right to identify with, and use the label of dyslexia. There is a sense that this use is codified by implicit conventions within the community, as illustrated through the analysis of Sarah's (10.2.2) and Liz's (9.1.1) data. In the narrative from all the participants, the diagnostic process is imbued with the power to illuminate, inform, and forgive, affording second chances. Zayn specifically recalls a very extreme reaction to his failure of an advanced life support (ALS) skills course – passing this course was considered so central to the role and identity of a junior doctor, to him, that failure of it challenged his sense of legitimacy. Possession and use of the diagnostic label allowed him to afford himself a sense of self-forgiveness, enabling him to try again. *Forgiveness* is a concept that appears to be central to the power theme that recurs across the data corpus. This runs parallel to the other concept that informs *self* – that of being *not good enough*: a concept which represents these trainees actively deprecating, or perceiving a deprecation to their self image. Forgiveness affords the ability to persist in spite of the deprecation and notions within *not good enough,* which

is also strongly represented in John's (14.3.2), Brian's (8.2.1) and Gemma's (12.1) narrative.

15.2 Belonging

The theme of *belonging* is represented by a complex relationship between a sense of not fully, legitimately or authentically belonging to the medical professional group, and related talk is characterised by notions of (non-)*conformity*, associated with the notion of implicit operant conventions, as well as talk that constructs *communities* in a variety of different ways. The relationship between themes identified in the individual participant's data and the cross-analytical theme of *belonging* is summarised in table 15.2 and will be explored in more detail below.

15.2.1 Black Sheep

Amanda's narrative yielded the term 'black sheep' (int-1, 16) which captured the tension between a sense of partial belonging, and imminent discovery and rejection from the medical community resonated with the themes identified in the data from all participants. This metaphor evokes a sense of being part of the flock, but sticking out as different. Historically, this metaphor is associated cultural notions of value (the wool of a black sheep being of lower value) and stigma (in some parts of England black wool was considered bad luck, or even the devil's mark) (Ammer, 2003). The association of stigma, lesser value and a different sort of belonging resonates with the narrative that each participant weaves around their experiences of training and working in the medical profession. Brian and Sarah reflected on how perceived judgement and actions of others may reinforce these notions, whereas Amanda's use is self-applied in a self-stigmatising or self-stereotyping manner, which is also represented in Zayn's use of 'weird' throughout his interview (Zayn, 1-int, 28).

Belonging	Black Sheep	Conformity	Community
Zayn	• Out-Group • Weird	• Cognitive Conformity	• Isolated • Comparison
Rubina	• Difference • Fitting In	• Conformity • Cognitive Conformity	• Community
Amanda	• Black Sheep • Passing	• Conformity of Praxis • Cognitive Conformity	• Mistrust of Community
Brian	• Impostorship	• Conventions • Rules	• Community
Liz	• Belonging	• Tribalism and Transgression	• Community • The Dyslexic Way
Sarah	• Gobby • Impostorship	• Expectations	• Diagnosis • Codified Use
Helen	• Professional Identity	• Disclosure • Feeling	• Professional Identity
Gemma	• Social Comparison • Difference	• Support	• Dyslexia
Paul	• Social Comparison	• Hiccup	• Community
John	• Belonging	• Conformity	• Community

Table 15.2: Table illustrating the themes from each individual case that were identified as corresponding with, or supporting the themes from the overall cross-case analysis within the superordinate theme of *Belonging*.

15.2.2. Impostorship

Participants also represented the notion of not fully belonging, and being a *black sheep* through their talk of *impostorship* and *passing*. This is also inherently related to the notion of being not good enough (15.1). *Impostorship* and *passing* are inter-related: *impostorship* as a theme was constructed through the talk implying fear of discovery and subsequent rejection as illegitimate or inauthentic membership to the medical profession; *passing* is constructed through talk of 'faking it', and implied through talk of 'just' passing or 'scraping' through assessments permitting progression in medical training. This confers a sense of perceived passing on the part of the individual – in that they interpret their performance or experience as an inauthenticity of qualification for group membership. This is in contrast to the external markers of acceptance that are implied through progression in training, or continued employment as a doctor. The implied sense of compromised, undermined, or less-legitimate belonging is central to the concept of *black sheep* within the theme of *belonging*. Whilst this theme is

represented in all participants' data, it is particularly strongly articulated in Sarah's (10.1.1) and Brian's (8.3.2) accounts.

15.2.3. Conformity

Belonging is represented as being contingent on conformity. This operates with reference to the medical professional group, but also within other communities. Of note, is the concept of conventions that are operant within the community of dyslexic peers that guide self-policing of the use of the label in bargaining and excusing. This notion is most developed in Liz's (9.1.1) narrative, but is reinforced by notions of conventions alluded to in the analysis of data from Brian, Gemma and Helen. Where it is represented in Liz's narrative, the conventions of the dyslexic community evoke a sense of transgression: a peer misuses the label (according to implicit conventions) and is therefore cast as a discordant member of their community. The sense of absoluteness of these conventions creates definition to this community, and when combined with the sense of struggle for and protection of scarce resources, alludes to a sense of tribalism.

The majority of the participants directly alluded to a sense of not conforming to enculturated expectations or conventions within the medical profession. A very specific form of conformity was identified in Rubina's narrative relating to feeling that she thinks like her medical peers: *cognitive conformity*. This is built on by contributions from other participant's data too, and is further developed and differentiated by Amanda's narrative, which explores different ways of *doing* things in a professional context: *conformity of praxis*. The participant's experience of the difficulties that they attribute to their dyslexia leads them to feel that the do not conform to the implicit conventions of the medical community, and therefore perceive this as a constant imminent threat to their group membership. This sense of threat is reiterated in talk that relates to impostorship and discovery.

15.2.4. Community

Community is represented in a variety of different ways throughout the participants' narratives: there is a sense of a community of dyslexic peers within medicine; the wider medical profession (which is implicitly assumed to be non-dyslexic); and a community outside of medicine, that may involve family or friends. This sense of community is

particularly apparent in Helen's narrative construction of self (11.4). Belonging to the community of dyslexic-peers is conferred upon diagnosis, and is alluded to through talk of recognising 'usual faces' in exam rooms and in clinical settings. Belonging to this community is associated with no longer feeling alone in their experience of struggle, such as in John's feeling of not being 'on [his] tod with all this' (John, int-1, 586). Community is also represented through talk of mistrust and risk, especially relating to disclosure, in relation to the (assumed non-dyslexic) medical community. Both the concepts of conformity and community allude to a common sense of precarious belonging: the community of dyslexic peers being manifest at times of assessment, or brief moments of recognition; the community of medicine being exclusive and risk-laden in their nature.

15.3 Coping

Talk representing *coping* was present in all participant's narratives. Through this talk, coping was constructed: as *strategies*, and in talk of *risks* and risk management; as well as through the exercise or surrender of *agency*, and the variable *attribution* of outcomes to self or difficulties; and through direct talk pertaining to experienced *difficulties* and personal *capabilities*. These are summarised in table 15.3, and explored in more detail below.

15.3.1. Difficulties and capabilities

Coping was often represented either by talk pertaining to how the participants coped with the difficulties they experienced, or implied through persistence in the face of such difficulties. Many of the participants reflected on how their dyslexia may contribute to difficulties or associated with certain capabilities. Analysis of John's narrative provided a novel way of conceptualising these difficulties: as those experienced (and 'seen') by those with dyslexia, and of those observed (and 'seen') by others – often with an interest (e.g. a particular teacher from school) or level of intimacy (e.g. wife). This way of understanding difficulties also converges on the concept of *visibility* relating to the way difficulties manifest, and how the diagnosis is one of a relatively invisible condition. Unsurprisingly, reflection on the diagnostic

process suggests that the trainees saw it as an opaque process of testing imbued with a sense of mystery.

Coping	Difficulties & Capabilities	Agency & Attribution	Strategies & Risk
Zayn	• IncredAbility • Galvinising Activity	• Holding On • Scraping By	• Safety Netting • Partitioning • Thresholding
Rubina	• Image Discordance • Diagnosis	• Conformity	• Management • Risk • Surrendering
Amanda	• Difficulties	• Passivity	• Partitioning • Risk
Brian	• Disability	• Attribution • Coping • Disclosure	• Coping • Reframing • Disclosure
Liz	• Struggle & Adaptation • Daily Little Damages	• Agency • Tentative Attribution	• Coping • Struggle & Adaptation
Sarah	• Frustration • Expectations	• Attribution	• Reframing • Coping • Bargain
Helen	• Struggle & Attribution	• Struggle & Attribution	• Blame • Conditionality of Support • Environment
Gemma	• Difference • Difficulties	• Self • Attribution	• Acceptance • Support • Plurality
Paul	• Hiccup	• Agency • Partitioning	• Reframing • Risk Factors
John	• Difficulties • Adapting	• Adapting • Helplessness	• Adapting • Reframing

Table 15.3: Table illustrating the themes from each individual case that were identified as corresponding with, or supporting the themes from the overall cross-case analysis within the superordinate theme of *Coping*.

15.3.2. Strategies and adaptability

Difficulties tended to be represented through reflection on managing: workload, personal organisation, time management, or dynamics in the clinical environment. However, talk of difficulties was often accompanied by an apologetic explanation of why the situation was challenging (e.g. interruption by others), or of strategies used to mitigate the struggles. Narrative of strategies was diverse, with a common thread of adaptability: a sense of malleability and flexibility that enabled the trainees to adapt to different environments, teams and their conventions. The power of the dyslexia label relates to this theme of strategies, through the way in which it is employed to

depersonalise the difficulties experienced, as illustrated in Paul's (13.1.2 and 13.2.2), Gemma's (12.2.2), and Brian's (8.2.3 and 8.4) accounts.

When participants discussed specific strategies, there was often reference to the application of additional effort, and expenditure of time that was considered extraordinary in comparison to the way they perceived their peers. Other approaches, that were often described in mechanistic terms, included: re-checking; adopting a specific approach to certain tasks (concision in clinical note-writing, developing a unique shorthand in personal work); drawing on preferences and abilities in visual forms (e.g. diagrammatic working); and asking others to check work. Of these approaches, the checking strategies appear contingent on an element of self-doubt in order to trigger their use, while others (e.g. developing a shorthand) appear to be activated by exertion of choice and agency.

15.3.3. Agency

The concept of *agency* was identified in discourse that pertained to either exerting (and having) agency, or surrendering (and not having) agency. Exerting agency was associated with positive approaches to coping, such as *reframing*, and to re-attribution of historical difficulties to dyslexia after diagnosis. There was a sense of having to surrender agency through the process of securing a diagnosis of dyslexia: accepting the personal risk – implied through fear of the potential for being found to be 'trying to make an excuse' (Amanda, int-1, 408), or 'just a gobby person' (Sarah, int-1, 387) rather than dyslexic. Beyond surrendering to the process of diagnosis, there was also a similar sense of resignation to the system of failure. This conveyed a sense of helplessness which is reminiscent of giving up, and accepting the sentiments conveyed with *not good enough*.

15.3.4. Attribution

Attribution was identified through narrative that pertained to a directionality and location of cause for outcomes that were dissonant with expectations. Participant narratives alluded to locating cause within: themselves; within a separate or partitioned part of themselves; or externally, to the system or factors of chaos. The relationship between perceived success or failure, and participant's direction of attribution eluded a coherent and consistent analysis. However, attributing to a

partitioned aspect of self, as alluded to by Zayn's discourse of 'parts' (e.g. int-1, 32) appear to confer a sense of protection to global sense of self, and sense of self-as-doctor.

15.3.5. Risk

Coping with reference to the management of risk is represented in terms of: the risks inherent to the process of diagnosis; risks inherent to the process of disclosure; and risks inherent with the clinical environment. Diagnostic risk pertains to the potential for the diagnostician to confirm notions of idiocy, laziness or stupidity instead of a diagnosis of dyslexia, particularly exemplified in Amanda's (7.2) account. The process of approaching a diagnosis was fraught with a sense of fear and personal risk. This was evident in the narratives of participants who were diagnosed later in life, compared to those whose dyslexia was recognised during childhood.

Discourse of risk was also identified in association with narrative pertaining to disclosure choices. Some trainees discussed openly disclosing their diagnosis of dyslexia, whereas others preferred to avoid it and alluded to conventions within the dyslexic community that govern the self-policing of the use of the label. There is a sense of fear of rejection or prejudgement in response to disclosing the diagnosis. Participants' decisions to conceal their diagnosis were often driven by the desire to prove themselves, which again returns to the notions of *not good enough*.

15.4 Pearls in the bed of oysters

Yardley (2015) and Smith et al. (2009) suggest that the presence of themes in the data from more than half of the study participants is a marker of quality for the research and analysis. Whilst this may reflect how robustly a concept is supported by the data, it is a view that is reminiscent of emipiricism that is discordant with the epistemology and axiology underpinning this interpretative and idiographic work. Smith (2011c) argues for the value of 'pearls' and 'gems' in corpuses of data from qualitative psychology. These are concepts emerging from data in few, or individual, cases that may not be supported by the group analysis of the wider corpus of data, but hold significance and value. Accordingly, whilst cross-case analysis of the data from this

project did not yield a degree of significance at group level, the following themes were identified in the data from some of the participants, and offer a significant contribution to understanding the experience of the phenomenon of failure.

15.4.1. Brute failure

All of the participants experienced difficulties, and explored a sense of failing to meet expectations (of self and others), but only a few recalled experiences of failure. Uniquely, John gave a vivid account of his somewhat protracted experience of failure. It is through his individual account that the notions of *constructed* and *brutal* failure were identified. Failure was construed as constructed by a system operating specific conventions that were misaligned to the perceived objectives of training. This was particularly evident in the discourse that reflected an importance on clinical (surgical) skills, and team working, as opposed to the abilities that test-constructs appeared to assess, such as the ability to answer questions under time pressure. The arbitrary, or misaligned nature of these conventions creates a sense of brutality to the process of failure – a process that has, or requires no explanation. The violent connotations of brutality are also present in the way John represents the process of failure as 'absolutely destr[uctive]' (int-1, 369).

15.4.2. Partitioning

The concept of *partitioning* with reference to the concept of self was first identified in Zayn's narrative (5.3), and was further identified in Amanda's (7.6.3), Brian's (8.2), Gemma's (12.2.2), and Paul's (13.3) data. Where this theme is identified, it presents itself as a means by which attributes, qualities or feedback can be encased or quarantined within a partitioned aspect of their *self*. In this sense, the participants created a plurality of selves, with some versions appearing to exert agency, whilst others were passive. Zayn even specifically imbued one part of his self with the ability to sabotage his academic and professional efforts. This partitioning was particularly identified in reference to failure or negative feedback, and appeared to be a means of acknowledging the feedback, whilst creating a distance between the implied negative sentiment, and a core or central sense of self.

15.5 Reflexive note

Throughout the process of data collection and analysis, the emotionality of the participant narratives, and the experiences they pertained to particularly resonated with me. Related to this was how easily I was able to build rapport with participants, and access and identify with their stories. There were times where this rapport was threatened, such as when Rubina disclosed her diagnosis of dyspraxia rather than dyslexia. During the interview process, I felt utterly derailed, and conflicted: was I to continue with the interview, or confront the issue that Rubina didn't meet the eligibility criteria. At the time, I felt overwhelmingly concerned about the potentially damaging effect me rejecting her contribution to the project could have on her, so I continued with the interview, and reflected in my research journal afterwards:

'I felt frustration (didn't she read or understand the email invite, or did she just disregard it?!) and also fear (what do I do now?). I am reminded of my recent episode with the educational psychologist who said I 'no longer have dyslexia' …this threw me into a panic about my very identity…How could I do that to another, denying the significance of their experiences based on arbitrary thresholds and labels? But from a research perspective, this utterly changes the focus of my questions, at least for her, from dyslexia (specifically) to SpLD (more broadly).'

And concluded that:

'I feel it would be wrong for me to cast her, her contribution, and her experiences aside as somehow ineligible. Besides, the emotion that came through in her interview confirmed that this process wasn't about me and my research…at least not entirely. This was an opportunity for her to learn, grow and be listened to, to have her struggles validated and cared about…this serves some sort of therapeutic function.'

(Research Journal – *on Rubina*)

This presented me with the ethical dilemma of having been given her contribution, in good faith, and whether I would retrospectively and unilaterally decide to withdraw it. I reflected on this tension, and a subsequent discussion with my supervisors (BN and JS). The subsequent decision to retain her contribution was informed by the evolution of my understanding complex nature of SpLD, and the slightly arbitrary division between different diagnostic sub-categories through the doctoral journey, and also considering the way Rubina donated her contribution on the basis of identifying, at least in part, with the label of dyslexia. This sense of tension recurred during the analytical process too, manifesting as uncertainty around the validity of my interpretation of her data. Stepping back from the data, sometimes physically, by

returning to it several days later, allowed me to re-engage with a renewed ability to put these anxieties aside and approach the data in a more grounded way.

I attempted to analyse the case studies in the order in which the participants chronologically engaged with the project and were interviewed. Another notable entry in my reflective journal was made after meeting with Helen. I felt particularly challenged by the manner in which she talked about her dyslexia. I came away from the interview with a sense that she did not feel her dyslexia had impacted on her life and professional development. I was concerned that this would limit the contribution that her narrative could make to the overall project. When I began to approach the analysis of her data, I was aware of this preconception. Concerned that I may inadvertently restrict my ability to access and engage with her data, I chose to abandon my initial attempt at analysing her data, and continue with the analysis of Gemma's case study, before returning to Helen's. Upon re-approaching Helen's data, it became apparent that her narrative had much to add, that I may have potentially missed or discounted.

Another concern I had related to the time that the analysis took. Interviews began in late 2014, and data collection continued until early 2016. It wasn't until I considered all data to have been collected that I attempted to begin the analysis of each case study. In total, the process of data analysis took over a year. Indeed, the interpretative project in this form of phenomenology could be considered an on-going exercise extending to the crafting of a narrative account of the analysis, and even into the third hermeneutic cycle of reading and interpretation of the thesis. I was concerned that this significant lapse of time could jeopardise the relationship I would be able to form and maintain with the participants through their data. However, returning to their narratives time and again helped build a unique relationship with each participant and their narrative. Subsequently, I genuinely feel that no one relationship was deeper or stronger than another, but each one entirely individual. Some relationships may have formed quicker than others, such as with Zayn. This may have been a reflection on the fact he was the first participant to engage with the project, or the intensity of the emotionality in his interview. But the measured and sensitive way I approached each participant and their contribution, combined with the reflexive way I engaged with the analysis of their data, illustrated above, enabled me to form a unique and intimate relationship with each of

the case studies that was co-constructed between me and the participants. I believe this individuality to be especially reflected in the way participants responded to the self-characterisation sketch exercise, and in the way the concept maps evolved to summarise the themes identified within their narratives.

The emotionality of the interview process featured in reflections on interactions with other participants too. I poured my concerns into my research journal like a confessional: *'was some of what he described akin to depression?'* and *'as a doctor, do I have a duty to advise and act?'* (with reference to John). In response to shared emotion, I found myself asking questions within the interviews that emulated a clinical risk assessment rather than the questions that guided my research. There was a strong notion that the interviews were somehow therapeutic to the participants. Beyond the catharsis of emotionality, the reflective space created by the interactions facilitated sense-making. In my journal, I reflected on two interviews where I became conscious of a temptation to 'jump in' with the specialist knowledge about dyslexia that I have gained over the years. Instead, on becoming aware of this, I adopted more of mentoring approach, drawing out the participants' ideas, and reassuring them how what they interpreted from their experience was understandable.

Part 3: Discussion

In this part of the thesis, I will explore the analysis of the data from this project in the context of extant literature and theories, in order to draw out meaningful conclusions and recommendations to inform medical educational practice.

This section contains:

Chapter 16: Discussion

Chapter 16: Discussion

In this chapter, I will link the findings from the analysis to the extant literature and demonstrate the relationship between the findings and theoretical concepts, as well has how this work contributes to an advancement of understanding and theory in the field.

16.1 Doctors with dyslexia

This doctoral journey was undertaken out of a desire to better understand what dyslexia was, and how it influenced the education, training and practice of doctors. The project that was central to this journey was borne out of the need to develop a better understanding of the personal experiences of dyslexia, in the specific context of medical education, and how dyslexia specifically affected doctors in training. During the course of intense study, my personal understanding of dyslexia as a concept, and what it means to me, has evolved and matured to accommodate some of the complexity around the issue. On a personal level, exploring the way in which others' understand their difficulties and make sense from their experiences has further challenged the way I see SpLD, and changed my practice as both a doctor and educator. As outlined in the literature review, dyslexia is a complex phenomenon that is usually associated with negative affective experiences throughout educational development (Riddick, 2010; Morgan & Klein, 2000). To date, such an idiographic and in-depth study of the personal significance and impact of learning difficulties in a relatively socially privileged and empowered, highly skilled and highly qualified professional group of adults has not been undertaken. Single-institution analyses of assessment data have explored the differences in exam-context-specific performance of medical students with dyslexia, compared to those without, with variable results largely suggesting no significant difference between the two groups across a variety of assessment methods,

when learners with dyslexia receive reasonable adjustments (McKendree & Snowling, 2011; Gibson & Leinster, 2011; Rickets, Brice & Coombes, 2010). Further to this, small-scale qualitative inquiries have begun to explore the nature of difficulties that junior doctors face in the context of hospital-based medicine, which have yielded partial and context-specific insight (Locke et al., 2016; Newlands, Shrewsbury & Robson, 2015). Whilst these branches of inquiry approach the subject of dyslexia in medicine from different philosophical perspectives, drawing on different approaches, and aim to answer different questions, they share similarities in their superficiality with either appreciating the complexity of SpLD, and the nuanced and individual nature of performance and experience. Indeed, it is likely that no one approach or project could hope to capture the full complexity inherent within this particular field. What this study adds, is a detailed idiographic account of how trainees in the medical profession experience their dyslexia, and how that influences their sense of professional identity, with implications for how they perceive their difficulties and engage with the system through their work.

In the following sections, the analysis of the data will be interpreted and synthesised within a context of the extant literature and relevant psychological and sociological theories. The discussion will be structured according to the guiding research questions.

16.2 Research question 1: Challenges faced

What are the challenges that trainee doctors with dyslexia face that are specific to their dyslexia?

This question informed the development and use of the critical incident reflections (CIR), with the aim of collating examples of difficulties encountered by doctors with dyslexia. Based on personal experience of difficulties, I had anticipated a frequency of experiences that might result in one reflection every week or two, and attempted to mitigate anticipated difficulties with literacy and workload burden with the use of simplified recording devices. However, the response to the second phase of the project,

which comprised the CIR was poor, with only 3 of the 10 participants contributing to this component, and of that only 2 providing more than one reflection. Challenges that featured in participants' interview and CIR data are summarised in table 16.1.

Assessment failure:
Failing assessments were represented as both triggers for diagnoses of dyslexia, and also a reminder or manifestation-point. Assessment failure was represented as either more likely because of, or attributed to participants' dyslexia. Participants' narrative described struggling with the emotional impact of failure in light of their dyslexia.
Entering written information into clinical systems:
Struggling with spelling, recalling details to include, and structuring the information to form a coherent entry.
Recalling correct patient-related information:
Discussing cases with colleagues, and drawing on information from incorrect patients, misremembering information, or being unable to retrieve information.
Organisation and management:
In the context of environmental factors (e.g. change of team or ward, distractions and interruptions, or heavy workload demands).

Table 16.1: Table summarising the ways that challenges that doctors with dyslexia face in the workplace, as represented in data from the project participants.

In spite of the lack of data in the phase of the study specifically designed to address this question, participant narratives provided a wealth of data pertaining to difficulties that they had experienced throughout their lives, and the difficulties they experienced in the context of their clinical jobs. In reflecting on their difficulties, many volunteered that they could not be certain whether the experience was specific to dyslexia, or whether it would potentially be shared by others in medicine. This research prioritised the individual experience, and so did not include a form of comparison or control. Therefore, in addressing this question, the synthesis needs to approach a tentative answer focusing on the idiographic, acknowledging that research of this kind does not attempt to make horizontal generalisations, but to deepen understanding (Willig, 2013; Smith, Flowers & Larkin, 2009).

16.2.1. Identity formation, group belonging and stigma

From the analysis of the participants' data, it became apparent that the most significant challenge that these trainees with dyslexia experienced was not, as anticipated, specific task-related difficulties. A theme that spanned the data from every participant representing a significant psychological challenge that they faced was that of *belonging* (section 15.2). The most resonant concept within this theme was that of the *black sheep.* As explored in section 15.2.1, this is associated with a sense of conditional belonging, with lower worth (black wool) and stigma (the devil's mark). This metaphor conveys a sense of belonging to the flock, but sticking out. However, dyslexia *per se* is not inherently visible. Indeed, the concept of visibility is explored in the data from several participants, including Brian (8.1.3), Liz (9.2.2), Sarah (10.2.3) and Helen (11.2.1), contributing to the notion of manifestation of difficulties through certain conditions or risk factors, such as testing, workload intensity and distraction. The visible 'mark' (equivalent black wool) of dyslexia is manifest by the experience of difficulties. Analysis of John's (14.1.4) narrative further illustrated that there may be two broad categories of difficulties with reference to the experience of dyslexia: *experienced difficulties* where the learner feels they are struggling with something and attribute it to their dyslexia; and *observed difficulties*, where someone else, usually with specific qualities such as a special interest in the learner, or insight into dyslexia, notices signs of struggle that the learner may not be aware of. Therefore, unless the learner is in the company of such an interested or insightful *other*, their dyslexia-related difficulties are likely to only be perceived by the learner, and therefore remain invisible. The 'mark' that differentiates the black sheep from the rest of the flock may represent an internalisation of stigmatising notions of difference and a projection of 'discreditability' onto their identity (Goffman, 1963: p100). A theme related to *black sheep,* that was identified within *belonging* is that of *community* (15.2.4). *Community* represents the sense of belonging to a specific community of peers, and was associated with notions of support. Participants described this in terms of: doctor-peers with dyslexia; doctor-peers with unspecified or unknown dyslexia status; and to peers outside of medicine, such as friends and family. Narrative representing this theme was rich in interpersonal social comparisons within their reference communities, as well as between different groups

(e.g. between them as part of the dyslexic doctor peer group, and doctor-peers without or with unknown dyslexia status).

Identity can be considered a complex, dynamic and ever-partial process of associating with and assimilating social representations (Ryan & Deci, 2012). Self-categorisation theory (Turner et al., 1987) offers a means of understanding the process of these dyslexic doctors considering self as belonging, or not, or not-fully (as in the Black Sheep) to a group. In self-categorisation theory, individuals employ a variety of psychological mechanisms to accentuate or minimise characteristics that may or may not support identification with a group or category (Hogg, 2012). Identity is influenced by, and constructed from group membership and other social contexts (Ryan & Deci, 2012). As people go through their lives, some identities, and therefore group memberships, are adopted whereas others are not. This may relate to whether they possess fundamental traits that qualify them for membership to that group, but may also relate to the psychological needs that identities serve (*ibid.*):

- **Sense of relatedness:** identities that encourage social connection and group belonging.
- **Support feelings of competence:** identities that can support skill development and feel effective.
- **Fulfill the need for autonomy:** identities that can provide a platform from which people can exert their will.
- **Defensive:** identities that help avoid feelings of vulnerability; that help gain power; or react to imposed values.

Self-determination theory (Deci & Ryan, 1985) suggests that how much a person integrates multiple identities into their self-concept, and how they subsequently assimilate the related goals and values of these identities reflects how well the above psychological needs are likely to be met. Psychologically modifying the perception of information, such as feedback, serves to alter how these needs are met and how a positive sense of self-concept is maintained, through influencing self-categorisation and the assimilation of an identity. This can be seen as an action of self-protection (Sedikides, 2012). How the analysis of data from this project relates to psychological modification

of feedback and self-protection will be explored in more detail in relation to the 4th research question, which relates to *coping* (section 16.5).

16.2.2. Chaos

Within the theme of *self* a notion of *chaos* that characterised the lives of the participants was identified. *Chaos* was represented through the narrative of many participants, including Amanda (7.6.2), Gemma (12.1.1), Paul (13.1.3), and John (14.2.1), but was also evident in the lives of Sarah and Brian. This theme represents the way these doctors derived meaning from the factors in their wider lives that were influencing their experience at work, and were characterised by significant events such as bereavement and illness. It is unlikely that these participants in particular, and doctors with dyslexia in general, would be alone in experiencing such life events. However, the idea that there is a simmering pot constantly nearing a point at which it would bubble over, seems particular to the experience of the interface between life-event-factors, work-related factors, and the impact that dyslexia has on their ability to cope, be that due to self-management and organisation strategies, pace of work, or the ability to partition and focus on aspects of life. Resource theories of stress and coping would suggest that the appraisal of factors as 'dominating chaos' may reflect the nature of these doctors' psychological resources, such as social support, self-efficacy or optimism that preserve wellbeing in the face of stressors (Krohne, 2001). The relationship between self-efficacy and self-concept was introduced in the literature review (section 2.2), and will be explored in more detail in relation to the analysis of data from this project under the 4th research question, which relates to coping (section 16.5). The resource of social support may have particular relevance in the case of the dyslexic doctors involved in this study, as the sense of incomplete or somehow illicit group belonging may undermine their ability to cultivate or access social support within the context of specific reference communities (such as their doctor-peers with unknown dyslexia status). Therefore, the authenticity of the sense of belonging from group membership may represent an important factor in determining the interpretation and framing of events and factors as *chaos,* as well as an individual's ability to cope with the associated stress.

16.3. Research question 2: Sense-making

How do trainee doctors with dyslexia make sense of their successes and failures (academic and / or clinical) in relation to their learning difficulty?

Narrative relating to how feedback was interpreted was prevalent across the whole group of dyslexic doctors involved in this study. Specifically, how feedback received throughout the course of their life had informed a sense of not being *good enough,* and how this can be *attributed* to, or *reframed* by their diagnosis of dyslexia. When focusing on the way that the participants in this study understood and made sense of the feedback from their training or work as a doctor, themes of *attribution* (15.3.4), passing and scraping by, and *partitioning* (15.4.2). Perhaps most drastic, though, is the insight gained from the identification of the 'thematic pearl' of *brute failure* in one participant's narrative.

16.3.1. Brute failure

Like brute facts, *brute failures* were represented as not requiring an explanation. This representation of failure is conferred with brutality, by a system that is perceived as cruel or uncaring. Moreover, in talk relating to *brute failure* there appeared to have a sense that the failure was constructed by the system. This interpretation is not to say that the pass / fail judgement is unjustified or must somehow be avoided on humanitarian grounds. However, it raises questions about how learners interpret this feedback, and how likely they are to engage with it to learn and improve, or how likely they are to reject the feedback or withdraw their efforts and abandon their training. Patel et al. (2015), who similarly drew on IPA, identified that the emotional impact of failure on medical students had traumatic connotations, where their participants disclosed feelings of fear, concern of being exposed as an idiot that resonate with the data from the participants of my study. However, the notion of brutality is different from trauma in that there is an inherent notion of action-being-done to the learner, who is cast as a victim. The personally destructive effects of failure are shared by how Raj felt 'completely gutted' (Patel et al., 2015: p4). This resonates with John's feelings of being destroyed, but his specific use of language directs this at the system that

operates the failure, as it is a 'they' who 'absolutely destroyed' him (John, int-1, 374). This is accompanied by metaphors of being 'kicked in the teeth' (John, int-1, 300) that convey a violence that reinforces the notion that this is a process that is perceived with a significant amount of brutality. Whilst it behoves the educational community to consider if such perceptions reflect the way in which processes of feedback and failure are contextualised and carried out, this perception may represent the specific impact that dyslexia has had on this particular learner: whilst being a member of this group, and being held to equivalent expectations, that membership is incomplete and deprives John of access to the psychological and social resources to cope. Therefore, harsh judgements have an impact on his self-concept that is unattenuated and unmitigated by the protective factors, such as a high degree of self-efficacy, or in-group social support alluded to in the discussion of *chaos*. Harsh judgements may be specifically injurious to self-worth and selt-concept, which will be explored more in section 16.5.

16.3.2. Attribution

Attribution theory (Weiner, 1976 & 1980) offers a lens through which we can assess the pattern by which an individual attributes causes to events, or sources of responsibility for behaviours or outcomes. These causes can relate to an internal or external locus of control, and can be considered according to their stability (Manusov & Spizberg, 2008). Self-efficacy, a component of self-concept, is a belief about one's own 'capabilities to organize and execute the courses of action required to produce given [academic] attainments' (Bandura, 1997: p3, quoted in Margolis and McCabe, 2006: p219). Academic attribution style is believed to relate to self-concept, with academically successful learners being more likely to have high self-concepts and to attribute success to an internal locus (Marsh, 1984). Directing attributions can also serve the purpose of protecting self-concept by either attracting resources, such as sympathy, or deflecting blame and responsibility (Manusov & Spizberg, 2008). It is recognised that dyslexia, and the experience of related difficulties, can negatively impact on children's self-esteem and self-concept and that the associated internally located focus of attribution can become stable in the absence of remediation (Humphrey & Mullins, 2002a & 2002b).

When the doctors in this study drew on attribution to make sense of their experience of feedback, there were a variety of different styles and approaches that were illustrated. Many used negative and self-deprecating language in attributing their experience of difficulty or failure to themselves (internal locus). This is particularly evident in the talk that relates to the notion of not being *good enough* (15.1.2). The *overhang* (e.g. Amanda, 7.3 or Ruth, 10.1) effects of early experiences on self-concept are illustrated through this negative self-talk, and may reflect a stability or permanence of the effect that developmental experiences have on adults, in spite of the demonstrable academic success and professional attainment. The *attribution* talk also suggested the locus of control could be directed at the dyslexic *part* of their self, which carried a sense of disconnect, distance or quarantine from the broader self-concept. This augments the notion that particular styles of attribution may recruit resources to help the learner, by suggesting an internal process by which the impact on a more central, core, or higher-level self-concept is minimised through this quarantine and partitioning.

The way in which these dyslexic doctors used negative self-talk with reference to internally attributing their failures or difficulties challenges the understanding of the 'self-serving bias', which would suggest that learners more readily attribute positive outcomes to themselves, with the converse being considered true of negative outcomes (Marsh, 1986). Whilst there were examples of attributing failure to a partitioned element of their identity: the dyslexic 'side' or 'part', failure appeared to usually be internalised and assumed within the self. Humphrey and Mullins (2002b) note that children who have experienced persistent difficulties, like dyslexia, develop a learned helplessness, which can be defined as: 'the state that people fall into when, usually as a result of constant failure, they feel that there is no point in making the effort to attempt tasks because of what they perceive as the inevitability of failure' (Burden, 2005). There are elements of learned helplessness present throughout the narrative of all participants, illustrated by the apparent internalisation and repetition of negative self-talk or resignation to perceived failure. Seligman (1972 & 1990) outlines that there are factors that can prevent, or 'innoculate' against learned helplessness, and also suggests that it can be treated or even cured, which provides

hope for addressing the negative influence on self that is illustrated in these dyslexic doctors.

16.3.3. Partitioning and self-concept

The concept of *partitioning* was identified in the data from five of the ten participants: Zayn (5.3), Amanda (7.6), Brian (8.2), Gemma (12.2) and Paul (13.3), and relates to the theme of *coping* that resonates across the whole cohort of participants in this study. Where partitioning was identified, the doctors described 'parts' or 'sides' of their self that contained a specific attribute. This process was articulated as both a plurality of selves, and also as a singular self, with partitioned components within the singular, which resonates with Marsh and Shavelson's (1985) model of self-concept. The process of *partitioning* of and within self represents a mechanism by which attributes are quarantined to that specific 'part'. This is similar to the 'intra-psychic' self-protection mechanism of *compartmentalism*, whereby 'impenetrable walls' can be erected between two simultaneously held identities (Breakwell, 1986: p95). There appear to be important subtle differences, however, as the *compartmentalism* in Breakwell's threat-management theory results in the separate identities that are 'never directly compared' (*ibid.*), and is part of a process of assimilation that keeps that identity element static. In contrast, where *partitioning* was identified, it appeared that participants embodied their dyslexia in a singular global self, and although it may be quarantined, there was dynamic permeability. That part of their identity often had agency, and was actively involved in the ongoing development of their personal and professional identities. Unsurprisingly, *partitioning* was largely evident through talk of feedback and failure. As such, this quarantining of a specific attribute (e.g. poor performance in a specific domain) is an attempt to protect a higher-order self-concept, and is resonant with psychological theories of self-protection (Sedikides, 2012), which will be explored in more detail in section 16.5.

The way people see and evaluate themselves is considered integral to their identity, and identity-formation processes (Oyserman, Elmore & Smith, 2012). Subsequently, identity formation is influenced by construction of self-concept, which can be defined as '*composed of such elements as the perceptions of one's characteristics and abilities: the percepts and concepts of the self in relation to others and to the environments; the value*

qualities which are perceived as associated with experiences and objects; and the goals and ideas which are perceived as having positive or negative valence' (Rogers, 1951: p138 quoted in Burden, 2005: p5). How learners see themselves is believed to influence their learning, as their experiences in learning are reciprocally believed to influence their sense of self (Riddick, 2010). Self-concept is multi-faceted and hierarchical, with different domains (Marsh & Shavelson, 1985). Global self-concept is a complex of cognitive structures that represent cognitive and affective evaluations that are employed to make sense of the lived experience with reference to specific domains, such as: academic performance, social interactions, emotionality, and physical self (Oyserman, Elmore & Smith, 2012; Riddick, 2010). The exact nature of the domains is problematic: whilst there is broad agreement on an academic and non-academic self-concept, finer granularity introduces uncertainty and disagreement in the field (Riddick, 2010). As people develop, grow and mature, their self-concept becomes more complex, with the structure taking on different levels of hierarchy (Marsh, 1990 & 1992). However, research in this field is largely restricted to positivist inquiry in children and adolescents, leaving questions about on-going development in adult learns unanswered. I believe the different domains of self-concept that people develop are likely to be contingent on their specific contexts, including their educational and professional experiences. A student reading medicine at university, for example, is unlikely to develop the same sub-domains in academic self-concept as a student reading a different subject such as geography, as the two disciplines will be different in content, and will carry their own set of expectations and values, reflected in different teaching and assessment practices. Therefore, defining the exact details of lower-level organisation and structure of self-concepts is probably unnecessary, and is likely to dilute the nuanced understanding that can be afforded by valuing individuality and focusing on the idiographic, reflected in this research.

Examining the relationship between the data from this project, and the established literature around self-concept theories, there appears to be two developments that extend our understanding in relation to adult learners in professional contexts. One is that in the process of becoming a doctor, the professional identity appears to occupy a higher-level space in the self-concept hierarchy. The other is that the academic domain can itself have a variety of different sub-domains, with hierarchies within them. These

domains appear to be malleable and can be employed to protect higher-level self-concepts (illustrated in figure 16.1).

The analysis of participant data yielded information about how they saw themselves as doctors, how their sense of selves-as-doctors was influenced by factors both within and outside the working environment, and by their dyslexia. Representations of facets of their perceived identities were evident through the pictures, and accompanying talk, of the SCS exercises. Particularly prevalent were the 'tokens of doctorness' such as the ubiquitous stethoscope. In some examples, such as Zayn and Rubina, these tokens existed in a state of tension with expressed doubts over the significance of their medical selves. This could represent how elements of the doctor-self are present within academic (clinical knowledge), social (friends and family coming to identify you as a doctor), and physical (tokens of doctorness that can be worn or augment physical appearance). However, the persistence of these tokens represents a concept related to self that has become pervasive with the assumption of the professional role of a doctor, even if group membership and identity are perceived as incomplete. Furthermore, the analysis of data pertaining to the themes of *partitioning* and *attribution* suggests that there is a means for learners to quarantine negative feedback to lower-level constructs within specific domains of self-concept as a means of protecting higher-level self-concepts. This, combined with multifaceted notions of thinking (see: *cognitive conformity* in the analyses of Zayn, Rubina and Amanda) and feeling like a doctor suggest that the doctor-self-concept is higher level, is permeable to all facets of self-concept, and is closely linked to both an individual's self-esteem and global self-concept (figure 16.1).

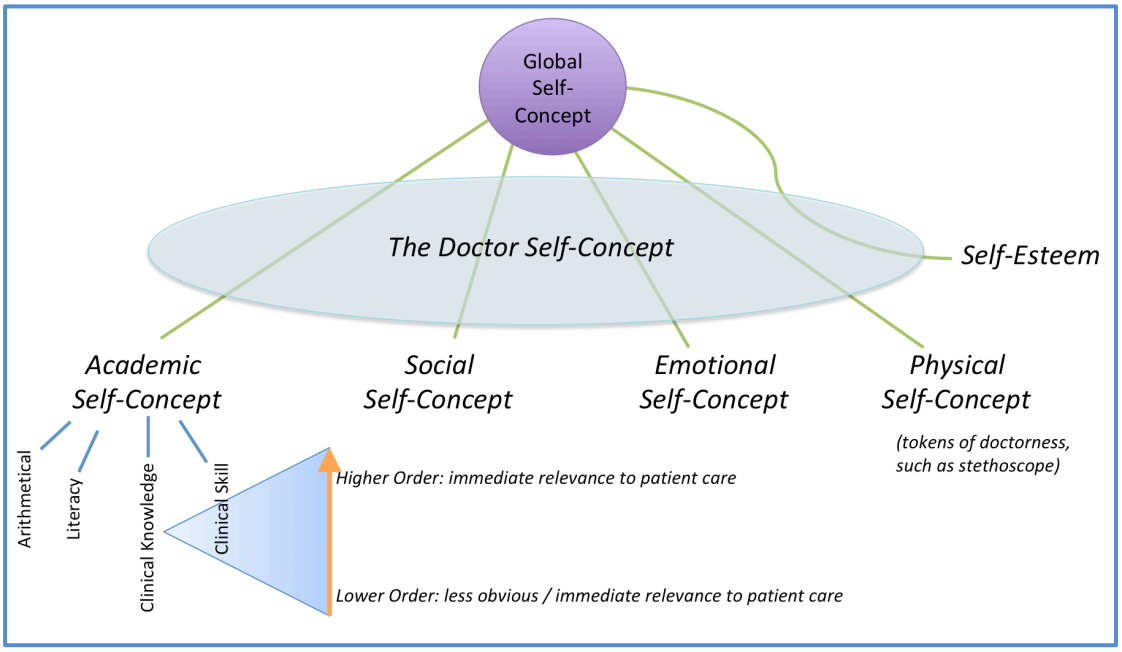


Figure 16.1: Diagram illustrating the relationship between Global Self-Concept, the different multi-facets of Self-Concept, and the introduction of additional levels of abstraction. *Original illustration* after Marsh (1990).

Within the domain of academic self-concept, the analysis of data from this project alludes to the potential for a multiplicity of sub-domains, such as academic self-concept having specific domains that extend beyond the subjects suggested by the earlier work in the field, such as English, science, history and maths (Marsh & Shavelson, 1985; Marsh, 1990 & 1992). Perhaps unsurprisingly, with further academic development, the academic self-concept domain appears to adapt to the complexity of the subject being studied, to include clinical knowledge and skills. Furthermore, within these lower-order, or distal, domains there is a further hierarchy. In talk relating to failure, doctors minimised their performance feedback by ascribing it to a seemingly lower-level subject. For example, when failing a medical school exam, John attributed the failure to an exam with graphs. This was contrasted to explaining how he performed better in practical exams of clinically applied knowledge or skills. The implication being that within the domain of clinical knowledge, that which pertains to direct patient care is valued more highly, whereas that which is more abstract in nature, features lower in the hierarchy. If this does indeed represent a mechanism by which core aspects of higher-order self-concept elements can be protected, this provides a novel way to conceptualise both the significance of the Doctor Self-Concept and the way in which identity threats are perceived and defended against.

16.4. Research question 3: Negotiating identity

How does having dyslexia factor into the negotiation and development of identity within a learning and professional team environment?

The answer to the question of professional identity is inherently linked to social identity of groups (e.g. the medical profession). In the earlier discussion of the *black sheep* (16.2.1), we can see evidence of an undermined sense of belonging and group membership that infers a compromised professional identity on the group level. The discussion of the analysis thus far has alluded to the significance of the doctor-self within self-concept theory, as well as how this may be protected or affected by attribution style in dyslexic doctors. Negative feedback is an example of an explicit self-threat, and it is considered a 'fundamental behavioural law' within psychology for people to maximise positive experiences, whilst minimizing negative ones in an effort to enhance and protect self (Sedikides, 2012: p372). The partitioning explored above represents a process through which these doctors protected themselves against the feedback, failure and experiences that were interpreted as self-threat. The driver for this behaviour appeared to be the higher-level Doctor-Self-Concept (figure 16.1) that seems to be particularly vulnerable to self-threat in the form of negative feedback. This has implications for how feedback is received, assimilated and acted on by learners in medical education.

Identities can be considered multiple, and co-constructed through interaction (Monrouxe, 2013). Drawing on Costello (2005), Monrouxe (2010) explores the notion of *identity dissonance* in medicine, which is believed to affect people from groups that traditionally suffer prejudice, discrimination, marginalisation or deprioritisation, such as women and people from non-white or lower socio-economic backgrounds. Identity dissonance is believed to be a psychologically distressing experience of difficulty of the integration of new professional identities into personal identities (Monrouxe, 2010). Costello (2005) and Monrouxe (2010) allude to race and gender as 'othering' features that predispose to identity dissonance, but the data from this project would add dyslexia, or at least the self-identification with this SpLD, as a risk factor for this

dissonance too. Dissonance was evident in the participants' identities in a variety of different ways, through the concepts of *black sheep* and *not good enough*, which represents a tension or difficulty in assimilating the cultural norms (expectations, practices and conventions) of the new medical identity into their own. In addition to this, however, there was a very explicit dissonance in the exploration of Rubina's identity, whereby an ambiguity and confusion of identities was illustrated by her simultaneous identification as dyslexic and non-dyslexic-but-dyspraxic, as well as the tensions explored between her dehumanised self-as-doctor and the importance of her life outside of medicine.

16.4.1. Black Sheep and cognitive conformity

As explored above (16.2.1) a different mode of group membership was identified in the data from the doctors with dyslexia involved in this project: the *black sheep* form of belonging. Much of the talk alluding to this concept is associated with significant emotional overhang from earlier experiences, which appear to have created a sense of defectiveness that has been internalised, which will be explored in more detail in the next section (16.4.2). Whilst the participants' narratives and SCS representations described visible, and physical *tokens of doctorness* that would denote group membership (such as the stethoscope), the visibility of their difference was less obvious. There were examples where task *performance* was felt to mark them out as different, and undermine their group membership (e.g. when Zayn failed his ALS course), or where task *execution* created observable differences (e.g. Rubina's handwriting, or the spelling errors in Brian and Sarah's emails and written pieces of work). However, these are momentary and context-specific othering features, which have the potential to be shared by those outside of this community of dyslexic doctors. The black sheep, however, is consistently and continuously marked out as different from the rest of the flock. *Cognitive conformity* is a non-visible, but potentially stable construct identified in the data from four of the participants in this study: Zayn (5.1), Rubina (6.3), Amanda (7.6), and John (14.1). By not cognitively conforming (thinking like a doctor), they felt that their standing within that professional group was somehow undermined. Analysis of Amanda's data expanded on this, adding the concept of conformity of praxis (doing things like a doctor). Monrouxe (2010) draws on Bourdieu's (1990) writings on habitus to illustrate the role that unconscious 'acquired patterns of thought and behaviour'

have in the construction of social-group identity (Monrouxe, 2010: p44). From a narrative psychology perspective (*ibid.*; Monrouxe, 2009), the stories that these individuals have come to tell themselves (i.e. 'I do not think like other doctors, therefore I am not as much of a doctor as them') has become an embodied component of their identity.

When Rubina recalls a conversation with a more senior doctor, who questions her medical qualifications because of the justification she gives for her personal choice to not receive the seasonal influenza vaccination, she is prompted to question whether she thinks like a doctor. Furthermore, this interaction is laden with negative affect directed inwardly as shame, and outwardly as sadness and fear. These strong emotions have the potential to act as a barrier or negative incentive to engaging with the medical social group, and thus both reinforce the sense of undermined belonging, through isolation, but also to distance these doctors from the very social network that may provide clinical-task-related and psychological support (Firth-Cozens, 2001), further hindering their access to the psychological resource of social support..

16.4.2. '80% person', not good enough and overhang

The notion of *black sheep* applies to social identity and group membership. Considering identity on the personal level, however, brings a different theme into focus: the relationship between *not good enough,* perceiving self as an '80% person', and the emotional *overhang* associated with developmental learning difficulties throughout life.

The notion of being an '80% person' was similarly articulated by both Sarah (10.1) and Brian (8.5). However, the idea of being somehow incomplete resonated with the theme of *good enough* identified in the data from all participants. This sense of being less-than-whole was associated with how participants felt others may perceive them in light of expectations that are normalised within the medical culture. This sense also appeared to represent how they perceived themselves, often in relation to their sense of doctor-self. The concept of not being *good enough*, which was identified in the data from all participants, illustrates an internalisation of judgements and perceptions of others or self against perceived expectations. Narrative from participants describes this with reference to current clinical practice, such as how supervisors or peers may perceive them, as well as historically, such as how teachers or parents appeared to

judge them. The historical sense of not being *good enough* appears to be caused by a psychological *overhang* from experiencing difficulties, feeling or being marked as different, and from expectation-referenced judgements. As a result, participant narratives were strewn with negative self-talk, drawing on labels such as idiot, stupid, lazy or waste of space and applying it to their sense of contemporary self-as-doctor. The relationship between being good as a person, and good as a doctor is complex. Reflections in participant data would suggest that negative feedback on their training and work as a doctor interacts with previously experienced adversity to confirm internalised notions of not being good enough as a person, reinforcing the idea that the doctor-self is proximal, permeable and influential to global self-concept and self-worth.

When considering the model of self-concept illustrated above (figure 16.1), the doctor-self-concept transcends the lower-hierarchy domains, and approaches the global-self. As such, it can be considered more 'core' with the power to more directly influence global sense of self, which includes self-efficacy and self-esteem (Riddick, 2010). When a self-threat, such as negative feedback in the form of exam failure as a doctor, attacks an element of self that is distal to the doctor-self-concept, there is a resultant insult to the higher-level concept that threatens the global self-concept, and can impact on self-esteem too. It appears that a mechanism of partitioning may quarantine this threat, thus minimising the impact on higher level self-concepts constructs. Feedback suggesting someone is bad at a particular skill or knowledge-domain has the potential to threaten his or her higher-order sense of doctor-self-concept. Because of the way the doctor-self-concept appears to develop as a core part of self-identity, threats that impact on this higher-order concept appear to threaten global self-concept. In short, if someone perceives that they are considered to not be a good enough doctor, this is internalised as they are not a good enough person. Fortunately, research on damage to self-concept and self-esteem in children and adolescents gives hope, suggesting that negative changes in self-concept and self-esteem may be amenable to remediation and internal coping strategies (Riddick, 2010; Armstrong & Humphrey, 2009; Lawrence, 2006).

16.5. Research questions 4 and 5: Coping and Strategies

When embarking upon this project, I had envisioned the discovery of a pattern of successful strategies that doctors with dyslexia employed to help them cope with their dyslexia-related difficulties in the clinical workplace. This was a naïve hope, reflecting an as yet un-matured understanding of both dyslexia and of the research process. Along the doctoral journey, and through engaging with the participants and their data, the complexity of difficulties faced, and the notion of coping became apparent. Therefore, the two research questions, below, will be addressed under the combined heading of coping and strategies:

Research Question4:

How do trainee doctors with dyslexia cope with their learning difficulties?

Research Question 5:

What learning strategies do junior doctors with dyslexia develop and use in their training?

A variety of different strategies to protect against self-threat were identified in the analysis of data from the participants in this project. *Partitioning* in relation self-concept has already been explored above (16.3.3). Other themes related to coping that was identified in the data, common to all of the participants, was the sense of forgiveness (conferred by label of dyslexia), perseverance (in the face of perceived injustice and hardship), and how this related to coping.

16.5.1. Forgiveness and self-compassion

The process of diagnosis with, and subsequent label of dyslexia is imbued with power. The participants in this study described a process of retrospective sense-making, that explained and re-contextualised their experience of difficulties. Where they had felt they were perceived as being stupid or lazy, they were able to reframe this as experiencing dyslexia. The diagnostic label carries legitimacy, but also the ability to reattribute: in reframing, the outcome (poor or slow performance) is no longer internal or personal, but external and depersonalised. It is the dyslexia that now serves as the locus of attribution. This re-contextualised understanding affords the ability to, at least

partially, retrospectively forgive themselves. However, this effect does not appear to have been strong enough to overcome the psychological *overhang* that was evident in many of the participants' narratives. Additionally, analysis of the language used by participants in relation to this retrospective attribution and forgiveness suggested a hesitancy and tentativeness. The uncertainty implied by this may reflect a lack of confidence in identifying whether a difficulty was, indeed, due to their dyslexia, or may represent an unconsciously hesitant and apologetic approach to re-attributing, reframing and forgiving.

The dyslexia label also had the power to forgive in another sense, thus affording a second chance. Both Zayn (5.2) and John (14.2) described in detail how they faced failure, but knowing they had dyslexia somehow enabled them to persist in their efforts, instead of giving up. In the instances this was identified in the participants' narrative, this had significant implications in maintaining a training, and career, trajectory where they would have otherwise have left in order to protect their self. I alluded to the relationship between negative feedback (e.g. exam failure) and a threat to both self-concept and self-esteem. Persistent negative feedback, especially exemplified in John's case, can be both threatening and damaging to the self. The power of the label of dyslexia to confer a sense of forgiveness, allows for an acceptance of this failure, and persistent engagement in the failed activity. The revised theory of learned helplessness would suggest that repeated failure, when attributed to a stable external locus of control, would leave to a giving up reaction (Abrahamson, Seligman & Teasdale, 1978). Where the label of dyslexia is used in a forgiving or explanatory capacity, it appears to function as an external, or at least away-from-self, locus. However, use in this way appears to confer the ability to counter a giving up reaction, in fact spurring them on. This may be due to the modifying effects of partitioning, so that the trait remains embodied, but quarantined from the core or higher-order self-concepts.

Analysis of the participants' data suggests that there is a tension between using the dyslexic label as a means of forgiving oneself, and using it as an 'excuse'. The notion of the label functioning as an excuse appears to be associated with fear of how others may perceive the specific action of using the label at that time from those within as well as outside of the dyslexic community. It was in the analysis of Liz's data that the codification of the use of the label was most clearly identified. In one example, she

described how seeing a colleague attribute his job-related difficulties to dyslexia caused her to feel angry, implying a transgression of unspoken conventions within the community (9.1).

Although the theories relating to self-protection and self-enhancement (Sedikides, 2012) explored thus far would suggest that humans may hold more concern for themselves over others, this does not appear to hold to be universally the case both in the wider psychological literature, nor in the analysis of data from this project. Kristen Neff advances that 'common experience suggests people are much harder and unkind towards themselves than they ever would be to others they cared about, or even to strangers' (2003; p.87). Self-compassion theory builds on positive and clinical psychology, and advances the importance of compassion to self when suffering occurs, regardless of whether the cause is outside or within the individual's control (Gilbert, 1989; Neff, 2011). Compassion involves an awareness of suffering and pain, and resisting self-protective strategies to disengage and distance from this suffering (Neff, 2003). Self-compassion is considered to consist of the interaction between:

- **Kindness:** Extending a non-judgemental and understanding kindness to oneself, and resisting harsh judgement and criticism.
- **Humanity:** Feelings of common humanity, and seeing one's experiences as part of a shared human experience, rather than something that marks out difference and defect.
- **Mindfulness:** The balanced awareness and acceptance of mindfulness, and resisting the tendency to over-identify with painful thoughts and feelings.

(Neff, 2011 & 2003; Gilbert, 2009)

Self-compassion is negatively associated with 'performance-avoidance' goals, which are associated with 'ability attributions' and evaluative social comparisons as a means of defending or enhancing self-worth (Neff et al., 2005: p266). Conversely, self-compassionate learners tend to be motivated by curiosity and a desire to develop and master skills, making 'effort attributions' and viewing mistakes as integral to the learning process (*ibid.*). The analysis of data from the participants in this study identified recurring examples of within-group social comparisons. Self-worth is intrinsically related to self-esteem and self-concept (Neff, 2011). In the discussion above, self-

concept has been shown to be related to the intermediary doctor-self-concept, which is vulnerable to negative feedback. Therefore, it seems that the doctors with dyslexia involved in this study are habitually tuned to the performance-avoidance orientation that is associated with poor self-compassion. This appears to reflect factors that are shared within the culture of medicine, rather than unique to these dyslexic doctors specifically. There is hope, however, as encouraging learners to adapt to a more positive, and self-compassionate, style of attribution and coping with failure may be amenable to brief psychological interventions (Smeets et al., 2014). Research on younger learners would suggest that forgiveness and self-compassion in experiences shared by and illustrated in the data from these dyslexic doctors is likely to have a significant role in well-being and mental health (Riddick, 2010; Burden, 2005).

16.5.2. Risk management

Working and training in medicine is fraught with risk to both the patients cared for by the system, and those working and training within it (Lupton, 2013). The fear that the dyslexia-related difficulties that the doctors involved in this study experience would somehow pose a risk to their patients was evident throughout their narratives. Where potential for error was discussed, it was described in apologetic terms, couched by the caveats of caution and safety-netting. The term safety-netting is used commonly in medicine, and general practice in particular, to refer to mechanisms by which we account for and mitigate diagnostic uncertainty (Almond, Mant & Thompson, 2009). I use the term here to allude to strategies that participants described, not to mitigate uncertainty or error in diagnosis, but to mitigate the risk of a perceived difficulty manifesting as an error through their clinical work. The common strategy employed relied on a system of re-checking. This applied to receiving, giving and recording information. These strategies often required the investment of, what was perceived to be, significant additional time and effort and were perceived as effective. Employing such strategies, however, is contingent on a degree of self-awareness of patterns of difficulty, and an element of self-doubt that provides an opposing force counteracting over-confidence and complacency. This appears to be different from the perfectionism and extreme conscientiousness that is perceived as a common trait in the medical profession (Peters & King, 2012). Perfectionism and conscientiousness are driven by a motivation to attain a high standard. This trait is often associated with feelings of

inadequacy, but this is not the same as the self-doubt that characterises the safety-netting behaviours illustrated in the data from the participants in this study.

A different conceptualisation of risk was identified in the data: that posed by the processes of diagnosis or disclosure to the individuals. The diagnostic process was almost uniformly approached with apprehension that it would not find them to have dyslexia, thus confirming the negative judgements they had sustained throughout their development. This is a fear I can very readily identify with, having gone through a process of reassessment in recent years. The process of disclosure was associated with the risk of stigma and prejudice, but also with another risk constructed through the codification of the use of the label. There is implied associated judgement if a diagnosis is disclosed in a way that contravenes the implicit conventions of the community of dyslexic doctors. Each disclosure decision involves a calculation of risk of a potential loss, versus the potential benefit from disclosure, and is believed to be particularly challenging for adults in the workplace (Gerber & Price, 2012). It appeared no less challenging a decision to negotiate for the participants of this study, with the added fear of implications for their professional image and training progression. The reframing identified in the analysis of this data supports the reframing strategies identified elsewhere, which 'allows for one to identify strengths and parlay them into success experiences, while still being aware of weaknesses that have to be mitigated or bypassed' (Gerber, Reiff & Ginsberg, 1996: p98, quoted in Gerber & Price, 2012; p144).

Both of the conceptualisations of risk from the data analysis explored hereto share a common fear of the system: a fear that the interaction between their difficulties and the system in which they work, evident in the discourse construing workload and distractions as factors that may overwhelm their coping strategies; and a fear that the system will in fact become less accommodating and accepting of them should they disclose their dyslexia, rather than responding with the support and nurturance that they arguably need. Risk in this sense is individual-focussed, which neglects the wider system factors that contribute to the experience of difficulty and error in clinical work. By encouraging an educational approach towards risk management in a social model perspective of difficulty, the focus may be shifted from the individual to the system and the support offered by and within it (Walker et al., 2013; Shrewsbury et al., 2018).

16.6. Summary

There is a growing awareness of doctors with SpLD training and working in the medical profession, and a developing appreciation for the job-related task-specific challenges they may face (Shrewsbury, 2016; Newlands et al., 2015; Locke et al., 2016). This work has demonstrated the potential for doctors with dyslexia to experience an undermined sense of professional group membership that may influence both their professional identity development, and the way they engage with their team and wider community of practice in medicine and medical training.

The way in which these learners perceived feedback construed failure as brutal and potentially damaging. There was clear evidence of psychological distress that remained as an overhang from developmental learning experiences, which has the potential to frame on-going learning and feedback. This interacted with an element of their self-concepts that constructed a threat to their very sense of self. Drawing on the elements discussed: a shared sense of chaos, the impact of feedback on sense of self, and the nature of group membership, it behoves us to more carefully consider the holistic wellbeing of learners in medicine who experience difficulties like dyslexia. It is likely that these factors interact to undermine their access to psychological resources, such as self-efficacy and social support, and put them at greater risk of isolation and burnout, in a group that is already considered at greater risk of these phenomena compared to the general population (Brooks, Gerada & Chalder, 2011). Practitioners in the field of dyslexia support an individual counselling approach (Lawrence, 2006) and this may be compatible with offering brief interventions targeted at developing self-compassion in learners (Smeets et al., 2014; Neff, 2011b).

16.7. Validity, rigour, trustworthiness and limitations

It is suggested that qualitative and interpretative work needs a strong case to illustrate the rigour and trustworthiness of the findings, in order to stand up to scrutiny from the wider community (Finlay, 2011). It is important to reiterate the nature and aims of the work reported in this thesis: the project aimed to develop a deep understanding of the experience of a very specific phenomenon, with the hope of inspiring ways of thinking

about how medical education supports and includes, or not, doctors with dyslexia. The intention was not to measure or compare, not to test or generalise or assert claims of proof. Therefore, whilst it may be tempting to suggest a weakness of this study is the lack of comparison with non-dyslexic doctors, it is important to recall that this was not the aim. Nor is this comparative approach aligned to the philosophical perspectives that underpin this work, which value the voice and representation of the individual lived experience. All work of an interpretive nature is inherently limited by the myriad factors that influence the perspective and abilities of the interpreter undertaking the analysis, and also the audience interpreting the report of the work (Smith, Flowers & Larkin, 2009). However, these same factors have the potential to add value, and advance unique understandings. It could be argued that quantitative work is just as susceptible to differential interpretation and bias, as is often played out in the political and medical spheres (Limb, 2012; Thiese, Arnold & Walker, 2013, Harford, 2016).

Finlay states that 'good phenomenological research evokes the lived world' (2011: p261). It is my hope that though presenting each participant's case study as a lucid narrative, as well as through discussing the re-interpretation of the data analysis in light of related psychological theories in a coherent manner, I have showcased an accessible and vivid account of the relationship with the lived world of these doctors.

Phenomenological research is considered to suffer epistemological limitations by virtue of predicating access to the lived world through language (Willig, 2013). This access therefore presumes an ability for participants to accurately articulate their lived experience. In accessing their reality this way, we are in essence accessing their interpretation. IPA specifically acknowledges this, and, contrary to other forms of phenomenological inquiry, aims to access the meaning-making processes that inform participant interpretations (Smith, 1996; Smith, Flowers & Larkin, 2009). In order to clearly demonstrate credibility, transferability, and dependability of qualitative research, criteria have been developed and, largely, agreed as outlined in chapter 3. How these have been met are outlined in table 16.2.

Table 16.2

Sensitivity to context

Context of the field: a wide range of theory and literature, outlined in both chapter 2 and chapter 16, has been accessed in situating this research in a unique niche.

Participants themselves: I demonstrate this by reflexively situating myself as an insider, and by observing a compassionate and authentic curiosity throughout the interview, and data analysis and reporting processes.

Ethical considerations: demonstrated through the nuanced ethical considerations to work of this manner, in this field, complemented by my reflexive deliberations in section 15.5

Commitment and rigour

Prolonged engagement with the topic: beyond the fact that this doctoral journey has been sustained over a 6 year period, I reflect on how I specifically sought to further my understanding and knowledge of both dyslexia (1.1) and conducting research in the field (chapter 3). The data, forming part of the topic, has also suffered my sustained engagement, and I reflexively describe how I approached it and, at times, took a step back to gain perspective in section 3.7.

Development of methodological competence: as well as attending a variety of practical training workshops in IPA and complementary methodologies, I have demonstrably accessed a wide range of literature to inform and defend my choice of approach. In addition to this, I have demonstrated a level of competence sufficient to enable me to make coherent and aligned methodological contributions.

Immersion in the data: I provide a reflexive account of the process in which I engaged with the data from participants, and then showcase a depth and persistence to the immersion with the data through the nuanced analyses presented in the case studies.

Completeness of the data and their analysis: completeness of data was limited primarily by the extent to which each participant contributed. However, the richness of the data that was contributed, combined with the number of participants in the study furnished the project with a rich dataset that enabled an in-depth, comprehensive analysis.

Groundedness and interpretation that addresses variation and complexity observed: In my analysis, I showcase how the language I draw upon is grounded in the participants' data, and how the interpretation of this is both interpreted in light of that participant as a whole, as well as part of the community of the ten doctors who participated in this study.

Transparency and coherence

Clarity and persuasiveness: by presenting the analysis in a way that builds on the exploration of each case-study, I have provided a coherent narrative that synthesises the contributions of this data, on an individual and group level, to the field and wider theoretical literature.

Accessibility of reporting of the project: I have combined a narrative to reporting and synthesising the analysis of this project with an exploration of the field of medical education and dyslexia, contextualised by my unique experience affording me insider status.
Additionally, I have taken care to avoid specialist jargon, and explicitly delineate the meanings of terminology and theory used, as well as grounding my choice of words in the analysis of participants' data.

Interest, impact and importance
Interest: this is arguably subjective, but it is my hope that I have presented a compelling and interesting account of the experience of dyslexia by the doctors involved in this study, as well as drawing out interesting ways in which the wider community can now think about dyslexia in medical education, and address the challenges faced by this group of learners. *Usefulness: the unique contributions of this project to the understanding of professional identity formation, group membership and self-threat interpretation and management offers an important* *Impact: the potential for this work to impact on practice in medical education, and in work with adults who experience dyslexia, hinges on the contributions to our understanding of professional identity formation and group membership. The analysis of the data hints at a need to more carefully consider the holistic wellbeing of learners who experience difficulties, and the discussion draws links to wider psychological theories that may offer means of supporting them.*
Independent Audit
A sample of my analysis of data from this project underwent a form of audit, whereby a member of my early supervisory team (JS) independently analysed transcripts from a participant, which then fed into a discussion between both supervisors (BN and JS) and myself at the time. The analysis and narrative construction of a coherent interpretation was reviewed at several points in supervisory meetings (BN and KM), with notes and discussions refining the reporting. *Additionally, the groundedness of the analysis is demonstrated by the extensive use of excerpts and references back to the participants' data. This is also openly shared in the appendices of this thesis, providing an opportunity for further scrutiny and audit of the analysis.*

Table 16.2: table outlining the qualities that demonstrate the research reported in this thesis meet accepted criteria for validity, rigour and trustworthiness.

When considering the limitations and strengths specific to this project, the number of participants and their level of engagement operates in both a negative and mitigating way: for IPA, 10 participants would conventionally be considered over-ambitious (Smith, Flowers & Larkin, 2009). However, when considering the variable, but largely poor rate of sustained involvement through each phase of the project from each participant, the larger sample enabled collection of a sufficient amount of data to facilitate a rich analysis of a complex issue from various perspectives. These participants were self-selected, which is likely to have had some impact on the nature of the story they had to tell, but was also potentially an enabling factor in terms of their motivation to participate. Another limitation of this study was the strict adherence to one methodology. Triangulation with complementary forms of enquiry may have enabled a more comprehensive and generalisable analysis. However, the inherent limitations of the timeframe and scale of an individual doctoral project bare

acknowledging, and the findings from projects such as this have the potential to serve as a foundation for further work that will augment, triangulate, extend and further elucidate the issues central to the line of inquiry.

16.8. Contribution to knowledge

The project outlined and reported in this thesis offers several unique contributions to the fields of medical education, educational psychology and qualitative psychological methodology. This thesis offers an updated review of current literature relating to doctors with dyslexia, contextualised uniquely within a nuanced discussion of the complexity of the dyslexia concept. The use of IPA in medical education research remains fairly novel, with only one other example of work drawing on this methodology (Patel et al., 2015). The lived experience of learners with dyslexia has been explored from a phenomenological perspective by a number of researchers (Tincher, 2005; Tanner, 2010; Philpott, 1998). However, the in-depth psychological exploration of meaning from these experiences, drawing on IPA specifically, is new to the field of dyslexia research.

In this project, I combined the self-characterisation sketch (Kelly, 1955a; Deniloco, 2005) as a tool to collect data within IPA drawing on personal construct theory (Kelly, 1955a). The link between personal construct theory and phenomenology and IPA specifically is established by scholars from both fields (Butt, 2003 & 2005; Smith, 1996). However, the use of this particular approach as a visual elicitation method was particularly novel and proved to be incredibly effective. A personal reflection on the use of this method, however, would add slight caution. The SCS is a powerful tool, enabling participants to access deep ideas of meaning and self-construal. Undertaking an SCS exercise has the potential to touch on intimate, and potentially painful aspects of self that may elicit strong emotional responses. The SCS becomes informative to the research process and the participant, and in so doing has the potential to be cathartic and therapeutic. This is not overly surprising given the psychotherapeutic origins of this

technique (Kelly, 1955b). At times, the tension between the inquisitive and therapeutic may test the boundaries between skilled researcher, and caring professional.

The incorporation of methods from personal construct theory into IPA can be found from the earliest examples of this phenomenological approach (Smith, 1998 & 1999). However, the specific use of the self-characterisation sketch exercise is novel, and extends the use of visual methods within phenomenological work in general (Silver, 2013). The analysis of data from this project offers a unique insight into the way that doctors construe their personal and professional identity. The notion of a continuously developing self-concept, to incorporate the higher-level professional identity construct extends the understanding in the field of medical education. This construct provides a means of understanding how feedback may be perceived as a self-threat, and why this may interact with professional identity formation, team working and engagement with continued professional development, as well as highlighting areas of need in learner support. This work makes original links to concepts in wider psychological literature and practice that offer opportunities to explore how dyslexic learners in medicine may be better supported.

16.9. Opportunities for further work

Research of this kind is exploratory in nature, and has focused a spotlight on the lived experience of a specific group of people. To understand what elements of these experiences are shared with medical learners in other groups, it may be helpful to target a programme of comparative inquiry. Empirical work in psychology has explored the nature, structure, and organisation of self-concept in children and adolescents. The understanding of the continued development of self-concepts in adult learners in professional contexts may benefit from further study, drawing on similar methodologies.

The most pressing opportunity, however, is that which relates to how the impact of the factors mentioned in this discussion (undermined sense of group belonging, and the perception of self-threat) on learners': experience and assimilation of feedback; access and use of psychological resources; and how these may affect their engagement with

their wider team. This has implications for both their perseverance in the learning context, but also for the functioning of a safe and supportive team in the clinical context. Both have the potential to affect patient care, but the latter more directly so. Building on this, there is scope to explore strategies around self-compassion that may mitigate the impact that psychological overhang appears to have on the way dyslexic doctors interpret feedback, failure and how this contributes to their professional identity formation.

16.10. Conclusion

In drawing this thesis, and doctoral journey, to a conclusion, I would like to reflect on a number of changes. Firstly, my understanding of the complex concept of dyslexia and other SpLD has evolved, as has my appreciation for different approaches to scientific inquiry. Notions of finding a common pattern of difficulties and successful strategies, with the hope of informing an educational intervention, that guided earlier stages of the development of this project, were laudable but naïve. What has emerged from this project, however, is a greater focus on an under-represented issue in education generally, and medical education in particular: the emotionality of learning, and the role that past and present experiences of adversity play on identity development and group membership.

Doctors with dyslexia face challenges throughout their medical school and postgraduate professional training. It is recognised that SpLD may influence task-specific difficulties, dyslexia appears to impact on identity formation and group membership negotiation too. Where dyslexic doctors feel like a 'black sheep' within their medical flock, they may perceive feedback more harshly, and may encounter psychological barriers to engaging with their wider team. This has implications for the way in which doctors direct their efforts in continued professional development, as well as the way in which they access psychological resources to maintain this trajectory, maintain their wellbeing, and maintain their high standards of practice. It would behove the medical education community to consider questions relating to group formation and identity within the community of practice, and questions relating to our

systems of feedback and failure. This has implications for processes around transition and induction, as well as practices around progress (e.g. ARCP). For example: What is it that our failure practices achieve; how do they achieve it; and how this can be reconceptualised to maximise the outcome for both patients and learners?

Considering the prevalence of perfectionism and neuroticism in the profession, it is likely that all learners in medicine would benefit from a greater attention to self-compassion in the process of personal and professional development. However, this project evidences a need for the role that brief interventions targeted at developing self-compassion has for professionals with dyslexia to be further explored. A programme of work to continue the investigation into this field might consider drawing on a variety of different approaches, taking inspiration from and extending the empirical work of Marsh and colleagues (Marsh & Shavelson, 1985; Marsh, 1990) in order to clarify the nature of self-concept structure, organisation and development in doctors. This would be a necessary step in furthering our understanding of self-threat and self-protection. It would appear that self-compassion theory offers a glimmer of hope that may address issues that damage self-concept. Replicating the work of Smeets et al*.,* (2014), which developed individuals' self-compassion, in the context of medical education would be worthwhile. However, it is likely that, given the dynamic and interdependent way in which we work in medicine, an approach adapted to affect change at a community or culture-level may hold the key to supporting learners experiencing an undermined sense of membership, or threatened sense of self.

References:

Abrahamson LY, Seligman MEP, Teasdale JD. (1978) Learned helplessness in humans: critique and reformulation. *Journal of Abnormal Psychology*, 87(1): 49-74.

Academy of Medical Educators. (2014) *Professional standards for medical, dental, and veterinary educators*, *3rd edition*. Cardiff: Academy of Medical Educators.

Alexander-Passe N. (2006) How dyslexic teenagers cope: an investigation of self-esteem, coping and depression. *Dyslexia,* 12(4): 256-275.

Almond S, Mand D, and Thompson M. (2009) Diagnostic safety-netting. *British Journal of General Practice*, 59(568): 872-874.

Alster EH. (1997) The effects of extended time on algebra test scores for college students with and without learning disabilities. *Journal of Learning Disabilities*, 30: 222-227.

American Psychiatric Association. (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA: American Psychiatric Publishing.

Ammer C. (2003) *The American Heritage Dictionary of Idioms*. Boston, MA: Houghton Mifflin Harcourt.

Armstrong D and Humphrey N. (2009) Reacting to diagnosis of dyslexia among students entering FE: development of the resistance-accommodation model. *British Journal of Special Education,* 36(2): 95-102.

Ashworth P. (2015) 'Conceptual foundations of qualitative psychology' in JA Smith, ed., *Qualitative psychology: a practical guide to research methods.* 3rd edition. London: Sage.

Association of Dyslexia Specialists in Higher Education. (2011) *Good practice guidelines*: Guidance for good practice: reasonable adjustments. Accessed on 01/07/2012 via: http://adshe.org.uk/resources/resources/good-practice/

Badley G. (2003) The crisis in educational research: a pragmatic approach. European Educational Research Journal; 2: 296-308

Bandura A. (1997) *Self-efficacy: the exercise of control*. New York, NY: Longman.

Bennett C. (2008) I'd prefer to have a doctor who can tell left from right. *The Guardian*, Sunday 3rd August. Accessed on 22/12/2017 via: https://www.theguardian.com/commentisfree/2008/aug/03/equality.highereducation

Bennett CM, Baird AA, Miller MB, Wolford GL. (209) Neural correlates of interspecies perspective taking in the post-mortem Atlantic Salmon: an argument for multiple comparison correlation. *15th Annual Meeting of the Organisation for Human Brain Mapping.* San Fransisco, CA. Accessed on 18/12/2017 via: http://users.stat.umn.edu/~corbett/classes/5303/Bennett-Salmon-2009.pdf

Benner P. (1994) *Interpretive phenomenology: embodiment, caring, and ethics in health and illness.* London: Sage.

Berlin R. (1887) Eine besondere art von wortblindheit (Dyslexie). Monograph. Weisbaden: J. F. Bergmann Publisher. Accessed on 12/1/2017 via: http://gdz.sub.uni-goettingen.de/dms/load/img/?PPN=PPN513409602&IDDOC=294878

Berrios GE. (1989) What is phenomenology? A review. *Journal of the Royal Society of Medicine*, 82: 425-428.

Blummer H. (1969) *Symbolic interactionism: perspectives and method*. Englewood Cliffs, NJ: Prentice-Hall.

Bourdieu P. (1990) *The logic of practice*. Cambridge: Polity.

Braun V and Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2): 77-101.

Breakwell G. (1986) *Coping with threatened identities*. London: Methuen & Co. Ltd.

British Dyslexia Association (BDA). (2009) *Dyslexia research information: What is dyslexia?* Accessed on 15/12/2017 via: http://www.bdadyslexia.org.uk/about-dyslexia/further-information/dyslexia-research-information-.html

British Dyslexia Association. (2012) *Dyslexic: definitions*. Accessed on 7/1/2017 via: http://www.bdadyslexia.org.uk/dyslexic/definitions

British Dyslexia Association. (2017) *Dyslexia and specific learning difficulties in adults*. Accessed on 7/1/2017 via: http://www.bdadyslexia.org.uk/dyslexic/dyslexia-and-specific-learning-difficulties-in-adults

British Medical Association. (2012) Medical training pathway. Accessed on 7/1/2017 via: https://www.bma.org.uk/advice/career/studying-medicine/insiders-guide-to-medical-specialties/medical-training-pathway

British Psychological Society: Division of Educational and Child Psychology. (1999) *Dyslexia, literacy and psychological assessment.* Leicester: British Psychological Society.

Brooks SK, Gerada C, and Chalder T. (2011) Review of literature on mental health of doctors: are specialist services needed? *Journal of Mental Health*, 20(2): 146-156.

Brookfield SD. (2009) *The skillful teacher: on technique, trust, and responsiveness in the classroom*. 2nd edition. Chichester: John Wiley & Sons.

Brown B. (2010) *The gifts of imperfection: let go of who you think you're supposed to be and embrace who you are.* Centre City, MN: Hazelden Publishing.

Burden R. (2005) *Dyslexia and self-concept: seeking a dyslexic identity.* London: Whurr Publications.

Burden R. (2008a) 'Dyslexia and self-concept: a review of past research with implications for future action'. In Reid G, Fawcett AJ, Manis F, and Siegel LS. *The Sage handbook of dyslexia.* London: Sage.

Burden R. (2008b) Is dyslexia necessarily associated with negative feelings of self-worth? A review and implications for future research. *Dyslexia*, 14(3): 1880196.

Butt T. (2003) 'The phenomenological context of personal construct psychology' in Fransella F, ed., *International handbook of personal construct psychology*. Oxford: John Wiley & Sons Ltd.

Butt T. (2005) Personal construct theory, phenomenology and pragmatism. *History and Philosophy of Psychology,* 7(1): 23-35.

Butterfield LD, Borgen Wa, Amundson NE, and Maglio A-ST. (2005) Fifty years of the critical incident technique: 1954-2004 and beyond. *Qualitative Research*, 5(4): 475-497.

Camber R. (2007) Dyslexia 'is just a middle-class way to hide stupidity'. Mail Online, 28th May 2007. Accessed on 17/12/2017 via: http://www.dailymail.co.uk/news/article-458160/Dyslexia-just-middle-class-way-hide-stupidity.html

Carroll JM and Iles JE. (2006) An assessment of anxiety levels in dyslexic students in higher education. *British Journal of Educational Psychology*, 76(3): 651-662.

Chapman J. (1988) Learning disabled children's self-concepts. *Review of Educational Research*, 58(3): 347-371.

Clark A, and Morriss L. (2017) The use of visual methodologies in social work research over the last decade: a narrative review and some questions for the future. *Qualitative Social Work*, 16(1): 29-43.

Cohen L, Manion L, Morrison K and Morrison KRB. (2007) *Research methods in education.* 6th Edition*.* Hove: Psychology Press.

Cottrell D, Kilminster S, Jolly B and Grant J. (2002) What is effective supervision and how does it happen? A critical incident study. *Medical Education*, 36: 1042-1049.

Crotty M. (1998) *The foundations of social research: meaning and perspectives in the research process.* London: Sage.

Deci EL and Ryan RM. (1985*) Intrinsic motivation and self-determination in human behaviour.* New York: Plenum Press.

Deniloco P, and Pope M. (2001) *Transformative professional practice: personal construct approaches to educational research*. London: Whurr Publishers.

Deniloco P. (2005) 'A range of elicitation methods to suit client and purpose' in F Fransella (ed) *The essential practitioner's handbook of personal construct* psychology. Chichester: John Wiley & Sons.

Döhla D and Heim S. (2016) Developmental dyslexia and dysgraphia: what can we learn from the one about the other? *Frontiers in Psychology*, 6: 2045.

Downing SM. (2003) Validity: on the meaningful interpretation of assessment data. *Medical Education*, 37: 830-837.

Downing SM. (2004) Reliability: on the reproducibility of assessment data. *Medical Education*, 38: 1006-1012.

Dunn WR, and Hamilton DD. (1986) The critical incident technique: a brief guide. *Medical Teacher,* 8(3): 207-215.

Earle S and Sharp K. (2000) Disability and assessment in the UK: should we compensate disabled students? *Teaching in Higher Education*, 5: 541-545.

Earle S, Adams M and French D. (1999) A national survey of assessment practices in higher education: special provisions for students with disabilities and learning difficulties. *The Skill Journal*, 65: 22-24.

Edwards J. (1994) *The scars of dyslexia: eight case studies in emotional reactions*. London: Casell.

Elliott JG and Gibbs S. (2008) Does dyslexia exists? *Journal of Philosophy of Education*, 42(3-4): 475-491.

Elliott JG and Grigorenko EL. (2014) *The dyslexia debate*. Cambridge: Cambridge University Press.

Elliott SN and Marquart AM. (2004) Extended time as a testing accommodation: its effect and perceived consequences. *Exceptional Children*, 70: 349-367.

Epstine RM. (2007) Assessment in medical education. *New England Journal of Medicine*, 356: 387-396.

Equality Act. (2010) London: HMSO.

Evans D and Dowling S. (2002) Developing a multi-disciplinary public health specialist workforce: training implications of current UK policy. *Journal of Epidemiology and Community Health*, 56(10): 744-747

Ezzy D. (2002) *Qualitative analysis: practice and innovation*. Abingdon: Routledge.

Finlay L. (2011) *Phenomenology for therapists: researching the lived world*. Chichester: Wiley-Blackwell.

First MB, Reed GM, Hyman S, and Saxena S. (2015) The development of the ICD-11 clinical descriptions and diagnostic guidelines for mental and behavioural disorders. *World Psychiatry*, 14(1): 82-90.

Firth-Cozens J. (2001) Cultures for improving patient safety through learning: the role of teamwork. *Quality in Health Care*, 10(II): ii26-ii31.

Flannagan JC. (1954) The critical incident technique. *Psychological Bulletin* 51(4): 327-358.

Frank-Josephson C, and Scott JU. (1997) Accommodating medical students with learning disabilities. *Academic Medicine*, 72(12): 1032-1033.

Fransella F. (2003) 'Some skills and tools for personal construct practitioners' in F Fransella (ed.) *International handbook of personal construct psychology*. London: Wiley.

Fredrick C. (2015) Research design and evidence (diagram). *Wikimedia Commons*. Accessed on 27/02/2017 via: https://commons.wikimedia.org/wiki/File:Research_design_and_evidence.svg

Frith U. (1999) Paradoxes in the definition of dyslexia. *Dyslexia*, 5: 192-214.

Galaburda AM, Sherman GF, Rosen GD, Aboiz F and Gesschwind N. (1985) Developmental dyslexia: four consecutive cases with cortical anomalies. *Annals of Neurology*, 18: 222-233.

Galvin KT, and Todres L. (2011) Kinds of well-being: A conceptual framework that provides direction for caring. *International Journal of Qualitative Studies in Health and Well-being.* 6: 10362.

Galvin K, and Todres L. (2013) *Caring and Well-being: a lifeworld approach*. Abingdon: Routledge.

Gammell C. (2008) Dyslexic student challenges multiple choice exams. *The Telegraph*, 29th July 2008. Accessed on 01/01/2018 via: http://www.telegraph.co.uk/news/uknews/2471455/Dyslexic-student-challenges-multiple-choice-exams.html

General Medical Council. (2010) '*Gateways to the professions – Advising medical schools: encouraging disabled students'*. London: General Medical Council. Accessed on 15/07/2012 via: http://www.gmc-uk.org/education/undergraduate/gateways_guidance.asp

General Medical Council. (2013) *The good medical practice framework for appraisal and revalidation*. Manchester: GMC UK. Accessed on 7/1/2017 via: http://www.gmc-uk.org/static/documents/content/The_Good_medical_practice_framework_for_appraisal_and_revalidation_-_DC5707.pdf

Gerber PJ, and Price L. (2012) 'Self-disclosure in adults with learning disabilities and dyslexia: complexities and considerations' in Brunswick N (ed) *Supporting dyslexic adults in higher education and the workplace*. Chichester: Wiley-Blackwell.

Gerber PJ, Reiff HB, and Ginsberg R. (1996) Reframing the learning disabilities experience. *Journal of Learning Disabilities*, 29: 98-101.

Gibbs T, Brigden D and Hellenberg D. (2006) Assessment and evaluation in medical education. *South African Family Practice*, 48(1): 5-7.

Gibson S and Leinster S. (2011) How do students with dyslexia perform in extended matching questions, short answer questions, and objective structured clinical examinations? *Advances in Health Science Education*, 16(3): 395-404.

Gilbert P. (1989) *Human nature and suffering*. Hove: Lawrence Erlbaum.

Gilbert P. (2009) *The compassionate mind*. London: Constable.

Ginsberg E. (1996) *Passing and the fictions of identity*. Durham, NC: Duke University Press.

Goffman E. (1963) *Stigma: notes on the management of spoiled identity*. New York, NY: Penguin Books.

Goswami U. (2008) Reading, dyslexia and the brain. *Educational Research*, 50(2): 135-148.

Greenhalgh T. (2014) *How to read a paper: the basics o evidence-based medicine.* Oxford: John Wiley & Sons.

Guyatt G, Sackett DL, Sinclair JC, Hayward R, Cook DJ, and Cook RJ. (1995) Users' guides to the medical literature: IX a method for grading health care recommendations. *JAMA*, 274(22): 1800-1804.

Guyer BP. (1988) Dyslexic doctors: a resource in need of discovery. *Southern Medical Journal*; 81: 1151- 1154.

Gwernan-Jones R. (2010) *Making sense of dyslexia*. Unpublished PhD thesis, The University of Exeter. Accessed on 3/10/2017 via: https://ore.exeter.ac.uk/repository/bitstream/handle/10036/3308/Gwernan-JonesR.pdf?sequence=2

Gwernan-Jones R. (2012) 'Socio-emotional aspects of dyslexia: we're all in this together'. In Brunswick N (ed). *Supporting dyslexic adults in higher education and the workplace*. Chichester: Wiley-Blackwell.

Hafferty FW and Gibson GG. (2001) Learning disabilities and the meaning of medical education. *Academic Medicine*, 76: 1027-1031.

Halcomb EJ and Davidson PM. (2006) Is verbatim transcription of interview data always necessary? *Applied Nursing Research*, 19: 38-42.

Hammersley M. (2007) The issue of quality in qualitative research*. International Journal of Research and Method in Education*; 30: 287-305.

Harford T. (2016) How politicians poisoned statistics. *Financial Times*, April 14th. Accessed on 01/02/2018 via: https://www.ft.com/content/2e43b3e8-01c7-11e6-ac98-3c15a1aa2e62

Harper D. (2012) 'Choosing a qualitative research method' in Harper D, and Thompson AR, eds., *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. Chichester: John Wilet & Sons, Ltd.

Harré R. (1979) *Social Being.* Oxford: Blackwell.

Harrison AG, Edwards MJ, and Parker KCH. (2011) Identifying students feigning dyslexia: preliminary findings and strategies for detection. *Dyslexia,* 14(3): 228-246.

Harvey B. (1981) Plausibility and the evaluation of knowledge: a case-study of experimental quantum mechanics*. Social Studies of Science*; 11: 95-130.

Hastings R and Remington B. (1993) Connotations of labels for mental handicap and challenging behaviour: a review and research evaluation. *Mental Handicap Research*, 6(3): 237-298.

Higher Education Statistics Agency. (2012) *Bespoke data service*. Accessed November 29, 2012 via: http://www.hesa.ac.uk

Hinshelwood J. (1917) *Congenital word blindness*. London: H. K. Lewis & Co. Ltd. Accessed on 12/1/2017 via: https://archive.org/details/congenitalwordbl00hinsrich

Ho A. (2004) To be labelled, or not to be labelled: that is the question. *British Journal of Learning Disabilities,* 32_ 86-92.

Hogg M. (2012) 'Social identity and the psychology of groups.' In Leary MR and Tangney JP (eds). *Handbook of self and identity, second edition*. New York: Guildford Press.

Hollenbeck K, Tindal G and Almond P. (1998) Teachers' knowledge of accommodations as a validity issue in high-stakes testing. *Journal of Special Education*, 32: 175-183.

Humphrey N and Mullins PM. (2002a) Self-concept and self-esteem in developmental dyslexia. *Journal of Research in Special Educational Needs*, 2(2).

Humphrey N and Mullins PM. (2002b) Personal constructs and attribution for academic success and failure in dyslexia. British Journal of Special Education, 29(4): 196-203.

Ingesson SG. (2007) Growing up with dyslexia: interviews with teenagers and young adults. *School Psychology International*, 28(5): 574-591.

International Dyslexia Association (IDA). (2002) *What is dyslexia?* Accessed on 15/12/2017 via: https://dyslexiaida.org/definition-consensus-project/

International Dyslexia Association. (2017) History of IDA. Accessed on 12/1/2017 via: https://dyslexiaida.org/history-of-the-ida/

Jaarsma P and Welin S. (2011) Autism as a natural human variation: reflections on the claims of the neurodiversity movement. *Health Care Analysis*, 20: 20-30.

Jackson KM, and Trochim WMK. (2002) Concept mapping as an alternative approach for the analysis of open-ended survey responses. *Organisational Research Methods*, 5(4):307-336.

Jackson NE, and Coltheart M. (2001) *Routes to reading success and failure: toward an integrated cognitive psychology of atypical reading*. Hove: Psychology Press.

Jones A and Kindersley K. (2013) *Dyslexia: assessing and reporting – the Patoss guide.* London: Hodder Education.

Julian ER, Ingersoll DJ, Etienne PM and Hilger AE. (2004) The impact of testing accommodations of MCAT scores: descriptive results. *Academic Medicine*, 79: 360-364.

Kelly G. (1955a) *The psychology of personal constructs, volume 1: a theory of personality*. New York: Norton & Company Inc.

Kelly G. (1955b) *The psychology of personal constructs, volume 2: clinical diagnosis and psychotherapy*. New York: Norton & Company Inc.

Krishnan S, Watkins KE, and Bishop DVM. (2016) Neurobiological basis of language learning difficulties. *Trends in Cognitive Sciences*, 20(9): 701-714.

Krohne HW. (2001) 'Stress and coping theories' in Wright JD (ed) *The international encyclopaedia of the social and behavioural sciences*. Amsterdam: Elsevier. Accessed on 17/01/2018 via: http://www.burnout.nl/docs/Krohne-Stress-history-overview.pdf

Landerl K, Wimmer F, and Frith U. (1997) The impact of orthographic consistency on dyslexia: a German-English comparison. *Cognition*, 63: 315-334.

Langdridge D. (2007) *Phenomenological psychology: theory, research and method.* Harlow: Pearson Prentice Hall.

Larkin M and Thompson AR. (2011) 'Interpretative phenomenological analysis in mental health and psychotherapy research' in Harper D and Thompson AR (eds) *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners*. Chichester: Wiley.

Larkin M, Watts S, and Clifton E. (2006) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3: 102-120.

Lauchlan F and Boyle C. (2007) Labels and special education: is the use of labels in special education helpful? *Support for Learning;* 22: 36-42.

Laverty SM. (2003) Hermeneutic phenomenology and phenomenology: a comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3): 21-35.

Lawrence D. (2006) *Enhancing self-esteem in the classroom*, 3rd edition. London: Paul Chapman.

Lewis G. (2002) *The Turkish language reform: a catastrophic success.* Oxford: Oxford University Press.

Limb M. (2012) Misuse of statistics continues to plague healthcare, conference hears. *BMJ,* 334:e1526.

Lincoln YS, and Guba EG (2003) 'Paradigmantic controversies, contradictions and emerging confluences.' in Denzin NK, and Lincoln YS, eds., *The landscape of qualitative research: theories and issues*, 2nd Edition. Thousand Oaks: Sage.

Little D. (1999) Learning disabilities, medical students, and common sense. *Academic Medicine*; 74: 622- 623.

Little D. (2003) Learning differences, medical students, and the law. *Academic Medicine*; 78: 187-188.

Locke R, Scallan S, Mann R, and Alexander G. (2015) Clinicians with dyslexia: a systematic review of effects and strategies. *The Clinical Teacher*, 12: 394-398.

Locke R, Alexander G, Mann R, Kibble S, and Scallan S. (2016) Doctors with dyslexia: strategies and support. *The Clinical Teacher*, 13: 1-5.

Lupton D. (2013) *Risk*. Abingdon: Routledge.

MacDougall M. (2009) Dyscalculia, dyslexia, and medical students' needs for learning and using statistics. *Medical Education Online,* 14(2): 1-8.

Manusov V and Spitzberg B. (2008) 'Attribution theory' in Baxter LA and Braithwaite DO (eds) *Engaging theories in interpersonal communication*. Thousand Oaks, CA: Sage.

Margolis H and McCabe PP. (2006) Improving self-efficacy and motivation: what to do, what to say. *Intervention in School and Clinic*, 41(4):218-227.

Marsh HW. (1986) Self-serving effect (bias?) in academic attributions: its relation to academic achievement and self-concept. *Journal of Educational Psychology*, 78(3): 190-200.

Marsh HW. (1987) The big-fish-little-pond effect on academic self-concept. *Journal of Educational Psychology*, 79(3): 280-295.

Marsh HW. (1990) The structure of academic self-concept: the Marsh/Shavelson Model. *Journal of Educational Psychology*, 82(4): 623-636.

Marsh HW and Shavelson R. (1985) Self-concept: its multifaceted, hierarchical structure. *Educational Psychologist*, 20(3): 107-123.

Maxwell JA. (2012) *A realist approach for qualitative research*. London: Sage.

Maynard M. (1994) 'Methods, practice and epistemology: the debate about feminism and research.' In Maynard M and Purvis J, eds., *Researching women's lives from a feminist perspective.* Abingdon: Taylor & Francis Ltd.

Miles TR. (2004) Some problems in determining the prevalence of dyslexia. *Electronic Journal of Research in Educational Psychology*, 2(2): 5-12.

Miles TR, and Miles E. (1990) *Dyslexia: a hundred years on*. Buckingham: Open University Press.

Monrouxe LV. (2009) Negotiating professional identities: dominant and contesting narratives in medical students' longitudinal audio diaries. *Current Narratives*, 1: 41-59.

Monrouxe LV. (2010) Identity, identification and medical education: why should we care? *Medical Education,* 44: 40-49.

Monrouxe LV. (2013) 'Identities, self and medical education' in Walsh K (ed) *Oxford Textbook of Medical Education*, Oxford: Oxford University Press.

Moody S. (2010) 'Identifying dyslexia' in: Bartlett D, and Moody S, editors. *Dyslexia in the workplace: an introductory guide*. Chichester: Wiley. P. 3-11.

Moody S. (2015) Dyslexia, dyspraxia and ADHD in employment: a view from the United Kingdom. *Career Planning & Adult Development Journal*, 31(4): 142-150.

Moran D. (2000) *Introduction to phenomenology*. Abingdon: Routledge.

Morgan WP. (1896) A case of congenital word blindness. *British Medical Journal*, 2: 1378.

Morgan E and Klein C. (2000) *The dyslexic adult in a non-dyslexic world*. Oxford: Wiley.

Musto J. (2013) *How do medical doctors with specific learning difficulties (SpLD) cope in a clinical* setting. Unpublished PhD thesis, The University of East Anglia. Accessed on 11/05/2018 via: https://ueaeprints.uea.ac.uk/53384/Jennifer_Musto_PhD_Thesis_10.3.15.pdf

National Association of Clinical Tutors UK. (2013) Who does what in foundation and specialty training? Accessed on 7/1/2017 via: http://www.gmc-uk.org/Final_Appendix_1___Who_Does_what.pdf_53817350.pdf

Neff KD. 2003) Self-compassion: an alternative conceptualisation of a healthy attitude towards oneself. *Self and Identity*, 2: 85-101.

Neff KD. (2011a) Self-compassion, self-esteem, and well-being. *Social and Personality Psychology Compass,* 5(1): 1-12.

Neff KD. (2011b) *Self compassion: stop beating yourself up and leave insecurity behind.* New York: William Morris.

Neff KD, Hsieh Y-P, and Dejitterat K. (2005) Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4: 263-287.

Newlands F, Shrewsbury D, Robson J. (2015) Foundation doctors and dyslexia: a qualitative study of their experiences and coping strategies. *Postgraduate Medical Journal,* 91: 121-126.

Norwich B. (2014) How does the capability approach address current issues in special educational needs, disability and inclusive education field? *Journal of Research in Special Educational Needs*, 14(1): 16-21.

Novak JD, and Cañas AJ. (2007) Theoretical origins of concept maps, how to construct them, and uses in education. *Reflecting Education*, 3(1): 29-42.

Novita S. (2016) Secondary symptoms of dyslexia: a comparison of self-esteem and anxiety profiles of children with and without dyslexia.

Oakley A. (1981) 'Interviewing women.' In Roberts H, ed., *Doing feminist research*. London: Routledge & Kegan Paul.

Oliver M. (1990) *The politics of disablement.* London: Macmillan.

Ormston R, Spencer L, Barnard M, and Snape D. (2003) 'The foundations of qualitative research.' In Ritchie J, Lewis J, McNaughton Nicholls C, and Ormston R, eds., *Qualitative research practice: a guide for social science students and researchers.* 2nd edition. London: Sage.

Orton ST. (1925) 'Word blindness' in school children. *Archives of Neurology & Psychiatry,* 14(5): 581-615.

Orton ST. (1937) *Reading, writing and speech problems in children.* New York: W. W. Norton.

Oyserman D, Elmore K, and Smith G. (2012) 'Self, self-concept, and identity.' In Leary MR and Tangney JP (eds). *Handbook of self and identity, second edition*. New York: Guildford Press.

Patel R, Tarrant C, Bonas S, and Shaw RL. (2015) Medical students' personal experience of high-stakes failure case studies using interpretative phenomenological analysis. *BMC Medical Education*, 15: 86.

Peters M and King J. (2012) Perfectionism in doctors. *BMJ*, 344:e1674.

Philips SE. (1994) High-stakes testing accommodations: validity versus disabled rights. *Applied Measurement in Education*, 7: 93-120.

Philpott MJ. (1998) A phenomenology of dyslexia: the lived-body, ambiguity, and the breakdown of expression. *Philosophy, Psychiatry & Psychology*, 5(1): 1-19.

Pitoniak MJ and Royer JM. (2001) Testing accommodations for examinees with disabilities: a review of psychometric, legal and social policy issues. *Review of Educational Research*; 71: 53-104.

Pollack DE. (2002) *Dyslexia, the self and higher education: learning life histories of students identified as dyslexic.* Unpublished PhD thesis. DeMontfort University. Accessed on 03/10/2017 via: https://www.dora.dmu.ac.uk/bitstream/handle/2086/4089/DX220723_1.pdf?sequence=1

Prasad P. (1997) 'Systems of meaning: ethnography as a methodology for the study of information technologies.' In Lee AS, Liebenau J and DeGross JI, eds., *Information Systems and qualitative research*. London: Chapman and Hall.

Purcell-Gates V. (2007) *Cultural practices of literacy: case studies of language, literacy, social practice and power.* Hillside, NJ: Lawrence Erlbaum Associates.

Purcell-Gates V, Allier SL and Smith D. (1995) Literacy at the Hearts' and Larsons': diversity among poor innercity families. *The Reading Teachers*, 48(7): 572-578.

Ramus F, Altarelli I, Jednoróg K, Zhao J, Scotto di Covella L. (2018) Neuroanatomy of developmental dyslexia: pitfalls and promise. *Neuroscience and Behavioural Reviews*, 84: 434-452.

Rassool N. (2009) 'Literacy: in search of a paradigm' in Soler J, Fletcher-Campbell F and Reid G (eds.) *Understanding difficulties in literacy development: issues and concepts*. Milton Keynes: Open University.

Reid G. (2009) *Dyslexia: a practitioner's handbook*. Fourth edition. Chichester: John Wiley & Sons Ltd.

Renfrow DG. (2004) A cartography of passing in everyday life. *Symbolic Interaction*, 27(4): 485-506.

Rice M and Brooks G. (2004) *Developmental dyslexia in adults: a research review*. London: National Research and Development Centre for Adult Literacy and Numeracy.

Rickinson M. (2010) *Disability equality in higher education: a synthesis of research*. Higher Education Academy EvidenceNet. Accessed on 12/07/2012 via: www.heacademy.ac.uk/evidencenet

Ricoeur P. (1984) *Time and narrative, vol. 1.* Chicago, IL: University of Chicago Press.

Riddell S and Weedon E. (2006) What counts as a reasonable adjustment? Dyslexic students and the concept of fair assessment. *International Studies in Sociology of Education*; 16: 57-73.

Riddick B (1995) Dyslexia: dispelling the myths. *Disability & Society*; 10: 457- 473.

Riddick B, Farmer M and Sterling C. (1997) '*Students and dyslexia: growing up with a specific learning difficulty'.* London: Whurr.

Riddick B, Sterling C, Farmer M, and Morgan S. (1999) Self-esteem and anxiety in the educational histories of adult dyslexic students. *Dyslexia*, 5(4): 227-248.

Riddick B. (2000) An examination of the relationship between labelling and stigmatisation with special reference to dyslexia. *Disability & Society*, 14: 653-667.

Riddick B. (2001) Dyslexia and inclusion: time for a social model of disability perspective? *International Studies in Sociology of Education*, 11: 223- 236.

Riddick B. (2003) Experiences of teachers and trainee teachers who are dyslexic. *International Journal of Inclusive Education*, 7: 389-402.

Riddick B. (2010) *Living with dyslexia: the social and emotional consequences of specific learning difficulties / disabilities*. Second edition. Abingdon: Routledge.

Rix J. Does it matter what we call them? Labelling people on the basis of notion of intellect. *Ethical Space: The International Journal of Communication Ethics,* 2006; 3(4): 22-28.

Roberts TE, Butler A and Bouriscot KAM. (2005) Disabled students, disabled doctors – time for a change? A study of different societal views of disabled people's inclusion to the study and practice of medicine. *Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine*, Special Report: 4.

Robson C. (2011) *Real world research*. 3rd edition. Chichester: John Wiley & Sons, Ltd.

Rogers C. (1951) *Client-centred therapy*. Boston: Houghton Mifflin.

Rogers C. (2011) Mothering and intellectual disability: partnership rhetoric? *British Journal of Sociology of Education,* 32(4): 563-581.

Rosenberg M. (2015) *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Rosebraugh CJ. (2000) Learning disabilities and medical schools. *Medical Education*; 34: 994-1000.

Royal College of Physicians. (2005) *'Doctors in society: medical professionalism in a changing world. Report of a Working Party, December 2005.'* London: RCP.

Runyan MK. (1991) The effect of extra time on reading comprehension scores for university students with and without learning disabilities. *Journal of Learning Disabilities,* 24: 104-108.

Russell G, Ryder D, Norwich B, and Ford T. (2015) Behavioural difficulties that co-occur with specific word reading difficulties: a UK population-based cohort study. *Dyslexia*, 21: 123-141.

Ryan RM and Deci EL. (2012) 'Multiple identities within a single self: a self-determination theory perspective on internalisation within contexts and cultures.' In Leary MR and Tangney JP (eds). *Handbook of self and identity, second edition*. New York: Guildford Press.

Sandars J. (2009) The use of reflection in medical education: AMEE Guide No. 44. *Medical* Teacher, 31: 685-695.

Searcy CA, Dowd KW, Hughes MG, Baldwin S, and Pigg T. (2015) Association of MCAT scores obtained with standard vs. extra administration time with medical school admission, medical student performance, and time to graduation. *JAMA,* 131(22): 2253-2262.

Sedikides C. (2012) 'Self-protection' In Leary MR and Tangney JP (eds). *Handbook of self and identity, second edition*. New York: Guildford Press.

Seligman MEP. (1972) Learned helplessness. *Annual Review of Medicine*, 23: 407-412.

Seligman MEP. (1990) *Learned optimisim: how to change your mind and your life*. New York: Vintage Books.

Sharp K and Earle S. (2000) Assessment, disability and the problem of compensation. *Assessment & Evaluation in Higher Education*, 25: 191-199.

Shavelson RJ, Hubner JJ, and Stanton GC. (1976) Self-concept: validation of construct interpretations. *Review of Educational Research*, 46(3): 407-441.

Shaw SCK and Anderson JL. (2017) Twelve tips for teaching medical students with dyslexia. *Medical Teacher*,39(7): 686-690.

Shaw SCK, Malik M, and Anderson JL. (2017) The exam performance of medical students with dyslexia: a review of the literature. *MedEdPublish*, 6(3):2. Accessed on 3/10/2017 via: https://www.mededpublish.org/manuscripts/1049

Shaywitz SE, Mody M, and Shaywittz BA. (2006) Neural mechanisms in dyslexia. *Current Directions in Psychological Science,* 15(6): 278-281.

Shaywitz BA, Shaywitz SE, Pugh KR, Menl WE, Fullbright RK, Skudlarski P, Constable RT, Marchione KE, Fletcher JM, Lyon GR, and Gore JC. (2002) Disruption of posterior brain systems for reading in children with developmental dyslexia. *Biological Psychiatry*, 52(2): 101-110.

Shehu A, Zilla E, and Dervishi E. (2015) The impact of the quality of social relationships on self-esteem on children with dyslexia. *European Scientific Journal*, 11(17): 308-318.

Sherratt M. (1994) *Galileo: decisive innovator.* In Knight D, and Kohlstedt SG, eds., *Cambridge Science Biographies Series*. Volume 6*.* Cambridge: Cambridge University Press.

Shrewsbury D. (2011) State of play: supporting students with specific learning difficulties. *Medical Teacher,* 33(3): 254.

Shrewsbury D. (2011) Supporting medical students with Specific Learning Difficulties: An international comparison of institutional provisions and perceptions. Oral presentation: ASME Doctors in Difficulty? Strengthening foundations in early years, London.

Shrewsbury D. (2012) Trainee doctors with learning difficulties: recognising need and providing support. *British Journal of Hospital Medicine*, 73(6): 345-349.

Shrewsbury D. (2013) Educators' perceptions of issues relating to the inclusion and support of junior doctors with dyslexia in General Practice training. Oral presentation: CRMDE The Birmingham Conference, University of Birmingham.

Shrewsbury D. (2014) Disability and participation in the professions: examples from higher and medical education. *Disability & Society*, 30(1): 87-100.

Shrewsbury D. (2015) Disability and participation in the professions: examples from higher and medical education. *Disability & Society*, 30(1): 87-100.

Shrewsbury D. (2016) Dyslexia in general practice education: considerations for recognition and support. *Education for Primary Care*, 27(4): 267-270.

Shrewsbury D, Mogensen L and Hu W. (2018) Problematizing medical students with disabilities: a critical policy analysis. *MedEdPublish*, 7(1):45.

Silver J. (2013) 'Visual methods' in Willig C (ed) *Introducing qualitative research in psychology, 3rd edition*. Maidenhead: Open University Press.

Simos PG, Fletcher JM, Bergman E, Breier JL, Foorman BR, Castillo EM, Davis RN, Fitzgerald M, and Papanicolaou AC. (2002) Dyslexia-specific brain activation profile becomes normal following successful remedial training. *Neurology*, 58:1203-1213.

Smeets E, Neff K, Alberts H, and Peters M. (2014) Meeting suffering with kindness: effects of a brief self-compassion intervention for female college students. *Journal of Clinical Psychology*, 70(9): 794-807.

Smith JA. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11: 261-271.

Smith JA. (1998) Towards a relational self: social engagement during pregnancy and psychological preparation for motherhood. *British Journal of Social Psychology,* 38: 409-426.

Smith JA. (1999) Identity development during the transition to motherhood: an interpretative phenomenological analysis. *Journal of Reproductive and Infant Psychology,* 17(3): 281-299.

Smith JA. (2007) Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being*, 2: 3-11.

Smith JA. (2011a) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1):9-27.

Smith, JA. (2011b) Evaluating the contribution of interpretative phenomenological analysis: a reply to the commentaries and further development of criteria. *Health Psychology Review, 5, 55-61.*

Smith JA. (2011c) 'We could be diving for pearls': The value of the gem in experiential qualitative psychology*. Qualitative Methods in Psychology Bulletin*, 12: 6-15.

Smith JA, Flowers P, and Larkin M. (2009) *Interpretative phenomenological analysis: theory, method and research.* London: Sage.

Smith JA, Harré R, and Van Langenhove L. (1995) 'Idiography and the case-study' in JA Smith, R Harré and L Van Langenhove, eds., *Rethinking psychology*. London: Sage.

Smith JA, Jarman M, and Osborne M. (1999) 'Doing interpretative phenomenological analysis' in M Murray and K Chamberlain (eds) *Qualitative Health Psychology*. London: Sage.

Smith JA, and Osborn M. (2015) 'Interpretative phenomenological analysis' in JA Smith (ed) *Qualitative psychology: a practical guide to research methods.* 3rd edition. London: Sage.

Snowling MJ. (2006) *Dyslexia*. Second edition. Oxford: Blackwell Publishing.

Snowling MJ and Hulme C. (2012) Annual research review: the nature and classification of reading disorders – a commentary on proposals for DSM-5. *Journal of Child Psychology and Psychiatry*, 53(5): 593-607.

Song Y, Bu Y, Hu S, Luo Y, and Liu J. (2010) Short-term language experience shapes the plasticity of the visual word form area. *Brain Research*, 1316: 83-91.

SpLD Assessment Standards Committee. (2016) Suitable tests for the assessment of Specific Learning Difficulties in Higher Education (Revised March 2016). Accessed on 7/1/2017 via: http://www.sasc.org.uk/SASCDocuments/REVISED%20guidelines-March%202016%20a.pdf

Stanovich K. (2005) The future of a mistake: will discrepancy measurement continue to make the learning disabilities field a pseudoscience? *Learning Disability Quarterly*, 28(2): 103-106.

Tanner K. (2010) *The lived experience of adults with dyslexia: an exploration of the perceptions of their educational experiences*. Murdoch University: Unpublished PhD thesis.

Tannock R. (2012) DSM-5 changes in diagnostic criteria for specific learning difficulties: what are the implications? International Dyslexia Association. Accessed on 12/01/2018 via: https://dyslexiaida.org/dsm-5-changes-in-diagnostic-criteria-for-specific-learning-disabilities-sld1-what-are-the-implications/

Task Force on Dyslexia. (2001) Report. Dublin: Government. Accessed on 15/12/2017 via: https://www.sess.ie/sites/default/files/Dyslexia_Task_Force_Report_0.pdf

Tincher DL. (2005) *A phenomenology perspective of dyslexia*. Capella University: unpublished PhD thesis.

Tindal G, Hollenbeck K, Heath W and Almond P. (1997) *The effect of using computers as an accommodation in a statewide writing test*. Eugene: University of Oregon Press.

Thiese MS, Arnold ZC, and Walker SD. (2013) The misuse and abuse of statistics in biomedical research. *Biochemia Medica*, 25(1): 5-11.

Thomas C. (2004) How is disability understood? *Disability & Society*, 19(6): 569-583.

Thomas G. (2011) *How to do your case study: a guide for students and researchers.* London: Sage.

Turnbull JM. (1989) What is...Normative versus criterion-referenced assessment. *Medical Teacher*, 11: 145-150.

Turner JC, Hogg MA, Oakes PJ, Reicher SD, and Wetherall MS. (1987) *Rediscovering the social group: a self-categorisation theory*. Cambridge: Cambridge University Press.

Van Manen M. (1990) *Researching lived experience: human science for an action sensitive pedagogy.* Albany, NY: The State University of New York Press.

Van Manen M. (2007) Phenomenology of practice. *Phenomenology & Practice*, 1(1): 11-30.

Van Manen M. (2014) *Phenomenology of practice: meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press Inc.

Varpio L, Ajjawi R, Monrouxe LW, O'Brien BC, and Rees CE. (2017) Shedding the cobra effect: problematizing thematic emergence, triangulation, saturation and member checking. *Medical Education*, 51(1): 40-50.

Vellutino FR, Fletcher JM, Snowling MJ and Scanlon DM. (2004) Specific reading disability (dyslexia): what have we learned in the past four decades? *Journal of Child Psychology and Psychiatry*, 45: 2-40.

Wagner RF. (1973) Rudolf Berlin: originator of the term dyslexia. *Bulletin of the Orton Society, 23(1): 57-63.*

Walker S, Dearnley C, Hargreaves J, and Walker EA. (2013) Risk, fitness to practice, and disabled health care students. *Journal of Psychological Issues in Organisational Culture*, 3(4): 46-59.

Wass V. Van der Vleuten CPM, Shatzer J and Jones R. (2001) Assessment of clinical competence. *The Lancet*, 357: 945-949.

Weiner B. (1976) An attributional approach for educational psychology. *Review of Research in Education*, 4: 179-209.

Weiner B. (1980) The role of affect in rational (attributional) approaches to human motivation. *Educational Researcher*, 9: 4-11.

Wheldall K and Pogorzelski S. (2009) 'Is the PhAB really fab? The utility of the phonological assessment battery in predicting gains made by older low-progress readers following two terms of intensive literacy instruction.' in Fletcher-Campbell F, Soler J and Reid G (eds.) *Approaching difficulties in literacy development: assessment, pedagogy and programmes*. Milton Keynes: Open University.

Willig C. (2013) *Introducing qualitative research in psychology, 3rd edition.* Maidenhead: Open University Press.

Wilson J, Mandich A, and Magalhães L. (2016) concept mapping: a dynamic, individualised and qualitative method for eliciting meaning. *Qualitative Health Research*, 26(8): 1151-1161.

Woollett K and Maguire EA. (2011) Acquiring 'the Knowledge' of London's layout drives structural brain changes. *Current Biology*, 21(24): 2109-2114.

World Health Organisation. (1992) *International classification of diseases and related health problems,* 10th edition. Geneva: World Health Organisation

World Health Organisation. (2001) International Classification of Functioning, Disability and Health (ICF). Accessed on 6/1/2017 via: http://www.who.int/classifications/icf/en/

World Health Organisation. (2009) WHO patient safety curriculum guide for medical schools. *World Alliance for Patient Safety*. Accessed on 01/02/2018 via: http://www.who.int/patientsafety/activities/technical/who_ps_curriculum.pdf

Yardley L. (2015) 'Demonstrating validity in qualitative psychology' in Smith JA (ed) *Qualitative psychology: a practical guide to research methods.* London: Sage.

Yeung AS, Li B, Wilson I and Craven RG. (2014) The role of self-concept in medical education. *Journal of Further and Higher Education,* 38(6): 794-812.

Yule W. (1973) Differential prognosis of reading backwardness and specific reading retardation. *British Journal of Educational Psychology*, 43:244-248.

Zeleke S. (2004) Self-concepts of students with learning disabilities and their normally achieving peers: a review. *European Journal of Special Needs Education*, 19(2): 145-170

Dyslexia and Medicine:

The experience and the impact of dyslexia on the education, training, and practice of doctors.

Volume 2 of 2

Submitted by

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MSc, MBChB, BMedSc (Hons), MRCGP, DCH, DRCOG, FHEA, AMBDA FE/HE

to the University of Exeter as a thesis for the degree of Doctor of Philosophy in Education, March 2018.

I certify that all material in this thesis which is not my own work has been identified, and that no material has been previously submitted and approved for the award of a degree by this, or any other University.

(Signature): .....

This research was funded by a Studentship from the College of Social Science and International Studies, University of Exeter.

This volume contains the appendices that support the work reported in volume 1 of this thesis.

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Appendix 1: Letter of approval from ethics committee

MSc, PhD, EdD & DEdPsych theses.

UNIVERSITY OF EXETER

Graduate School of Education

Certificate of ethical research approval

MSc, PhD, EdD & DEdPsych theses

To activate this certificate you need to first sign it yourself, and then have it signed by your supervisor and finally by the Chair of the School's Ethics Committee.

For further information on ethical educational research access the guidelines on the BERA web site: http://www.bera.ac.uk/publications and view the School's Policy online.

READ THIS FORM CAREFULLY AND THEN COMPLETE IT ON YOUR COMPUTER (the form will expand to contain the text you enter). **DO NOT COMPLETE BY HAND**

Your name: Duncan Shrewsbury

Your student no: 540003899

Return address for this certificate: 6 Westmead Crescent, Birmingham, B24 0JS

Degree/Programme of Study: EdD (SNIE)

Project Supervisor(s): Prof. Brahm Norwich and Prof. Jane Seale

Your email address: dhs205@exeter.ac.uk | d.shrewsbury@doctors.org.uk

Tel: 07875499845

I hereby certify that I will abide by the details given overleaf and that I undertake in my thesis to respect the dignity and privacy of those participating in this research.

I confirm that if my research should change radically, I will complete a further form.

Signed:..... .....**date:**.....**23/4/14**.....

Chair of the School's Ethics Committee
updated: March 2013

Certificate of ethical research approval

TITLE OF YOUR PROJECT:

"The impact of dyslexia in medical education and practice"

---

1. Brief description of your research project:

The project is an exploration into the lived experiences of doctors in training who have dyslexia. This is to develop an understanding of how dyslexia may impact on learning, training and everyday practice in the medical profession.

The project will operate from an Interpretative Phenomenological Analysis (Smith *et al*, 2009). Data will be obtained by drawing on a mixed methods approach, building detailed case studies of approximately 6 participants over three phases. The first phase will be an interview designed to ascertain background and contextualising information about the participant. The second phase of the case studies will be a self-diarising exercise structured around a Critical Incident Technique (after Flannagan, 1954) debrief. The data from the interviews and diaries (phases 1 and 2 respectively) will then inform a final phase of in-depth interviews. This plan has been summarised in figure 1.

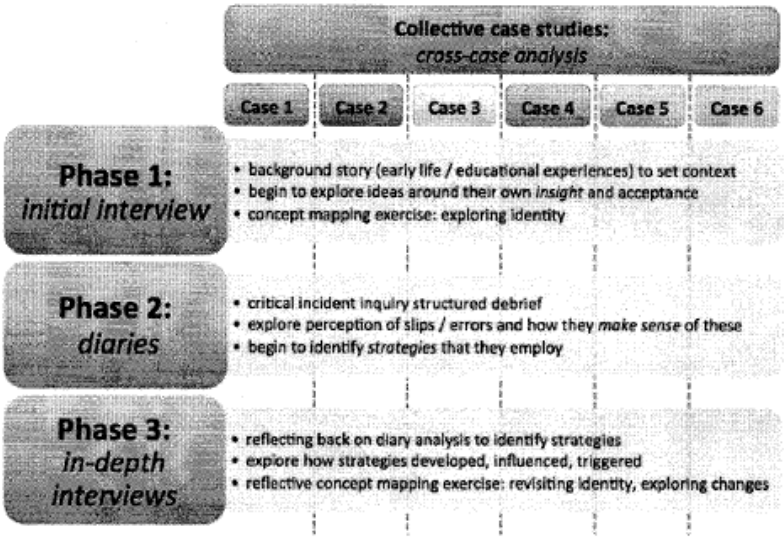

Figure 1: summary of research strategy

Chair of the School's Ethics Committee
updated: March 2013

2. Give details of the participants in this research (giving ages of any children and/or young people involved):

The focus of this study is the experience of trainee doctors with dyslexia. The term 'trainee doctors' is used to include all doctors (having graduated from medical school with a primary medical qualification) who are in training posts. Historically, trainee doctors were referred to generically as 'Juniors', or 'House Officers' and 'Housemen' (equivalent to FY1), and 'Senior House Officers' (equivalent to FY2 to CT2 / ST3).

This project proposes to recruit about 6 trainee doctors to study. This smaller number is justified by the virtue that each participant will provide several quanta of data to be used in slightly different ways. Furthermore, to allow for focused, in-depth analysis within the timeframe of the EdD, it is practical to limit the number of participants recruited to the study, so that the project does not become swamped with data.

Inclusion criteria: 1). Doctor (medical) working within a training post in the UK

2). Known diagnosis of dyslexia

Give details (with special reference to any children or those with special needs) regarding the ethical issues of:

3. <u>informed consent:</u> Where children in schools are involved this includes both headteachers and parents). Copy(ies) of your consent form(s) you will be using must accompany this document. a blank consent form can be downloaded from the GSE student access on-line documents: **Each consent form MUST be personalised with your contact details.**

Trainees who respond to the email invitation will be sent a participant information sheet, detailing the intentions of the research project and the commitment. At the first meeting, the information sheet (PIS) and a consent form will be discussed and signed. See appendix 1 (PIS) and 2 (consent).

NB: it is assumed that the trainees will have capacity.

4. <u>anonymity and confidentiality</u>

Recruitment: Participants will be recruited via email sent out by a third party (Local Education and Training Board / 'Deanery'). These organisations hold distribution lists for regional trainees under their charge. All trainees will be sent the email, which will specifically invite those who know they have dyslexia (i.e. meet the inclusion criteria) to respond to the PI directly.

There are a number of doctors who, through having heard of me and / or my research, have contacted me prospectively, seeking opportunities to be involved in my work. Provided they meet the eligibility criteria, they will be allowed to participate, and they will be afforded the same subsequent anonymity that other participants will receive.

Data analysis: When the data are analysed and reported, they will be completely anonymised so that participants' identities are protected. Participants will be given the opportunity to select an alias. All activities will be conducted in accordance with the British Educational Research Association's, and the University's, ethical guidelines.

5. Give details of the methods to be used for data collection and analysis and how you would ensure they do not cause any harm, detriment or unreasonable stress:

Phase 1: initial interviews

Participants will initially be interviewed to create a portrait of their sense of self and their lives to that point. This will set the context of further work, giving detail into the way that their previous experiences go into shaping choices and behaviour in the future. The initial interviews will be semi-structured and recorded, augmented by field notes and concept maps (appendix 1). Through reflecting on previous, early, experiences of working as a doctor, this phase may begin to address the first two research questions. However, the purpose of this phase is not to directly address specific research questions, but to provide sufficient background to contextualise the participants' lived experiences in their unique cultural and historical contexts. Based on previous work, it is anticipated that these interviews may take about an hour.

- Data will consist of audio-recorded interview, field notes and concept maps.

Phase 2: critical incident diaries

Through the use of diaries, structured around a critical incident technique (Flanagan, 1954) debrief, participants will be able to present a record of their lived experience. The snap-shot of their lives could be captured through one of several means: audio diaries; online reflection, using www.surveygizmo.com as a platform to collect information as free-text responses to debriefing stimulus questions; email; or telephone interview.

It is anticipated that, given the literacy-related difficulties that characterise dyslexia and the time-pressures faced by trainee doctors, the participants may prefer diarizing by a means of audio-recording or telephone interview. However, the participants will be able to explore which mode of diarising they would prefer.

Due to potential conflict between shift patterns, which could cause delays in being able to talk over the telephone, the telephone debriefing option will not be actively encouraged as it could potentially be problematic. Participants will be encouraged to record a diary entry after a shift at work, on alternate days, for at least two weeks. This frequency has been chose to be as comprehensive as possible in terms of capturing a true sense of their experience, without being too intrusive. The participants will, after all, have many demands on their time, which may make full participation in this part of the project difficult. Therefore, the period of diarising can be negotiated- but a variety of different working contexts (on-call and 'normal' days) will be encouraged.

- Data will consist of participants' diaries. These may take the form of written responses, audio-recorded telephone interviews, or self-recorded audio-diaries.

Phase 3: in-depth interviews

Following the analysis of the diaries, participants will be invited to an in-depth interview. These interviews will be loosely structured according to the output from phase two, and will give participants to review the researcher's analysis of their diaries, and collaborate in reaching an understanding of the meaning making process (appendix 3). Moreover, the interviews will provide an opportunity to capture further data that will elaborate on how they have developed and how they use strategies to cope with the difficulties they experience due to having dyslexia. These interviews are likely to take two to three hours and will be recorded. Drawing on previous work, interviewing can be a draining process for researcher and participant. Therefore, it may be practical to interrupt these interviews with a significant comfort break or divide them into two linked interviews.

- Data will consist of audio-recorded interview and field notes.

Pilot: a procedural pilot will be undertaken, to test the interview prompts and the methods of data collection for the diaries (phase 2). One or two participants will be invited to help with the pilot, and will be given the opportunity to take part in the subsequent full-scale research project.

6. Give details of any other ethical issues which may arise from this project - e.g. secure storage of videos/recorded interviews/photos/completed questionnaires, or

Storage: Digital data will be securely stored on a password protected hard-drive belonging to the PI. This will be kept within the PI's domestic residence. Hard-copy data, along with signed consent forms, will be stored in a secure filing cabinet in the PI's domestic residence. Original data will be stored for a maximum time period in accordance with University policy.

Emotional distress: It is possible that having dyslexia may make sustained participation even more challenging for these trainees, as work may take them longer, their ability to time manage may be affected and the demands that participation could impose may cause additional stress or anxiety. Moreover, experience has taught me that the interview process can bring strong emotions to surface. Should participants become distressed, they will be given the opportunity to stop. Additionally, I will signpost supportive services in their region.

Professionalism and probity: I have an ethical obligation to ensure that I do not bring about any form of harm to potential participants in the research project. I also have a professional obligation, as a medical practitioner licensed by the General Medical Council myself, I am bound by duty and law to follow regulations that promote the protection of the public, of patients and of the professional image of the medical profession (GMC, 2013). Should a participant disclose something that is of concern to patient safety, I will undertake steps in accordance with GMC guidance, initially encouraging them to disclose matters to their supervisors, before suggesting that I may have to contact the necessary bodies myself.

7. Special arrangements made for participants with special needs etc.

This project will not involve, or recruit, persons under the age of 18 years. By the nature of the inquiry, the participants may have additional needs, owing to Specific Learning Difficulties. These needs will be met through direct negotiation between the participant and investigator. In anticipation of literacy-based difficulties, communication (email invitations, information sheets and consent forms) have been designed in a 'dyslexia friendly' way, according to guidance issued by the British Dyslexia Association.*

(* for example: www.bdadyslexia.org.uk/files/dfs_pack_English.pdf and www.bdadyslexia.org.uk/about-dyslexia/further-information/eyes-and-dyslexia.html)

8. Give details of any exceptional factors, which may raise ethical issues (e.g. potential political or ideological conflicts which may pose danger or harm to participants):

From section 6:

Professionalism and probity: I have an ethical obligation to ensure that I do not bring about any form of harm to potential participants in the research project. I also have a professional obligation, as a medical practitioner licensed by the General Medical Council myself, I am bound by duty and law to follow regulations that promote the protection of the public, of patients and of the professional image of the medical profession (GMC, 2013). Should a participant disclose something that is of concern to patient safety, I will undertake steps in accordance with GMC guidance, initially encouraging them to disclose matters to their supervisors, before suggesting that I may have to contact the necessary bodies myself.

***This form should now be printed out**, signed by you on the first page and sent to your supervisor to sign. Your supervisor will forward this document to the School's **Research Support Office** for the Chair of the School's Ethics Committee to countersign. A unique approval reference will be added and this certificate will be returned to you to be included at the back of your dissertation/thesis.*

***N.B**. You should not start the fieldwork part of the project until you have the signature of your supervisor*

This project has been approved for the period: April 2014 **until:** September 2016

By (above mentioned supervisor's signature):

Brahm Norwich .... **date:**.....24.4.14.....
.....

***N.B. To Supervisor:** Please ensure that ethical issues are addressed annually in your report and if any changes in the research occur a further form is completed.*

GSE unique approval reference:....D1.13.14.27.....

Signed:.....**date:**.....6/5/14.....
Chair of the School's Ethics Committee

Chair of the School's Ethics Committee
updated: March 2013

UNIVERSITY OF EXETER

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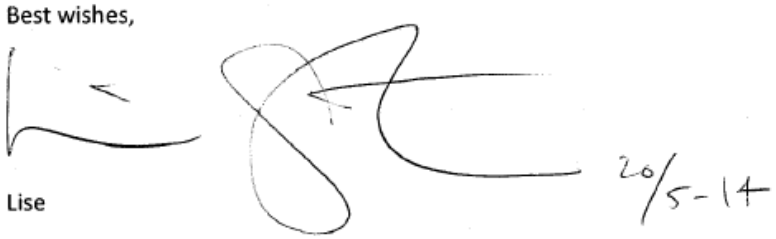
Exeter 20 May 2014

Dear Dr Shrewsbury,

This is just a brief letter to confirm that you have received ethics approval from the ethics committee of the College of Social Sciences and International Studies. We are recognized by the ESRC and also grant reciprocal recognition with a number of other bodies, including e.g. MODREC and NHS organizations. I am away at the moment and cannot post you a signed letter, but I hope this will do. The NHS is free to contact me at any time, and I would be happy to post a letter upon my return in June if necessary.

Best wishes,



Lise

Dr Lise Storm
Director of Research (IAIS)
Chair of the CSSIS Ethics Committee
Senior Lecturer in Middle East Politics
Institute of Arab and Islamic Studies, University of Exeter, UK

Appendix 2: Participant Information Sheet

Version: 1.0 (2/3/2014)

GRADUATE SCHOOL OF EDUCATION

INFORMATION SHEET FOR PARTICIPANTS

"The impact of dyslexia in medical education and practice"

Dear Colleague,

I am a dyslexic GP trainee in the West Midlands, studying for a doctorate at the University of Exeter. I am conducting research and need the help of other trainee doctors with dyslexia, to share their experiences with me. The aim is develop a better understanding of what it means to have dyslexia as a doctor.

What is the project about?

Purpose: The project is an exploration into the experiences of doctors in training who have dyslexia. This is to develop an understanding of how dyslexia may impact on learning, training and everyday practice in the medical profession.

What will participation involve?

Interviews: Participating in the project will involve being interviewed and completing a diary, either by recording (audio-diary) or another negotiated method. There are likely to be at least two interviews, one initially to get to know about you, and another to follow-up. These interviews should be enjoyable, but do aim to probe deeply into experiences. Participants will be completely respected throughout this process and can steer the direction that conversation takes to a great degree. These interviews are recorded, so that the researcher can analyse the data.

Diaries: The part of the project that involves keeping a diary will require you to record events, and your thoughts about these events, that relate your experiences in medical training and practice. These are usually a short and quick opportunities to reflect, and will follow a specially designed template. The diary will be analysed by the researcher and will be explored with you in an interview afterwards.

Withdrawing: Should you wish to withdraw from the study you can, and in the case of interviews, it may also be possible to withdraw data at a later stage (up to 14 days after the last interview). Participation is completely voluntary.

What will be done with my data?

Anonymity: Identities will be protected. When the data are analysed and reported, they will be completely anonymised so that participants' identities are protected. All activities will be conducted in accordance with the British Educational Research Association's, and the University's, ethical guidelines.

Dissemination: Ultimately, the project will be written up and submitted as a thesis for the degree of doctor of education (EdD) at the University of Exeter. Further to this, data may be presented at conferences and published in academic journals and texts. Copies of these outputs will be made available to all participants upon request.

If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

However, if you would like to participate in the project, and contribute to my work, then do please get in touch providing me with your contact details. If you have any questions about our project, either now or in the future, please feel free to get in touch.

Kind Regards

Duncan Shrewsbury (Principal Investigator)

PhD research student, University of Exeter

Email: dhs205@exeter.ac.uk | d.shrewsbury@doctors.org.uk

Student ID: 540003899

More information about me, and my work can be found at:
http://eprofile.exeter.ac.uk/duncanshrewsbury/

My supervisors can be contacted by:

Professor Brahm Norwich: b.norwich@exeter.ac.uk

Professor Jane Seale: j.seale@exeter.ac.uk

Appendix 3: Consent Form

Version: 1.0 (2/3/2014)

GRADUATE SCHOOL OF EDUCATION
CONSENT FORM

"The impact of dyslexia in medical education and practice"

Principal investigator: Duncan Shrewsbury

Email: dhs205@exeter.ac.uk or d.shrewsbury@doctors.org.uk

I ..... have been consulted about my participation in the research project entitled 'the impact of dyslexia in medical education and practice'.

- I have read and understood the participant information sheet for this study.
- I have had the opportunity to ask questions about the study and understand what is involved and give my consent.
- I have been fully informed about the aims and purposes of the project.

I understand that:

there is no compulsion for me to participate in this research project and, if I do choose to participate, I may at any stage withdraw my participation and may also request that my data be destroyed

data collected during the study may be looked at by individuals from regulatory authorities or other researchers to audit and verify the projects outputs.

all medical professionals, whose practice is licensed by the General Medical Council of the UK, have a responsibility to disclose information that may relate to compromise in safety of patients or the profession.

I have the right to refuse permission for the publication of any information about me

any information which I give will be used solely for the purposes of this research project, which may include publications or academic conference or seminar presentations. *No data will be attributable to individuals in the report or any future publication.*

if applicable, the information, which I give, may be shared between any of the other researcher(s) participating in this project in an anonymised form

the researcher(s) will make every effort to preserve my anonymity

I agree with the above statements, where applicable, and confirm by signing below that I fully consent to take part in this research.

……. ……

(Signature of participant) (Date)

……

(Printed name of participant)

One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s)

Contact phone number of researcher, Duncan Shrewsbury: 07875499845

If you have any concerns about the project that you would like to discuss, please contact:

Professor Brahm Norwich, Graduate School of Education, University of Exeter. Email: b.norwich@exeter.ac.uk, or telephone: 01392 724 805.

OR

Professor Jane Seale, Graduate School of Education, University of Exeter. Email: j.seale@exeter.ac.uk, or telephone: 01392 724 753.

Data Protection Act: The University of Exeter is a data collector and is registered with the Office of the Data Protection Commissioner as required to do under the Data Protection Act 1998. The information you provide will be used for research purposes and will be processed in accordance with the University's registration and current data protection legislation. Data will be confidential to the researcher(s) and will not be disclosed to any unauthorised third parties without further agreement by the participant. Reports based on the data will be in anonymised form.

Appendix 4: Coding Notes for Zayn

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
Well from primary school, I guess. I've always kind of not fitted in and that's been a common theme throughout the entire educational journey really. (16)	I've always not fitted in	Outwith the group	Outsider (belonging)
In primary school I was a bit more… I felt like I was in my own world, I didn't really connect with many people (18)	Own world		Outsider (belonging)
really I was quite creative, y'know creative at that point. Everything I'd do I'd see things differently and I wouldn't get caught up in typical, you know, things that you'd get caught up in at that age (22)	Creative rather than competitive	Strengths / skills	
I wasn't brilliant at reading but I did get by (25)	Getting by	Passing (passing exams, or passing for 'good enough')	Getting by (Unconscious / Perceived Passing...in they interpret themselves as passing [which is the conscious act of assuming traits of another identity to 'blend in / belong']) (also ? belonging to ? pseudo-member)
And I just remember feeling quite isolated but I'd do things that were quite weird (28)	Felt isolated + 'weird'	Weird as: super/un-natural, strange, abnormal (uses in contrast to 'normal') (Uses word weird a lot to describe difference...he felt his difference was	Deviant (belonging)

		positive, but 'weird') outwith *the* group	**?? self stigmatisation**
I think education was just something… I can't figure out like… (34)	Can't figure education out	Metaphor for ? education as a game, as a system to be worked out	? non-conformity (not playing the game by 'their' rules) (Crypto-deviant)
I don't remember much of my degree and I got a 2:1 in Biomed so it's kind of strange (35)	Don't remember my degree, I got a 2:I which was *strange* But worked *quite* hard, so was kind of *weird*	Strange: supernatural? It just *happened to* him (passive voice, lacking agency in this achievement)	This aligns with both Deviant (strange) and Getting By (passing – getting the 2:i)
in A-Levels like I used to study quite hard but I just got Bs so it was kind of weird how that worked. But not that Bs are really bad, it's just I worked really, really hard and just got Bs. (Laughs) But yeah, don't know what else really to say about (38)	Laughter – relating to working hard, getting As, Bs (A levels) and 2:i	Humour as a device: tension relief, sense of irony, disbelief... *Just* got Bs...a sense of failure here	Not good enough (*just* got Bs …tension / irony – laughing) Aligns with ? Perceived Passing (just got Bs) Aligns with 'Good Enough Tensions'
university was… I went through quite a lot of loneliness and I say now that those four or five… probably from 2006 'til two years ago… (43)	Loneliness of experience in education	Akin to isolation, outgroup	Lonely Existence (Outsider / Belonging)
… Like actually when I had this assessment done my whole life changed so everything that I felt in terms of loneliness became positive. (46) Because I think there was a label that was put on it or there was an explanation put on why I felt so isolated and I think that's where the whole	Reframed: label made loneliness as becoming positive	Explanatory power of label. Label changed personal meaning of loneliness (...does isolation now mean difference?) Label as reframing his personal meaning of	Diagnostic Reframing (Power of the Dyslexia Label)

meaning changed and it became more of a strength than a weakness (47)		isolation...using to explain difference	
It was quite overwhelming in terms of the information overload and the standard way of reading loads of lectures and retaining everything was a bit difficult for me. (52)	Information overload	Struggling with pace / volume Critical Incident = overwhelmed abilities / coping...failure of both exams and abilities	Overwhelming
The way I'd learn, I'd developed a method of repetition, so I'd have to go through all of the notes with the system, so I'd read it then I'd go through it in pencil then I'd go through it with red pen and then I'd go through with a highlighter, so by the end of it I'd gone through everything four times. And then through that I've learnt enough to get 50% which is kind of strange. (Laughing) So you just learn all these little techniques to get through things. (56)	Describing strategy for overlearning 'getting through' Laughter- using humour 'Just' and 'little'	Compensatory strategies *Passing* Surviving, not necessarily thriving Humour to diffuse tension / own sense of embarrassment or guilt Minimalizing language *Metacognition*	Coping (is this a means of / to belonging?)
(56)	Enough to get through (laughs)	'passing' ...scraping by (humour- discomfort, ? at notion of passing)	Scraping by (coping, belonging)
And I couldn't really pay attention in lectures, that was just something I didn't really ever connect with. I've never ever connected with lectures like where the person's standing at the front. (63)	Couldn't connect with lectures	Metaphor of learning as something physical to connect to... Learning as connection → network *Metacognition*	
There was a phase when I went through recording the lectures as well and I'd put it on through my music production software and put	Recording & speeding up & listening lots of times	Coping strategy → overlearning	Coping (is this a means of / to belonging?)

the speed up and then I'd just learn it loads of times, like listen to it loads of times, and it would stick a little bit better. So an hour lecture would be cut down to 40 minutes and I'd just keep going over it. Because the auditory side of it is… you know, I feel like… So I listen to audio books a lot, even in generally other things, listen to a lot of that. So yeah, I think that's about it really. (66)			Metacognition
the main thing is the music side of it, I feel that was what I was meant to do, that's what I feel natural doing as a musician. And the medicine, I just stumbled into it because I've seen it as a challenge and it's been like a marathon for me (70)	Music was what he was 'meant to do' Stumbled into medicine Metaphor of medicine as a marathon	medicine...challenging + ? 'unnatural' medicine as serendipity / accident? Lacks agency / control / choice here Challenge, hard work, race (against what?), endurance	(difficulty– comparison→)Deviant (belonging ...or not / outgroup)
and then now I'm doing an incredibly tough job but I feel quite happy within my skin after so long and I've never… So I don't regret it at all. (71)	Incredibly tough job but I feel quite happy within my skin after so long	Taken time to get comfortable in own skin (metaphor – wasn't comfortable with sense of self) ...only *quite* happy	(tough-difficult-not comfortable→deviant) belonging
I: What changed? R: Just the meaning, the way I thought about my purpose in life and what I was doing. I felt like I had some experience over time and… When you start as an FY1 even like it feels like you're out of your depth completely, and I by chance just ended up with the hardest job in the hospital doing respiratory medicine with no support, so everybody's really sick and I don't have a reg [registrar], hardly ever a consultant (78)	Reframing difficulties / difference / isolation changed *purpose* in life	(this experience helped him become 'resourceful', which helps when he is out of his depth)	Diagnostic Reframing (Power of the Dyslexia Label) Coping (& belonging)
When you start as an FY1 even like it feels like you're out of your depth completely, and I by	Describing factors contributing to feeling out of depth in job.	Sense of frustration, desperation...	Sink or swim → related to 'scraping by'

chance just ended up with the hardest job in the hospital doing respiratory medicine with no support, so everybody's really sick and I don't have a reg [registrar], hardly ever a consultant. And the team I'm with, there's a lot of annual leave and study leave because they're coming towards the end of their contract, the seniors. So by chance we've just been left on our own, so me and another two F1s, and because of our on-call rotas… It's a 50% banded job so because of the on-call rota none of us F1s are on the same team at one time, we're either on-call or we're on the ward, so it just happened like that. (83)	'out of depth' language describes a lot as happening to him / being done.	 → metaphor? Sink or Swim? Situational. Lacks control. Distributed agency...'the team'	(coping...and belonging)
there's no support and you are chucked in at the deep end with very sick people. But when I was in that situation I became quite resourceful, as I have been over the last six or seven years, I've had to figure out ways of getting things done. So, you know, even staying 'til late, getting there really, that's a huge thing to do, and writing everything down and having a clear tick box kind of list and not getting distracted by things, not letting the organisation part of it go at all; I'm never losing concentration on my organisational skills at work. At home not so much but definitely not at work like. The moment somebody calls I won't do it unless I've got a pen and paper ready to take down a message and I know everything for that day, where it is. And I think it's just because I'm scared; if I was to not be organised at work I'd have a breakdown. (Laughs) (93)	Not letting it ('organisation part of it all' go Drawing on what has learned to do, because of dyslexia Multi-tasking and telephone calls = high risk Staying late = huge 'thing' to do + 'not letting' the organisation part of 'it' go...	Control, agency...something tangible 'part of it' – partitions self, abilities and functions coping strategy ...evolved from fear describing potential critical incident not letting 'it' go...control, agency, something tangible.	Ownership (holding on -- *the opposite of letting go* -- is a bit like scraping by) ***Partitioning self*** (as part of coping...which in-turn is part of belonging?) Coping as *negative* (derived from fear and avoidance?)
I'm never losing concentration on my organisational skills at work. At home not so	Different at work versus at home	Different role / identity / part...partitioning	Partitioning social roles

much but definitely not at work like. (95)		of self and skills	
The moment somebody calls I won't do it unless I've got a pen and paper ready to take down a message and I know everything for that day, where it is. And I think it's just because I'm scared (98)	'just' because scared – won't take risks with information and organisations	Risk, thresholding (some things he won't accept – drawing the line somewhere), fear Fear in workplace, as driver of behaviour...relating to shame?	Thresholding (coping ...this feels distinct from 'scraping by' but similar to ownership, in that there is agency in the decision)
if I was to not be organised at work I'd have a breakdown. (Laughs) (95)	He would have a breakdown if wasn't organised	Metaphor – mechanically, physically, like a car / machine. *Followed by laughter-humour*	
it's not been that clear-cut as to what it actually is for me. I felt like… When they said to me, "Oh you're dyslexic" it just eased the pressure from my mind of… I used to feel quite badly about myself in kind of a self-hatred kind of way because I really wouldn't get where I wanted to go, and I'd have moments, like I'd have real extremes of moments… (102)	Dyslexia is not clear-cut. What is it for him Self-hatred but diagnosis eased that	Unclear personal meaning of dyslexia (not used to it, not understood or processed it...something separate / external) Hates part of self that is ? dyslexic...or different / dysfunctional	Self Hatred (**partitioning self**) Diagnostic Reframing *(his self-hatred)* (Power of the Dyslexia Label)
So the moments where I'm quite incredible, like I can play the piano just like that, and I wouldn't understand it, how I can just sit on the grand piano and play in a way that people think that I can play piano, or play guitar and it's… It makes me feel incredible, the way I can play, and then other moments when I can't do it at all. And it's the same in medicine. (106)	Moments where he is 'incredible' relates to music ('natural')	Incredible belongs to a different part of him – partitioning, attribution to something else... Musical part (ability) = natural Medical part (difficulty) = unnatural, by contrast?	Incred*ability* (**partitioning self**)
So there's been moments where I've known everything and I've been teaching my friend and then there's other moments where I just have a complete mind blank and that builds a very deep sense of hatred towards yourself, (107)	Mind blanks in medicine build deep sense of self-hatred (because of frustration at not being able to do something that you know you can do when you want to)	Self-criticality of difficulty building self-loathing Frustration → internal blame → hatred	Self Hatred (**partitioning self**)

So there's two sides of it, don't know if it's a psychiatric problem… (Laughs) But there's two sides of my mind; one is exceptionally impressive, even to myself, and the other's just… and it's kind of self-sabotaging, the other side of it. (113)	'Don't know if it's a psychiatric problem'	Medicalises (pathologising) struggle to ? borrow legitimacy from mainstream label	Legitimisiation through Jargonising (implied feeling of ***lack of legitimisation***)
	'impressive *even* to myself': When achieves → surprises himself Two sides of mind 'kind of self *sabotaging'*: conflicting purpose / intention	Low self-esteem attribution to other side / part (sabotage) self-sabbotge: purpose, intention...'extra-self agency' → still part of self, but a different, partitioned element. Metaphor- hemespherist discourse	Self Hatred (**partitioning self**)
And when I got the assessment from dyslexia it kind of gave me an answer as to why I didn't fit into everything else for all this time. And I've never owned the whole… (116)	Diagnosis explained why 'I didn't fit into everything else'	Pieces of puzzle not fitting Dx explaining out-group-ness Referring to parts...but never felt whole	Diagnostic Reframing *(his self-hatred)* (Power of the Dyslexia Label)
you get the power from that to be good at academics because it doesn't mean anything compared to being good at music (120)	Comparison to music galvinises against academic failure		Galvinising Activity (coping strategy → ***resilience***)
"… I'm currently working on an album so that is the thing that really drives me but to be good as a doctor I need to read some books and just get my knowledge up, but the experience I'd get on the wards with patients emotionally charges me to be a good musician. (125)	Emotional charge → heartache of day-job 'That *really* drives me'...cf. medicine → which ? doesn't? need to get my knowledge up	Painful, hurts him, *emotional labour* (cf. Iona Heath)...(this feeds what he is 'naturally' meant to do, which is music) Doesn't feel 'good enough' yet – needs to do more	Emotional Labour (doctor role → partitioning of social roles) (music =) Galvinising Activity (coping strategy → ***resilience***)
So like I'm motivated to make good music but to make good music you have to have the right experience as a doctor on your day job (127)	The *right* experience as a doctor	Does this mean there are ? wrong experiences? Music (good) won't come from his negative self-perceived poor performance?	(right vs. wrong experiences →) '**Essential Doctorness'** (→ Belonging)
you go through the heartache, you go through the deaths, you go through the adrenaline of being in crash calls and all this kind of stuff,	Heartache from deaths and adrenaline, fuels his music		*(Is this a 'right experience' to achieve 'doctoriness'?)*

seeing people die, breaking bad news, and then that fuels the music. (129)			
Definitely systematic thinking, that is something that I've always battled with. So I'll think about the end before the top, you know, the end bit before the first thing, (139)	Battled with systematic thinking	Metaphor – fight between natural style, and adopting style of thought / work	
And there's a lot of algorithms in medicine as well so sometimes I'll just… I'll have this flood of things. Sometimes there's a queue in my head. So if a patient comes in with chest pain you're meant to have like a systematic way of thinking about it, though practising I've kind of developed that systematic way of thinking (144)	'There's a queue in my head...flood of things' gets in the way of what 'meant to do'	Thought process as logistical problem Comparison / benchmarking against expectations. *Meant to do*...so not sure he actually does do it yet...? Doctors are supposed to...but ? he doesn't Also- sense of exasperation here (meant to) In his head, but not internal, not natural	Comparison → not meeting expectations
I've kind of developed that systematic way of thinking, but at first it was just like things would just blow into my head like that, totally erupt, everything I can think about with chest pain, so then I just wouldn't think systematically. (147)	Question would just blow up in his head: Explosive forces	Externatlised. Question / thought as an independent entity	Metacognition (coping strategy)
I think it matters a lot more now but it's easier now because you've got a physical person in front of you, so you've got a patient and that is what it's all about, whereas before it was a question and then it'd just blow up in my head so I would totally not understand what the question was asking, and that's why I wouldn't get the marks. (151)	Thinking 'right way' matters more now Importance of conforming 'that's why I wouldn't get the marks'	Greater importance now is a doctor ('matters a lot more *now'* – now he is a doctor) Cognitive conformity 'it'd just blow up' – thought as independent entity sense of excusing /explaining / mitigating here	**Cognitive Conformity**

it comes from a different part of my thinking. So when I'm with a person I'm speaking from a different part, whereas when it's just you and yourself and there's an exam it's slightly different, no actually it's very different. It's coming from a different place. I don't know why I feel like that but I do feel like that. And that might be why I did so badly in exams. (Laughs) (163)	'Comes from a different part of my thinking' (laughs)	Partitioning off parts of himself (cf. ? hemespherist discourse) Splitting agency (*that* might be why I did so badly in exams)...displacing blame / attribution (humour – uncertainty at what he is feeling / describing?)	***Partitioning self*** → abdicating agency, attributing failure to that 'part' of self as a means of protecting fragile self-concept
I had a lot of family stuff going on and there was a lot going on, and when I went to sit my third year exams I had put in so much work and it was one of those moments where you put a lot into that three hour exam and it's quite draining, and then towards the end I had to fill out the question and answer booklet thing for the computerised marking and then I filled out some of it wrong, I transferred the marks wrongly, and that caused all of my answers to be out of synch so I only scored about 39% on that exam, I failed it (180)	External factors of chaos – lot of family stuff	? attribution, overwhelming coping abilities – forcing a 'survive' instead of 'thrive' mindset ('passing'?)	Overwhelming (external forces overwhelming) → attributing failure to external source
	Describing transcribing difficulty leading to failure of exam, not relating to knowledge. Bureaucratic + system wouldn't facilitate mitigation	Shock, injustice...pettiness of barrier Prefacing failure with display of chaos...mitigating? Critical Incident (failure)	
Because I asked them to mark my main question booklet and they said that I'd passed the exam and all of that but I had to go through quite a lot of higher level people. So the Dean of Education, for instance, I had to book an appointment with him and speak to them, and then they just said, "Well it's kind of just tough luck really, you're going to have to redo the exam." (186)	Tough Luck	Sense of bargaining – 'they said that I'd passed' but ... Sense of injustice Negotiating hierarchy	Externalised attribution → tough luck & injustice
And I just could not think rationally that this was something that an adult would have to go through, you know, somebody of our quality of education and the amount of work that we'd put in and they're still saying that your whole summer is out the window (189)	Felt like treated like a child	Power / hierarchical discrepancy (? Cf. Transactional Analysis) Whole Summer = big deal	(difficulties →) Infantile

That, to me, I couldn't comprehend how a sane person could think like that, even though they'd marked it and formally said to me, "You passed the exam in terms of your knowledge." (192)	Couldn't comprehend how sane person could think like that	Felt the injustice was *insane*, made, maddening A recurring 'they' – embodied 'other. Them vs. Him	Them vs. Him (other, outside...externalised)
they referred me to Study Skills because they said like, "There must have been *something* that made you do that wrong," (196)	'there must be something that *made you do it wrong*'	Failure as trigger. Problem is with difficulty (learner) not system (exam booklets) This something = Problem is with difficulty (learner) not system (e.g. exam booklet)	Thresholding (different sense, this time his failure breached a threshold to look for a cause)
the Study Skills person said, "Let's do an assessment to see if there's anything that's lacking and then we can direct any kind of personalised thing towards that." (199)	Assessment to see what's lacking	Difficulty as a *lack*, or a *deficiency*	Deficient
they said the way I'd learnt music and all of that kind of stuff is characteristic of that kind of way of being. (202)	'characteristic of that way of being'	Dyslexia is *caricatured* Dyslexia as a way of being	Caricatured Dyslexia (to understand, cope and accept label)
And so then they did the assessment and then I got the report and then they tailored some of the study skills for me through that. I think it did help me (204)	They did the assessment	Mechanistic...*it* happened, *it* was *done* to him *It* did help	Externalisation
I think it did help me, it helped me quite a lot actually to get through the following couple of years and the following challenges. My mum was diagnosed with a brain tumour during my finals. (206)	My mum was diagnosed with a brain tumour (massive bombshell at the end...more [BIG] external factors)	Critical Incident – personal / family life	Power of Dyslexia Label → helped
But it was during finals and the moment that all started kicking off I was just like, "I have to come out of medical school because I can't handle it," but then somehow I managed to get through it and even… The written exams I passed with 51%, 52% so I just about scraped a pass, but I passed	'just' 'scraped' a pass	Passing – to gain entry to profession Passing as a professional 'just' passing.... in this sense, passing feels inadequate and somehow deficient	Scraping Through (perceived passing)

and that was the main thing and now I'm here (219)			
. So it was incredibly difficult, *incredibly* difficult, because just to have to switch off those parts of your mind, and for anybody I think it would be really difficult to do. (221)	Switching off parts of mind	Partitioning, some sense of control / selectivity (and ? therefore agency) Repeated *incredibly* difficult for emphasis	Partitioning Self (some agency in switching on/off)
they just talked to me about things and it wasn't necessarily they gave me specific tools, they just talked me through things like how to organise myself and how to think every day about managing your time and managing what work you have to do within a certain time. (225)	'they just organised everything for me' – describes approach *he* developed	Describes in disembodied sense, surrendering ownership / agency ('they') Minimalising language ('just') → ? didn't perceive value in it	<u>Abdicating</u> (or surrendering) <u>agency</u> (? Relating to partitioning and the process of externalising attributions)
I had a calendar on my wall and it had all my dates so then I could see my whole year in colour and then that just organised everything for me. (228)	Describing organisational difficulties	Disembodied discussion of Central Organising System (COS)	Coping strategy – but sense of <u>abdicating agency</u> here too
And even now I think difficulties, it's mainly organisational difficulties, yeah, because you have so much coming at you as a doctor, from nurses, from physios, from doctors, from patients, and if you don't have a central organisational system and are able to handle it then you're going to lose your job one day, or kill someone – even worse. (Laughs) (233)	Describing potential organisation difficulties High stakes – lose your job / kill someone Fear and humour	Disembodied COS Potential critical incidents Fear as driver for behaviour	**Fear** Metacognition
Yeah, I've never really spoken up about things that go wrong with me, I can never tell anyone, and so I've developed these mechanisms of handling it. (244)	Dyslexia = 'things going wrong with me'	Can *never* tell anyone → Fear of disclosure Fear driven coping mechanisms?	Deficient (self-stigmatisation) **Fear & <u>Shame</u>** (it feels like there is a lot of fear and shame here)
little mechanisms like that I feel that's where there's an explanation for to why I did all that kind of stuff and my friends didn't. Does that make sense? That's what I think I mean by that. It's now called dyslexia, like this way I am different, not in a good or bad way but just a	Describing strategies he always (instinctively) used Diagnosis now *explains* Stuff he always did differently is now called	Diagnosis reframing difference / isolation, different meaning	Metacognition ---

different shape (laughs), that's how I feel; everyone's a circle and I'm a triangle like that, that's how I feel. It's not anything better, nothing worse, it's just weird to a certain degree. (Laughs) (253)	dyslexia 'Everyone's a circle and I'm a triangle' Laughter	Metaphor- difference is circles and triangles, not good or bad...but it *is* weird....(cf. earlier use of weird in context of isolation) ?stigmatising (weird as deviant), ? referring to difference, isolation Defusing uncertainty / unease	Diagnostic Reframing -- ? self-stigmatisation (referring to self /process as weird, internalising and agreeing with social ideas of difference / deviance, and applying to self)
how I get these moments where I'm deeply, deeply insecure and when I'm incredibly impressively confident, but there's never consistency and that's the problem. (256)	'insecure' (*deeply* repeated) contrasts with 'incredibly impressively confident'	Highlighting degree / depth of insecurity. (Impressively confident- impressive to who, self? Contrast with low expectation or poor self image)	Insecurity → **deficient** / self-stigmatisation / shame
I: What happens with those moments? R: Nothing really, I don't think anything happens, it just makes me feel… I'm very introspective so I'll always think inwards and it makes me feel worse about myself when things happen wrong, but then it reminds me of what I can achieve when I'm able to do things really well and I get good feedback from that (263)	'it *just* makes' me feel worse about self'	It =External (? Physical) force Just = minimalizing the internal reaction Poor self esteem / unstable concept of self	Externalisation Poor self-esteem→ **deficient**
Yeah, so failing exams has always been something that reminds me of how badly I can do things. Even given that I've put so much work into things, I can still fail really, really badly, and you're with people who have not worked and I'm in that group, and I always felt like, you know, really a deep self-loathing. (270)	Amount of work + resultant failure is different → reminds him of how badly he can do Being in same group as people who haven't worked → deep self-loathing	In/Output discrepancy → sense of being unfair Social comparison, contributes to **deep**	Self-hatred → **Shame** (at discrepant performance)

		self-loathing	
whenever you hold a guitar it feels like you're holding a hand when you put your hand around the neck, and more so than family or anything else guitars have been that consistent support throughout my life. (279)	Comfort from holding guitar	Guitars = more supportive than family (like holding hand...whereas doesn't talk to family about difficulties / failures)	Incred*ability* → externalised to anthropomorphosised object Sense of isolation from social / human network
… I don't even remember life before that and… yeah. So a side of my impressive side in myself is when I can do a guitar solo and I can't reproduce it but you know that that's an impressive guitar solo. **I don't feel very responsible for it** because it comes from somewhere else, yeah. (284)	Impresses self 'impressive side' of himself- 'I don't feel very responsible for it because it comes from somewhere else'	In contrast to low self-expectation Partitioning 'impressive side' of himself attributing success / achievement to 'other' source of agency....external of him, but not from him	Incred*ability* → side / part → partitioned self.
I: It's interesting that when you do something well it comes from somewhere else but when you do something badly it's a deep self-loathing. R: Yeah, mm. **I: Do you have any thoughts on that?** R: Don't know actually, I think that's quite an interesting point. No, I think I've always battled with that kind of side of myself. (294)	Always battled with linking failure to self-hate	Attribution...(?global sense of) guilt from failure leading to (focal?) sense of hatred of that *part* of self	Is this guilt (I don't think so) or **Shame** (a great deal more internalised)?
during that time of loneliness is when I created the sound as a musician so I think that's where the… **it is actually coming from there.** And now I'm quite happy, like I'm in a relationship with an amazing girl for the past two years, and since then I've been quite happy but yet the music's not had that sense of depth, which is a bit **strange**. (Laughing) (314)	Loneliness = where created sound of a musician = 'it is actually coming from there' Different *place* and *time* 'A bit strange' Laughter reinforces discomfort at this	Again, partitioning, but this time linking loneliness (negative, isolation, weird) to positive (natural, sound of a musician) Doesn't ? understand it, or strange....links to weird (which he uses in context of isolation)....strange as in different,	**Partitioning Self** → coping strategy (contributing to **Galvanising Activity**)

	'strangeness' (is he masking embarrassment to share this with me?)	separate, isolated / isolating (as a factor)	Deviance (strange)
The thing is, it's kind of **weird**, like not weird but… how the two worlds collide in medicine and music (324)	Two worlds collide	Metaphor – 2(+) parts of him	Partitioning → this time, of social roles (different social worlds)
even now when I talk about music being 'hurt' but I visualise it in a way that… You know when you're getting blood taken and people know that the blood is what's keeping them alive but you have to go through a bit of pain to see the blood. Does that make sense? So they look at it and then, "Oh God, I can't look at the blood," but that's… without it you'd be dead, without the blood you'd be dead, completely. (329)	Pain of venepuncture to see blood, is likened to pain of experience to see what keeps you alive (in his case, music)	Metaphor Likening physical pain of *medical procedure* to emotional pain of experiencing difference The pain has helped him see – clarity (in meaning) afforded through emotional labour	Sufferance to Belong (need to go through pain to belong)
But people don't want to see it, and even to see it you'd have to like go through that pain of having a needle in your arm, so that pain is what you need to find out what it is that keeps you alive. So it's the access, right? And I think a lot of people walk around without… you know, blind to it completely but… So I always see this kind of thing (333)	Pain (of seeing / being aware)		
over the past two years since I've had the diagnosis, as you say, it's just given me a little bit of an understanding, so I'm no longer just wandering aimlessly in the dark, right? And I always felt like, as I said before, that I didn't fit in (347)	Diagnosis → no longer 'wandering aimlessly in the dark'	Clarity, ability to see (meaning) Temporal: didn't fit in (? Does now?)	Diagnostic Reframing → made clear, what was unclear, made sense of historically not 'fitting in' (NB: this doesn't appear to help him with the sense of not fitting in at present)
I just did not fit into that conversation even half the time and I just couldn't talk on that kind of level, my communication was very non-medical, like I just don't think as a doctor and I never felt like that (351)	Where am I so I can see where I'm going (c.f. wandering aimlessly in dark) 'just don't think as a doctor'	Contrast? Now can see Metaphor of journey	Cognitive Conformity (belonging)

		→ thinking like 'in-group'	
And this is a very insignificant thing and I've not actually had time to process it until now (355)	Surprised how small ('insignificant') thing (diagnosis) had big impact	Power of labelling difference	Not yet fully assimilated label *Diagnostic Reframing* as an on-going sense-making process.
And this is a very insignificant thing and I've not actually had time to process it until now even because I had the re-sit and I went straight into fourth year and my mum got sick between fourth year and fifth year, and then fifth year was just crazy and the moment you finish that you go into FY1, so I've not actually had time to process it. It's always been, "Okay, that's the situation, how do I deal with it now and how do I make sure I don't fail again?" I've somehow managed it the past two years. (360)	Time to process meaning of diagnosis ('just carried on') + 'Somehow managed to pass'	Just carried on → passing Not sure → lack of agency	Coping → scraping by → Perceived Passing
It's definitely given me… I think the main thing I've got from it is it's given me the confidence to be myself, right, to be not like everybody else, and that's okay (365)	Diagnosis gives confidence to be himself 'and that's ok'	Legitimises difference (weird / isolation)	Diagnostic Reframing → ? legitimising difference / deviance
, I had an appointment last week and he said that he was quite pleased with how I'm handling it and – **I:With handling your dyslexia?** R:Just FY1.. They don't know about… But just as an FY1 on a very busy ward with very little support (372)	Non-disclosure at work		**Shame** or fear
And I never underestimate how much planning you need in the job and so that's worked to my advantage because it comes across like I'm more	Because of difficulties → never underestimates need for planning	Coping mechanism / compensatory strategy	Metacognition - Coping

organised, (377)			
I did an ALS course at the start of the year and we had to do it before we started this job because there's such a huge on-call commitment, and this was like a week before I started and I was the only doctor of all of them to fail it and I got 91% in the… (382) So I scored the second highest in the entire cohort of about 30 people from that exam, which was kind of weird because usually I do badly on the exam but… and I knew that I'd prepared for it. And then the actual simulation, I kept failing it and it was really strange, and I just didn't know what was going on with me. Like it was another one of those points of… That was actually one of the lowest points I've had and I totally didn't (inaudible 00:32:23) but it was very low. (Laughs) It was a point where I was the only one of my whole group to fail it and I'd have to come back another day to do it again, and it was… I've never felt so insecure in my… And it was really, really bad because I was in a position where there was… (392)	Only doctor to fail ALS in cohort → difference, comparison, group identity	Core set of expectations to meet to gain membership to group	**Essential Doctorness** skill
	Lowest point. Strange (weird) didn't know what was going on...	Disembodied self High level of significance attributed to this event	Shame + self-hatred
	It wasn't like I didn't prepare (laughs) 'That is the place, that is that person'	Bargaining (humour) Partitioning self (difficulties now = different person) ...? distancing from self-loathing	Partitioning self Failure in *Comparison*
, I'd say that's it, that is the place, that is that person. I've become this person who I hate when that happens, like it's really bad. And then so after that - it was all the way in Telford or somewhere – I drove back home and I didn't even come back home, I went to this… it's like a nice hill at the back which overlooks the whole of the Midlands, I just went there and I sat there for like two hours, just sitting there, to get some break from things. (415)	Hate that person... Describing not being able to engage with social network (family)...driving to a hill... → to do what?! Needing to escape this reality		Not belonging → needing to escape Partitioning self → became a person he hates (through comparative failure) Isolation

			Blame...and **Shame**
. I wrote things like… I remember the first line was 'I hate myself sometimes', that was definitely the first line I (421)	Conditional self-hate (writing notes on thoughts re: ALS failure)	Shame → self-hatred	Conditional self-hate as a function of <u>shame</u>
I started realising being a doctor is being a soldier on a battlefield and like, you know, the battlefield's a hospital and you're a soldier for health and healing so you've got to fight the disease, you've got to have that kind of fighting spirit, physically you've got to be fit, you've to emotionally be fit, and I got to that kind of visualisation and that made me feel quite charged towards the end of it. I was like, "This is just a setback, it's a minor setback, I can just keep doing this." (429)	Describes being a doctor as being a soldier on a battlefield... Minor set-back	Metaphor for coping, expectations, regimental / 'fighting spirit' (links to trauma, stress, fear, aggression?)	***Fighting to belong*** → belonging as a battle
I managed to pass the second one, so that was fine. The main thing I identify with is it dips from one thing to the next. So I have like a really low period, *really* low, and then the next bit it's propelled me right to the top again, (432)	'Fine' (not impressive of weird, just *fine*) Managed...gives a sense of 'somewhow' → ? lacking agency, ? scraping by	Underplaying achievement	Scraping By
, and I don't know what that is, whether it's the dyslexia or anything else. It's been quite an isolated existence (434)	Isolating experience (ALS failure)	Failure as demarcation from group → isolation	Isolated
I just think strangely when it comes to things, even at work, it just baffles me how they can just, you know, not introduce themselves to patients sometimes (466)	His different way of thinking improves compassion / considerations of patient ('strange' and 'baffles')	Self-perception of benefits from difference (doesn't yet understand it)	His difference (seen as a strength here) is 'strange' → still **deviance**
By not thinking like a doctor, I don't know what I mean by that. I guess it's just compared to other people, I feel like I just still don't fit in. Like some	'Feel like I just *still* don't fit in'	Social comparison	Cognitive Conformity & *belonging*

people just seem to know how to do everything and I always think, "How is that possible?" I (450)		Temporal reference- *still* doesn't Frustration- just	
I just feel like they've been through medical school and then how they know how to be a doctor, or at least they've got that kind of confidence, whereas me, I've been through all of that and yet I'm starting from square one again and failing the ALS. (Laughs) And I was really sad that time, I've totally cut it out my life, that's why I didn't think about it, but yeah, it was quite bad (456)	ALS failure reinforced belief that 'doesn't know how to be a doctor like others do' 'a sign not meant to me (486)' Cut it out of his life	Being a doctor as a membership to a social (secretive / cult-like) body of practice-based knowledge? 'sign' – some sense of fate, extra-corporeal agency Cut it out- Metaphor: surgical excision, removal of disease	Cognitive Conformity + Essential Doctorness + Belonging
. If it wasn't for having a diagnosis or having a starting point I probably would've just said, "I'll take this as a sign that I'm not meant to be doing this," and just leave it, yeah. (459)	Diagnosis gave him permission to stay	Legitimises difference and struggle Affords ? extra chance (/ humanity of failure)	Diagnostic Reframing → permissive struggle / failure
think there's moments when I'm really confident and I think that's where it comes from. (467)	Confidence comes from somewhere else (different part)	Partitioning self	Partitioning Self → confidence comes from elsewhere (even positive traits attributed externally)
There's moments where people really need me and I'm there, without a doubt, and I don't have even an ounce of insecurity in myself at that point, I know for a fact that I'm there and I will make that person better, or feel better at least. (469)	Certainty in role and ability		Partitioning of social roles → certainty in role affords some sort of confidence (coping strategy)
putting everything together, including the experience, including the negatives and the depressing parts of it, it all gives that part of me a lot of strength (471)	Positive and negative experiences give him strength and compassion		
It's like you have that compassion, you've been	Diagnosis as a starting point	Metaphor of journey	Diagnostic Reframing

through something like that, you've been through loneliness, you've been through things, and things that were seemingly impossible but you've got through it so you can talk from a place with some confidence. So I think the diagnosis was just giving me a starting point; I didn't have that before, I was just like blindly walking around (476)			
	Before diagnosis was aimlessly wandering	Metaphor of journey Diagnosis affording clarity and direction	
It definitely gave me a clarity that I didn't have before and I never even really thought about until now because I didn't have time to think about it, it was just a matter of getting on with life and getting the grades and moving onto the next thing. (486)	Diagnosis gave him clarity		Diagnostic Reframing → clarity
	Diagnosis takes time to process. Pressure to continue, cope and 'pass' → denied time to process diagnosis		
So the label's been positive for you but it's not something that you share. R: No. I mean, with the consultants and people like that at work, nobody really knows but they're the type of people who wouldn't really care, like it's not like… If I was to say to them, "Oh I'm dyslexic," they'd be like, "And what?" you know, it is that type of team that I work with right now. It's not that they're not supportive, they're very busy people who don't have time to know everything about you, as long as you get the work done and as long as patient care doesn't suffer… (495)	Doesn't disclose diagnosis	? Fear or *shame*	Shame
	Doctors→ caring profession, but 'not the type of people who would care about diagnosis of dyslexia'	Wrong sort of condition (to deserve care) Hierarchy of difference / difficulty / impairment	Fear → label *falsely* used to legitimise struggle
	Too busy to care As long as work doesn't suffer	Lacking legitimacy?	? Hierarchy of diversity / difficulty → dyslexia as *undeserving* of compassion
, I don't want it to be something that I'm just, "Oh I'm dyslexic so I can't do this, I can't do that," I want to be given like a fair chance to prove myself a bit. And even if it means just work extra, come in early, stay later, I feel like it's worth (500)	Fear diagnosis would make 'unfair' → doesn't want to use as an excuse	Notion of *fairness* in struggles…rite of passage Resistance to excuse difficulties *Fair* chance to prove himself (to who?!)	Fairness & <u>*Deservingness*</u> Power of Dyslexia label → to be used inappropriately

			driv**e** to **Prove Myself** → passing (for who?) bridging Belonging & Coping
what tends to happen with me, everything blurs into one thing and I can be talking about one thing (515)	All part of same thing, all blurs together (laughs)	Conflicts with partitioning and disembodiment discourse...or could this reflect temporal aspect- now a doctor, parts are starting to come together, converging on new identity...?	Partitioning → cognitive blurring

<u>Self Characterisation Sketches:</u>

1. How *you* see *yourself*. How all of the bits of you and your life fit together.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]

	4 separate images...does this somehow reflect the partitioning of self that he describes? Disparate, separated into parts... Tear → tearful, sad, emotion Holding hands → Connection (always being there) Stickman → side-lines, afterthought....	Aspects of himself do not fit together or inter-connect...the way he sees himself is as divided, in several parts...	Partitioning
it's hands holding because I'm always there for her or anybody, without a doubt. Like I think whenever anyone needs me I'm always there, like even if it's a text message or a call or whatever, I feel like I'll always go there and I'll always be close	Sees himself as being supportive & caring → and important aspect of his personality	Supportive (but cf. support as 'umbrella' which is more like shielding, defending)	Caring

(583)			
I have these moments where when you get to that level of my thinking, like I feel a bit broken down and then I can't write properly. (Laughs) (589)	Broken down → mechanistic metaphor	He feels broken, dysfunctional, different	Different, deviant. ? also relating to *cognitive conformity*
I'm always supporting towards her so I guess I could put an umbrella, I think that would be good. Does that make sense?	Supportive of others (support as shelter → metaphor)		
I think that probably is the difficulty I get as a doctor because I think there's a huge emotional side of it that stays with me and then… And I try and get on with things but it's something that really does hold me back sometimes. I don't know if it's anything to do with dyslexia, probably isn't, but it's definitely a feeling that you can't do everything you can do for that person, there's always something else you can do but you can't do it physically. And I think that's where the people from outside see me as a doctor, people who know me probably would think that would be the one thing that holds me back, that I get a bit down, I feel a bit hard on myself. When I can't do something I'll get quite hard on myself and I think that probably represents it quite well. Let me put 'teardrop' so you know. (640)	Tear → difficulty he gets *as a doctor* is the 'emotional side' (partitioning)...but this isn't due to dyslexia... Hard on himself→ this is related to the complex way in which he sees himself and the expectations he places on himself → self hatred Others see him as a *weak doctor*?	'Try to get on with things' → sense of not achieving this, failure to meet expectations...that he sets for himself ('there's always something else you can do') and this is represented as a physical struggle Weakness → lacking some kind of doctor-specific strength	Partitioning Self-hatred Essential-Doctorness
I'll draw a stick-man <u>because that's how I feel sometimes</u>, like a stick-man, like nothing substantial. So like if I let my health deteriorates sometimes <u>I'm like physically weak</u>, I don't eat properly, so people looking in on that would be… you don't consider yourself as much, you know, so I see a stick-man and that's it, you know, just like bones and nothing there, like a weakness. I think	Self as a stick-man, as insubstantial and weak	Insubstantial is an unusual, and powerful, word to use towards self... lacking in substance (? Character, physically) ....he really doesn't like himself	

that would be a bit of a negative side of it but… (Laughs) (657)			

2. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.

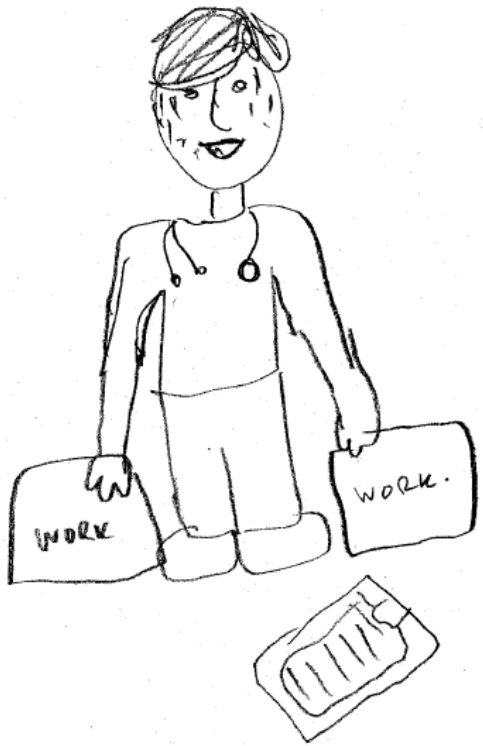
Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
		Two separate images: 1 = Rockstar Confidence ('Impressive side of himself') and 2= the baby, him as a doctor....juvenile, vulnerable...	
it's like rock star confidence and that's it, whether it's in medicine or anything in the world, like if you have this confidence that you know who you are, you know what your sound is, doesn't mean you're a musician or whatever, it's like even as a	Rockstar confidence is how he would ***like*** to be (but isn't?)		

doctor, if you know who you are… That's how I'd like to be and that's what that represents, not necessarily the music, it's the way of being when you have a guitar in your hand like Jimmy Hendrix does, it changes the way people listen to the guitar because he just knows who he is, knows his sound, even his personal side of things is different, but as a musician, as a rock star… You know, you can change the world as a musician just with confidence. (691)			
I think being a doctor is… I feel like… If I was to draw it… I feel like a baby. So if this was a baby it would be like… a really scary-looking baby. (Laughs) (701)			
That's how I feel, like I've just been born into this role as a doctor and I'm still kind of feeling it up and I still have to try and walk and fall and… you know. I don't know what I want to do, I don't know whether I want to be a GP or a hospital doctor (715)			
And it's interesting that you've drawn these two things as separate people, is that part of your life very separate from this part or is there any relationship between the two? R: This is strange because there is a huge overlap yet it's two very different ways of being, and that's quite transparent but not… So I made an album two years ago, it's called Complex Simplicities, and this is exactly what it is, it's a complex simplicity, and that's… A lot of things in my life are so simple but are not simply, it's really complex but it's simple, like it's a huge paradox. So even though they're two separate things it's	*Weird* (Complex Simplicities) Paradox – separate but the same		Partitioning – all part of a whole Weird – difference

also the same sometimes. It's weird. (731)			
And do your difficulties come into any of this anywhere at all? It's alright if they don't. R: Definitely in the medicine, definitely, yeah. I think that's why I do picture it like this. I don't think other doctors would because it might be a bit of a weakness to think that you're newly born into the industry. Because I still need to learn a lot of skill, I need to learn things to survive in the industry, in the field, but… I don't know. (739)	Sees his 'baby' self as a weakness, that would not be shared by other doctors		

3. How a *critical* other, someone who knows you very well, and is *critical* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]

		Sweating – working hard, perspiring, struggling...burden of work. Stethoscope- thinks others would see him as being a doctor – as an integral part of his personality	

Appendix 5: Coding Notes for Rubina

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
never had any kind of educational problems at school. (25)	Denies historical difficulties (excelled in primary school) *Difficulties were not manifest in lower-challenge setting*	Denial (or factual recollection) Coasting *Difficulties were not manifest **yet**…*	Denying / Minimalizing → fitting in [Sense of discovery as a time-bomb]
I never thought of myself as having dyslexia and I never struggled at school. I probably excelled in primary school and then going to a grammar school I was probably average but I never identified any features of dyslexia during that time in my life. (29)	'Probably average' + 'never identified' In medical school- started to notice *things* Manifested during skills test	Fitting in... comparison to peers -- Threshold reached for difficulties to manifest -- 'probably average' → uncertainty (over/under-estimation...given difficulties and esteem, probably under)	Fitting in Threshold Doubt
Going to medical school in 2008 that's when I kind of started to notice things so just I think the worst thing for me that I can remember it's not dyslexia I have it's dyspraxia I have and it really showed the most when I had a	Has dyspraxia, not dyslexia. Manifested at medical school	Common sense of identity...shared experience affording inclusion in study --	Confusion over identify → doubt, conflict with fitting in [did she want to identify as 'normal' at school, then as

surgical skills test to do. (31)		Wanting to belong....marginalised	'dyslexic' for this study...?!] Wanting to fit in (**Fitting in)**
So it was a day of suturing and during that day we just tied different knots and do different types of cuts and dissections and that's where it really came out. So for example we'd be shown by the teacher by demonstrating on the table how to do a suture and I just, I just, I couldn't do any of it. I just couldn't follow the directions and I couldn't, couldn't work it out and I kept having to kind of go to my friend sitting next to me after nearly every demonstration (35)	Difficulties 'came out' → 'outed' *Just* couldn't do it. Needed friend to help	Visible manifestation of difficulties (public display) 'outed' her... ...friend as guide	Threshold [specifically this public display feels different from a private realisation]
and that's probably the worst kind of day, a dyspraxia day I've, I've ever had and that's where it really comes out when it's to do with 3D type things, so when it's, it's not so much reading or writing that's the problem it's more physical things so suturing or things that require a specific order (50)	Denies literacy related difficulties (has *dyspraxia)* 'worst kind of day'	(*why identified with / wanted to participate in *this* study (about dyslexia) when has dyspraxia? – some shared sense of identity, or an unmet need)	Identity confusion [again, did she want to identify as 'normal' or 'non-dyslexic' to fit in, and then as 'dyslexic' to fit in with this study....is she a '**Fit-In Adept'**?]
That's where I find it really affected me. Working in microbiology this just, just happened yesterday, I'm really finding it affects me a lot in micro more so than I did in my F1 time. In micro we don't have any patient contact so I've not spoken to a single patient since I've been here so every day we have a lab round and we go round the lab and we look at different positive results. So	Where 'it' *really* affected her...	A tangible *it*, a separate *it*, a disembodied *it* (her dyspraxia)	Disembodied Difficulty
	Can't get the ball rolling	Metaphor- mechanistic, process, sticking / slow → slower processes (not meeting expectation) highlighting difficulty	Threshold [again, this relates to a publically displayed manifestation of

they'll pick up the results and they'll be like, "Oh [Rubina], you spoke about this case and everything. Can you tell me about this patient?" and I just can't get to the ball rolling (59)			difficulty]
Like I just cannot remember like they'll just tell me the story and I just need a face to put to the story because I, I just won't be able to remember and to organise my thoughts especially like they will have (65)	Can't think like them... Disorganised thoughts cf. others ('especially like they will have')	Not fitting in – can't 'cognitively conform'	Fitting In [does this related to **.** from other case studies?]
I just really struggle to remember abstract pieces of information without visual stimulus in a very visual (67)	'just really struggle' – sense of what she feels she struggles with (implicit normative reference) Needs visual cue	Abstract. Personal Sense of Struggle (private) Attempt at certain cognitive task → sense of struggle, ?? threshold	Threshold (abstract info) [internal sense of struggle, private]
I think I just don't understand simple concepts I think is the other thing where I find it kind of it's quite common. Things that other people would just kind of pick up very easily I just, I just don't understand for instance in micro there's lots of kind of resistant mechanisms and it's not necessarily that they're harder, just, I just don't understand it unless I have a visual, a visual kind of picture to help me explain (76)	Cant understand 'simple' concepts → ? belittling (implicit cultural expectation and normative reference) Compared to things other people 'would just kind of pick up' Needs visual cue	Knowledge / skill as **tangible**. Social comparison	Implied Cultural Expectations Different → *not* ***fitting in***
so in my first, first and second year I just really struggled compared to my peers. I just	Not understanding cf. peers suggesting	Not Keeping Pace – sense of private awareness (...doesn't appear to suggest that	Threshold (pace) → different /

wasn't getting concepts as quickly even after reading an even after it had been explained to me I was just kind of finding...I wasn't really understanding. (99)	difficulty prior to formal diagnosis Wasn't *really* understanding...? implied element of being able to look like was / 'faking it'	this was publically manifest in terms of failure, but the 'wasn't really understanding' may translate into ? reduced participation)	difficulty → not fitting in 'faking it' (as a means of trying to **fit in**)
Also with the educational side of things just organising my, my work, my time and the way it got very kind of messy and very confused especially because everything was new it was a completely different type of learning to, to school. (102)	Medical learning is different, a *bit chaotic* *Element of 'everything being so new'* – implying this chaos would settle as learns and adapts	Volume + breadth → cognitive chaos (a form of cognitive non-conformity to implicit cultural expectations within medicine)	Cognitive Chaos → marks out *Difference* ...process of **adaptation** to cope
I think so because the volume of things that I had to organise were a lot greater than school so I think I managed to cope in school (107)	Struggle to organise, where previously coped ...again, implying process of learning and adaptation to new environment and demands	Transition from 1 environment (school) to another (university / clinical practice) drives learning	**Learning & Adaptation** to cope
in school and you could get away with it but here you needed notes, you needed text books, you needed to go online, and it was just a struggle to fit everything together (111)	Struggle to fit everything together ...get away with it → **passing** / **faking it** possible in specific settings / contexts	Metaphor: knowledge as a puzzle- fitting pieces together	**Passing / faking it** as context specific / facilitated by environmental factors
then I spoke to one of my peers and she said that she had dyslexia and she said to go for the test because you've got nothing to lose	**Nothing to lose** in getting test for SpLD	Risk, gamble	Personal Risk / Threat

and that's, that's why I went. (112)			
So I had the assessment and then so we got the 25% extra time (117)	So *we* got extra time in exams	We = sense of community with others with SpLD / extra time	Community [creating sense of surrogate belonging]
and I met up with a specialist as well who assessed my needs to work out whether I need a special computer programme or whether I need a special printer or a special computer but I, I didn't take that help because I thought what would really help me is just to kind of more the visual kind of videos or picture type revision techniques and guides so I just stuck to, to doing that on the internet myself really. (122)	Special computer	Special = different / different = special	
	Fine dealing with *it* Help = 'special' → didn't think it would help her	Rejected help → power in retaining independence → agency *It* = disembodied / separate difficulty	Disembodied Difficulty Agency
I don't think I needed to talk to someone I think I was fine dealing with it myself and I think I was, I was able to kind of manage it myself (130)	Able to just kind of do it	Sense of magical thinking- since diagnosis(?) Manage *myself* → retaining independence → agency	Agency
I was able to just kind of organise myself a bit more by the time it hit third year because I kind of like felt that during first and second year what I needed to do and how I needed to organise my time and my notes. I didn't feel like I needed the help when I started. (134)	Able to just kind of do it... Didn't feel like needed help when started (but ? does now?)	Temporal reference → learning and adapting Able to organise self → independence → agency	Learning and Adapting Agency [as a means of deriving some sense of strength]

I still have a problem organising myself so I'm not, you know, I'll just, just make a list of things that I need to do but it, it's still not on this piece of paper it's on that piece of paper. (150)	Still has problem organising (despite previously denying difficulties)	Emphasised by repetition Chaotic	Cognitive Chaos → marks out *Difference*
So I think I've had a very different F1 I think to most people because I feel like my job's some kind of supernumerary. So my first job was ITU so I felt like a medical student in ITU; I didn't really touch anything or do anything. I don't have to put central lines or arterial lines but there wasn't too many kind of organisational or practical skills needed there and I did a psych job again for F1 so again there wasn't many practical skills or organisation skills and reading required for that. (160)	New job putting her into medical student shoes again: 'supernumerary, so I felt like a medical student'	Not part of team / denied doctor status ...towards the outside ...supernumerary → superfluous	Peripheral (participation) [I note here, on the emerging thought about the link with communities of practice (Lave & Wenger) in terms of peripheral participation…in the context of this established model, she implies she doesn't feel legitimate within the group…]
The only kind of normal job I had was a diabetes job and it was, I think it was difficult to be so organised because it was just and they page for that print-out with people's names and the space in between the names weren't very big so you'd write things next to the name and I have messy handwriting anyway and things get merged together and you miss things (165)	'Normal job' (benchmarking medical-ness of activities) - messy handwriting + small space → cluttered → chaotic → risk of errors	Tangible sense of professional identity related to professional activities involved in / undertaken: *Tokens of involvement* (does this make tangible markers of difference, e.g. 'messy handwriting' *Tokens of Difference*?)	Cognitive Chaos → marks out *Difference* *Tokens of Difference* & *Tokens of involvement*

		(token does *not* appear to = tokenistic)	
but it was such a hectic job like being, being organised wasn't really a priority it's just and having clear thought structure wasn't really a priority. I don't think my kind of wellbeing was a priority it was just get the jobs done and get things ready for the next day. (169) + It was a very, very short staffed hospital so it was just like kind of get on with it (174)	Wellbeing & organisation wasn't a priority...just getting the job done → survival	Survival 'trumping' coping with difficulties → treading water Difference between coping (? Thriving) vs. surviving (treading water)	Coping vs. survival
I really hated the job. It was a very hefty workload but I don't know, I think I just had quite difficult periods to work with so I always think even if you have like a really awful job as long as you have a, a good team around you it is kind of, it makes things better and it makes things bearable but I don't, well I didn't, I don't feel I've had very supportive team (183)	It was a very short staffed hospital...I really hated the job. (justifying why her wellbeing was deprioritised)	Deprioritisation of wellbeing → survival 'trumping' coping again...	Coping vs. Surviving
I think they did; often I would be told so it was diabetes job so I did things like synacthen tests and things like that so often I would be told to do something (201)	Ordered ('told to do something')	Lacking agency, following orders...akin to military discipline → servitude / subservient... speaks of confidence and agency	Confidence + Agency (doesn't have any)
I'd say, "Okay how do I do this or what do I have to do?" and then I'd, I'd be explained how, how to do it and then I wouldn't really understand and I'd just be like, "Okay yes" because I didn't, we didn't really have time to kind of just, you know, just keep asking questions and there weren't maybe's I didn't feel so comfortable in asking too many	No time to clarify instructions (increasing pressure, decreasing support) ? some expectation to 'just know' or to absorb information through brief interaction.		Cognitive Conformity [tangible, skill based] [recognise that I am

questions so I would just go away quite confused and whereas I thought maybe another person without the dyspraxia would have gotten it (205)	? some perception that others would have this ability and skill.	→ speaks of a sense of cognitive conformity (but in the sense of a skill)	
whilst I understand how to do it, it takes me a while to kind of work out how it works and how it's related to cortisol and why we need these timings and it just takes me a while longer to process these, to, to work things out so it would have been nice to have that kind of luxury of asking questions and being explained things in a bit more detail so that. (201)	Not comfortable asking questions ...luxury of asking questions ...takes her longer → difference / deviance → source of embarrasement	Uncomfortable- draw attention to difference / difficulties Luxury of checking- language suggests feels like a burden Again, this appears to link to cognitive conformity here, and how non-conforming casts her as 'different' and a 'burden' rather than an asset / legitimate member	Cognitive conformity (as burden)
So I think a lot of the time in medical school when we've, when we've had our clinical afternoons so for instance here if we're doing a neurology, we're doing neuro exam for the afternoon and learning about that it would, firstly it would take me a while to understand the order and the sequence of things so you know, presentations. It would take me a while to kind of memorise that and I don't understand things unless I have an order or a sequence so if I don't have that clarity in my mind then that will just get very confusing (212)	Takes her longer, needs order and sequence Inferring social comparisons →she takes longer, inferring that others 'just get it'...so she doesn't have that capacity / think like them.	?jargonising to legitimise difficulties	Cognitive Conformity (a slightly different aspect here → inferred social comparison)
I just find people will just need to be told once whereas I will need to be told several	Comparison to peers	Social comparison → inferring difference in	Cognitive conformity

times and then have to read up on it later as well to kind of really make it stick especially in micro I'm learning so much stuff (217)	Not learning / thinking like others	ability and processing	
Everything in micro is new to me you know but I'm finding sometimes my other F2 peers are who have not done micro are able to understand resistant mechanisms after being explained the first time whereas with me it's taken me a bit, a bit longer to get the grasp of how it works (220)	Supportive team→ used to it, accepted it, but *embarrassing*	Embarrassed by burden to team	Cognitive Conformity → inferred social comparison → difference = embarrassment.
There is an ongoing joke where about my bad memory because every day we go into the lab and we have the bench run and every day it's the same thing. They, they'll be like, "Oh so there's patient X, X, X that you spoke on the phone to" and it will just, I, I feel very embarrassed because they're working on them. So it can be embarrassing then I've accepted it myself and they're kind of used to it in micro. There is an ongoing joke where about my bad memory because every day we go into the lab and we have the bench run and every day it's the same thing. They, they'll be like, "Oh so there's patient X, X, X that you spoke on the phone to" and it will just, I, I feel very embarrassed because they're working on them. So it can be embarrassing then I've accepted it myself and they're kind of used to it in micro. (229)	Embarrassed 'bad' memory ongoing joke	Difference (cog. Conformity) = source of joke (reinforcing sense of embarrassment) Joke → token of membership	Cognitive Conformity Conflicting Sense of Group Membership
Is there something about that situation that is different from if perhaps there was a noticeable difference or a joke's been made in other situations?	Banter → different kind of joke because it is generalised banter, and knows them (& the intent) / that they are just joking, not bullying	Humour as device Interestingly, this speaks of having some form	Conflicting Sense of Group Membership

R: Yes because I just know that within that team there's a lot of banter about everyone so if it was just kind of only directed and targeted to me then it would be like, "Oh gosh, that's not, you know that's not right really" but they make, you know, it's, it's not like a bullying type of thing it's just because I know them quite well I know it's a joke but someone else that I didn't know so well it would be quite not very nice I guess. So it's difficult. So it's not something I can just change. (239)		of group membership → she is known to them, and they to her...which attenuates this 'banter' (joke instead of bullying) ...in turn, this joking appears to be a token of group membership (is this a 'tokenistic' form of membership though...like the 'class clown' or 'court jester')	
if we test positive on that computer test but I was a bit, I don't know, I think I was initially a bit embarrassed to go just in case I did the test and I didn't need referral and it would just be like, "Oh no you're actually, you don't have any learning disabilities, you're just not very good or not very clever." (257)	Testing as a sterile 'computer'-based activity Not a neutral judgement: 'what if' or 'actually just not very clever' Embarrassed	Diagnosis → fear of failing (test) → fear of not having 'reason' for difficulties....placing importance on explanatory value of label...? somehow enabling her to forgive herself for struggling... **shame** at potential (?? Fearful)	Diagnosis as Forgiveness [Assuaging Shame]
I procrastinated that and put that off for a year and then by the third year I was actually quite wanting to go and get tested because I felt like it would, having that 25% extra time in exams would make a difference because when I read things I just if, if, if it's a long then yes then it's just too many facts, too much information, information overload so it gets very confusing. So I knew it would be	Put it off, due to fear Knew potential benefit outweighed this, so eventually went to get tested	Again, this speaks of fear, and the value she placed on the potential for the diagnosis to explain her difficulties, and therefore allow herself some sense of forgiveness	Diagnosis as Forgiveness [process is risky → is fearful → barrier]

beneficial for me so I was, I was actually looking forward to going and getting tested. It wasn't anything apprehensive or negative at that stage. (261)			[as a barrier → high value = high stakes]
So I just went to speak, yes so we just had a chat just kind of similar questions, how are you finding school, how did you find primary school, secondary school, what symptoms do you notice and you just sit various writing tests, reading tests, verbal reasoning tests, picture test and that's it and then he just diagnosed me (270)	'I just went to speak' – *just* ...? surprise at steps taken to diagnose Had this done to her: *he just diagnosed me*	Sitting tests – like an exam, passive Surrendering agency	Agency (surrendering) [passivity in testing, surrendering to the process once the decision has been made]
I know there is a stigma behind dyslexia and dyspraxia but as for me I, I never really thought of it as anything kind of negative or bad because it's, it's just like how someone can think that psych problems aren't real problems it's ... you're organ is, your brain is still an organ you know (283)	'Knows' stigma is there But...she didn't see it negatively	Difference between perceived external perception of label (negative) and personal notion of label (positive)	Perceived Perceptive Differences [label can have at least dual, if not multiple, meanings and functions according to the perceptive position] (relates to: conflicted sense of self)
. It's a problem you have. It doesn't, it doesn't mean you're dumb or anything it just means you're different and you think differently and you have different talents and you have different weaknesses and strengths but I never thought it was anything bad and I	SpLD = a problem...problematic Difference	Problem as Othering (currently cannot un-think of problematizing and othering...both already established sociological concepts)	Power of Label (?? attenuates perceived

thought it was actually good because it gave me an explanation as to why I was having these problems so it provided some sort of clarity so I thought it, in a weird way I thought it was a good thing to have a diagnosis. (288)	Label helpful as an explanation	Power of Label (explain / reframe – so, in this instance, 'problem' is difference, not negative)	perceptive difference)
so if, if I went to that test then it turned out I didn't have dyslexia then I guess it would just mean that I'm not as clever as my peers so I guess that's not a great feeling to have but I guess having the dyspraxia makes it, makes me feel more tolerant and it doesn't make me feel as bad knowing that it takes another F2, (301)	No label = not clever Label makes it more acceptable to be different	Power of Label (explain / reframe – so, in this instance, 'problem' is difference, not negative) ...but there is fear here ('not a great feeling'): fear of not having a label apply to her situation...	Power of Label
Having this diagnosis makes me feel okay about having to be explained the same thing two or three times over, yes, it, it feels like it's more warranted and acceptable to be told things over and over again because it's not just I'm not listening or anything it's, it's just the different, different, different needs and different strengths and weaknesses. (306)	Difference =/= weakness Label grants a sort of permission to be different / seek help / ask Qs	Diagnosis as tangible Diagnosis as something soothing (makes me feel ok) Diagnosis as currency to buy acceptability...	Power of Label (Bargain for Acceptability) (Power to Soothe) [caution of 'bargaining chip' – which links to established discussion of use of labels in disabilities...especially for parents of children with disabilities / SEN]
firstly I think it's helped tremendously in terms of having that extra time in exams. I always say if I didn't have the extra time in my written finals I probably wouldn't have	Again – positive aspect of diagnosis and label...powerful: helped *tremendously*	Power of Label → bargain for help / acceptability	Dissociated Success

passed because like I said I just when I read long texts I just can't clarify thoughts; it's just too much. (314)	Attributing success to additional time (? Surrendering an element of ? agency / self-efficacy in the process)	**? splitting attribution / self-efficacy** [note that I cannot un-think of splitting from Zayn] ...? dissociated success (down to extra time, not self)	(within: conflicted sense of self)
. So it was good in terms of that and I mean I didn't get any extra help but it was always there if I wanted it or if I wanted to speak to someone I could have very easily have done that at university. (316)	Didn't get /need extra help, but knew it was there Label was good as afforded access, but didn't take advantage....	Power of Label (granting access) Tension: struggling + having access to support vs. not wanting to access support (she does refer to want...) → *Needing but not wanting support*	Needing but not wanting support (within: conflicted sense of self)
know I just think the label gave me some clarity and gave me a reason and made me feel not so bad about not understanding things or not being as fast or as quick as other people. (320)	Label gave clarity *Made* her feel not so bad Being slower / different made her feel 'bad' (guilt / failure) → label mitigated this	Power of Label → Clarity & Soothe **[Not healing, as such...but mitigating the negative self-image impressed by perceived difference]**	Power of Label → Clarity & Soothe
is this, how are my experiences with dyspraxia and dyslexia? I think I'm a thoughtful doctor and I think if I have a medical, sometimes...(327)	Identifying with dyspraxia AND dyslexia	(very) confused sense of identity → **muddled**	*Conflicted Sense of Self*

I think I'm a thoughtful doctor and I think if I have a medical, sometimes I have medical students shadowing me they don't understand something I take my time and I don't judge in my head, "Oh my gosh this person is really not understanding what's wrong with this person." I understand that people are different (330)	Her experience of difference makes her less likely to judge	Being different + having label → *Sensitised to difference and difficulty in others.*	Sensitised to Other [other, in this specific example refers to others experiencing difficulties (so is actually part of her 'group') but under this theme, there are other examples of being sensitised to Other-as-'normal' which contributes to sense of not belonging]
I have a registrar and he's generally very nice. He's a military reg so they're quite sometimes they can be a bit aggressive when they speak and we had, we walked past, we went to ITU today and we walked past the flu jabs clinic and they said, "Are you going to have your jab?" and I said, "Oh I don't really want to have one because I've not had, I've not had to ever and if I were to have the flu I want my own body to try and just fight it off rather than the vaccine doing it" and then we got back to the office and he was like, "So why don't you have the flu jab" and then I just told him, you know, "I want my own body to fight it off" and then he said, "Are you sure you're a doctor? Did you go to medical school? That's absolutely nonsense, that doesn't make any medical sense" and I just, I just thought that wasn't very understanding. (341)	Aggressive SpR Felt very judged **got tearful here** Her qualifications challenged ('did you go to medical school')	Undermined / Fear of Exposure (undermined / questioned / doubted / invalidated the token of her *potential / partial* membership to medical in-group)	Challenged Legitimacy

Rubina - Self Characterisation Sketches: *Coding Notes*

1. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
I'm not so interesting or my life's not so, I don't know (365)	Doesn't consider her life interesting → as if interest is some sort of qualification	Questions own Legitimacy (in this sense, legitimate participation in social life)	Self-Doubt
I think one of the main qualities my friends would say about me is I'm a very kind person and my main motto in life, I'm not religious or I don't have any rules or regulations in my life but the only kind of motto I live by is do what makes you happy (384)	Reference to how others see her Quality of kindness & happiness	Value of Kindness (it is important and valuable to her, and her self-image)	Kindness (value)
I think my greatest strengths and qualities are my kindness; I'm, I'm always trying to smile (390)	Values own sense of kindness and positivity	Her Kindness to others as a Strength to herself	Kindness (strength)
I'm always trying to smile and smiling outside of work and I think another kind of nice thing about me which I guess ties in hand in hand with this is I'm quite a very shy, introverted person. (392)	**Trying** to smile.... is smiling ? difficult, or does she feel that she sometimes fails at *trying*...? Smiles outside of work...doesn't try in work / smile in work?	Feeling pressure to imitate happiness in pervasively ('always') negative/sad/challenging circumstances	Conform (pressure to…)

	Sunny, positive, smiling. Floating. On top of the world. Love, music, spirituality of value to her. Work represented in carry-case...but note, no stethoscope! NB: SpLD / dyspraxia / dyslexia does NOT feature here…	Her SpLD isn't compatible with her positive self-image. Neither is her stethoscope (doctorness) but work is compatible (briefcase) ? questioning sense of professional identity here	Incompatibility (Difficulty & Happiness) (Token of Doctorness & Happiness)
I have a kind of very unique group of friends both white, black, yellow, pink as reflected. Quite honestly that was my family because I'm very kind of family orientated but I guess it just reflects, it just, you know, just try not, try just to not criticise really and make friends of any colour and all can find common ground people in any colour and like Muslim, black, white and I like that because just, just like how we saying with the dyslexia and the dyspraxia people have different qualities and different experiences and different things to offer and I do find I get different things from different groups and walks of life. (399)	Linking to above: value and beauty in diversity. Racial diversity as a metaphor for SpLD	Beauty in Difference (personally values diversity)	Difference (as good) [is this here counteracting the feeling of alienation / difference as negative, by valuing diversity herself + role modelling this inclusive attitude?]
I'm, I'm I guess again that ties in with something I like doing is just anthropology. I like to learn about different cultures, read about different cultures. I'm not so troubled yet that I think that's something that I, I like to do and my friends and I've been I guess that's reflected but it's just who they are and then just something quite odd about me	Referring to herself as odd for her unique interests.	*Identifies with difference and recognises tension between difference as odd, but also something*	Difference (tension between odd + good)

as well I'm really into my gangster rap; it's what my friends know me for. (406)	Not so troubled yet - ? referring to interest in other cultures (difference) or reading / study on a subject that is different from medicine...	*positive.*	
So it doesn't really fit in with my whole persona and my whole image but you know some of my friends find that quite strange but quite nice and quirky I guess and that, and that just replicates that I like to learn about different people and different cultures (414)	Unique interests 'don't fit with whole persona' ...of ? a doctor: perceived incompatibility interests	Tension: image vs. self... (2 different things)	Identity Tension
Yes. I've not drawn anything medical or in here because I feel like it's ...I'm I need friends rather than a doctor of medicine. I, I enjoy medicine but I suppose compared to my other peers it's not a passion role in my life; I don't like to go home and watch 24 Hours in A&E and Casualty. I, I hate; I actually don't like medicine outside of work. It doesn't really feature in, in my life ultimately and I'm not ... do you want to know ... nothing to do with my dyspraxia because again I don't feel it's so prevalent in my life it hinders my life. It's just something that it, it's not a big thing especially with my friends and family, you know it's not (laughter). (426)	Absence of medicine and SpLD from this view (sympathetic friend) as it isn't important... She doesn't like medicine outside of work: a partitioned / conditional sense of identity	Difference (not necessarily incompatibility) e.g. is a medic but it isn't as important to her as her colleagues... sense of recognising this as an 'other' quality that undermines her group membership	Undermining Legitimacy of Membership
I know it, it's not sort of the best at this stage in my career I shouldn't ... not that I hate medicine but it's, it's a job for me at the moment (432)	'It's just a job' → Guilt at not feeling passionate about medicine.	As above	Undermining Legitimacy of Membership
I think you're not, not alone there and there's quite a, a lot of people I think especially towards the end of foundation year two when they ... some people take, would take a little while to realise that and, and I think that's quite often why you see a surge of people travelling because they need to, they need to find themselves first. R: Yes, interesting I'm in that category. I'm not really sure I want to start with	"in that category' of doctors who need to find themselves... 'I might need a bit of a break'	Recognises a group ('category') <u>*within*</u> the profession that she belongs to ('I'm in that...')	Multiple Ways of Belonging [? Belongs in 1 way, but not others...or partial belonging, or peripheral belonging]

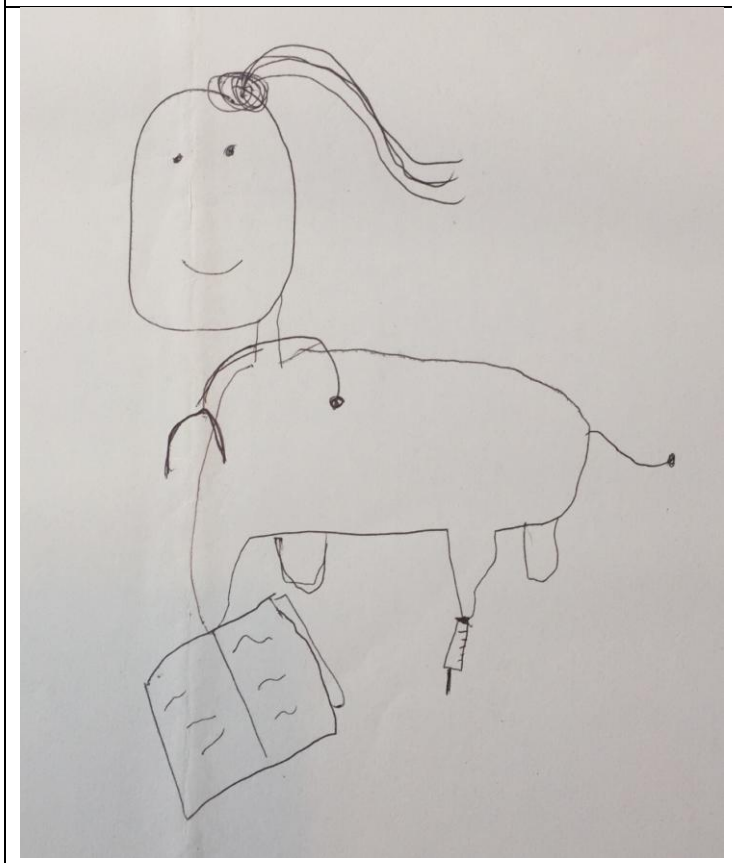
speciality training next year. I feel like I might need a bit of a break before I do it. (455)			

2. How *you* see *yourself*. How all of the bits of you and your life fit together.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
I think the only different thing would be sometimes when I meet new people sort of get ... they don't really, they get a bit shocked when I tell them I'm very shy, I'm very introverted. (467)	Surprise at her introversion	Discordance: way she feels (shy) and projects (confident)	Image Discordance [? Identity]
the fact that I'm quite shy and introverted might come off across as disengaged or rude or I don't know but to my friends that know me they just, they understand (473)	Concerned about misunderstood projection	Image discordance → worry	Image Discordance [worry]

3. How a *critical* other, someone who knows you very well, and is *critical* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
So I guess it's like an animal or just like a donkey you know. I guess this is all the so you know not, not the other things, not the world, not the ship, not the flowers it's just, just you know,	Feels supervisor sees her work-self as donkey.		Identity tensions → at work =

just a, a tool almost. (525)	Metaphor: doing the donkey work	Seen as a ***beast of burden***.	Depersonalised
	Stethoscope = doctor Donkey...beast of burden, animal, put to work Smile (small) Syringe → practical task (ok) Paperwork → burden Monochrome → no diversity, beauty, or vibrancy seen in previous image.	(de-intellectualised, following orders, servitude → lacking agency) (sense of sadness and regret)	(why doctorness is not compatible with happiness) [Work identity is not as a human person, it is a working animal
I've done a smile because I'm, I'm always smiling but it's the smallest smile I guess because if, if you're not really enjoying something sometimes medicine's interesting but it's, it's not a passion of mine so you know there's only so much you can smile and I guess this is what they see they don't, like I said they don't see any of the other kind of bits of you as a person it's just	It's the smallest smile...	Forcing smile → ***unhappiness as doctor*** Imitating happiness (obliged to do	Conformity (faking it)

medicine, medicine, medicine (539)		so → not a passion, but already recognised this is *unusual* in her profession)	
with a not so big smile I think because of I had very kind of dominant powerful colleagues on that, and I was the only kind of passive person so I think that could have been interpreted maybe as not engaging so much or not, not just not caring as much (543)	Felt pressured into smiling by dominant colleagues for fear of being labelled 'disengaged'	Imitation under pressure	Pressure to fake it (fear of 'failure' or 'disengaged') → **conformity**
it's a big firm and they don't have time to get to know, "Oh she's a bit quiet, she's a bit introverted. Maybe that's her reason for not being so, for being a bit passive." (548)... ... Rather than just kind of interpreting "She just doesn't care. She's quiet, she doesn't care" and that's it really. (553)	Feels anonymous and misunderstood in big team	Lost in the crowd Discordance → self vs. projection	Lost in crowd Discordance
I think in, in diabetes the practical things... they were okay because you do it every day you know. You have, as long as I have a routine like it's not hard for me. (559)	Routinized work not problematic	Routine as helpful	
. We have a lot of patients on that front and we're very under staffed so I, I'm a very visual person so I need to put a face to a name so if, if they were on the ward round and you know so "How's XY and Z doing?" I would really struggle to remember from the list 30 or 20, what they're talking about (562)	Struggle with large numbers of patients / list.	Recognised risk factor: list size & memory	Self-awareness (risks) [? relationship with *Critical Environmental Factors* that emerges later]
I had a very, very good peer and I think he ranks the most highly in the West Midlands he was an exceptional F1 and I did feel quite inadequate at times compared to him (565)	Comparison with others → sense of inadequacy	Social comparison & inadequacy	Social comparison
Did that have anything to do with making other people around him feel inadequate do you think? R: I think he did have that complex because he's just	Peer was aggressively self-confident	Describing a sense of ***disruptive pride*** from others (employed with intention)	**Inadequacy** from → disruptive pride (in others)

notorious for you know, "I've got this publication, I've got that publication and I was on Radio 4. I was featured in the BMJ. I did a diploma in dementia during my F1." He's very kind of not so modest and it's great that he's done all of this in ... and I guess, I guess compared to him especially having a learning disability probably any of a, a bit more in terms of wanting to ask or could you explain that to me a bit more because my colleague in the first you know so why shouldn't I? I guess, I guess I felt less inclined to just ask and can you explain things a bit further or, "Oh I don't remember that patient. Can you just remind me because you remember" so I don't want to make ... literally have to ask. (584)	Felt 'less inclined' to ask for help / clarification → 'especially having a learning disability'	Having a learning disability instils sense of shame, preventing help seeking	**Shame** (of / from label) → prevents peer support networking with such individuals
you mentioned how in that job everything was so chaotic that the sort of things that you struggled with, with the organisation and things like that didn't actually manifest because it was everything was like that anyway and I just wonder if because in this picture there wasn't anything that you point at and said, "Well that's, that's my dyspraxia" if that's because this is thinking about that setting where everything was like that - R: Yes. **I: - so nothing stood out particularly or?** R: Yes I, I think you're right. It was an overriding theme. **I: It was all going on there?** R: Yes. Yes it was, it was just like you said, <u>everything was a mess. It, it was there kind of constantly so it wasn't something I thought about because it was just always manifesting itself</u> so it's not like it's specifically defined something I can put in pictures because it, it was an overriding theme.	Environment was chaotic, difficulties 'constantly' manifest, so 'nothing stood out'	Chaos played a part in making difficulties manifest and masked difficulties	Critical Environmental Factors (→ Chaos manifested & masked difficulties)

Rubina – Critical Incident Reflection: *Coding Notes*

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
you rarely have a face to put with the patient histories/ details. Unfortunately as I am a very visual person I do find this hinders me in recalling which patient history belonged to which positive micro result, as I find it quite an abstract process to recall information in this way. (13)	Can't put a face to the name → risk	Risk from nature of work (environmental factor) (she needs to humanise / personalise the information...the nature of the work / way of working prevents this)	Critical Environmental Factor (can't put a face to the name) (Grains of thought lost in melee)
On a recent micro lab round I was asked to discuss a positive blood culture result for a patient I had discussed over the phone. I was scattered in my thoughts and had a dozen histories in my head, but was unable to match the history with the generic sounding name on the form. (16)	Scattered thoughts, mismatch of information with patient	Metaphor: thoughts as something tangible (seeds) to be scattered and lost	
Luckily I recognise I have issues with clearly organising information in my head and write everything down. I reviewed my notes and saw that I had actually given the clinical history for an entirely different patient. I discussed this with the consultant and, I had not yet called the team and we decided on a different antibiotic plan. Fortunately there was no impact on patient care, however if I had not realised my mistake, the	Self-awareness (of difficulty)→ coping strategy (notes) → safety net (checking) → near miss (avoided patient harm)	Coping (noting / second-guessing → from ? self-doubt) Safety netting (checking) (it is significant that she mentions that patient care had *not* been compromised – giving the impression	Coping (Safety Netting)

patient would have received the wrong antibiotics; a prescribing error (26)		she cares, and is concerned about this) (significance of 'prescribing error' → perceived as Big Issue)	
I feel this was more than a simple case of the SHO forgetting some details. I frequently encounter this type of problem when I have collected large amounts/ variable sources of information in a short time period. I feel like the information is confused, (34)	Frequently occurring problem	Pattern of difficulty (frequently) in environment (chaos)	Self Awareness (pattern of difficulty) Critical Environmental Factor (interacting with pattern of difficulty)
histories for 2 different patients may become mixed together (35)	Critical incident → risk	Critical Risk (patient histories mixed)	Critical Risk
I find the best way to help me segregate this information is to have an identifiable or visual piece of information associated with the patient e.g. a 55-year-old Farmer, the guy from Mexico etc. I have learnt throughout med school that once I have this initial piece of identifiable information then I can reel out the whole history, however if I cannot remember this initial snippet then I will not be able to recall the history. (40)	Coping strategy → forming narrative about patient (Strategy unravels if misses 'initial snippet')	Coping strategy → Humanising patient (implies has to work against system to *humanise*) Key humanising 'snippets' (job, sex, nationality)	Humanising (Coping)
round I felt very embarrassed that I could not recall this information, as this happens to me very frequently. However at the same time, it has been beneficial for me in terms of training as I have now gotten into the habit of reading the previous days documentation just before we enter the lab. This is time consuming, but I feel it will avoid me making potentially fatal errors in the future (49)	Pattern of difficulties causes embarrassment Coping strategy → pre-preparation	Embarrassment if difficulty public and frequent (shame) Pre-prep (over-working) as coping	Shame (from embarrassment) (driving over-working...to keep safe, to be 'as good as' others)

Appendix 6: Coding Notes for Amanda

Amanda – Initial Interview Coding Notes

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
I was always, as it were, the black sheep of the family because I wasn't very academic. (17)	Seen as black sheep of family + lazy (NB: common misperception of difficulties as laziness)	Negative, different / outwith, by choice Metaphor: Black Sheep Different/ce	Black Sheep [encompasses: difference, different value, 'badness', and disreputation to family / group, cf. English idiom]
I didn't excel academically until I really went to university, and I know my parents used to get quite frustrated at me and my teachers because they would say that I was being lazy and making lots of silly mistakes and not achieving my potential, as they saw it. (20)	Didn't excel academically until uni. Parents frustrated with perceived laziness and 'silly mistakes'	Over-hang from childhood stigma (of difficulties = laziness) Misperception: Silly Mistakes & Laziness	Misperception (others) [scope for self and others here…her self-misperception has evolved from being over-vigilant to the misperception from others] Overhang

I know as a young child, I kind of found it challenging to learn things like how to tell time. I used to find it difficult doing mental arithmetic, adding, I had trouble with handwriting which people just told me I wasn't trying and I wasn't learning because I didn't space it together and it used to go wobbly and my As used to turn into Ps and things like that. (24)	Told wasn't trying	Difficulties as lack of effort, choice (Allocating significant weighting to what she has been *told* she did by *others*. Somehow abdicating agency and sense of self to their authoritative 'objectivity')	Misperception (others) Overhang [sense of what she was *told* when younger *still* influencing sense of self now]
So my mum helped me a lot, teaching me how to write properly and read properly, because I'd get very frustrated when I used to try and practise reading and throw my books around and stop reading. (26)	Mum helped. She got very frustrated at struggles	Family support. Frustration- expectation of better (perceived, self, others) 'try' and 'throw books around' – sense of frustration shared by not meeting expectation)	Perceived Expectations (Family) Frustration (shared)
in terms of things like the dyspraxia, I don't think I had shoes that had ties on them until I was about fifteen. I could not tie up my school ties. I had an elastic one until I was about twelve, and I was really, really bad at ball games and things like that. (30)	Didn't have shoes with laces until 15yrs	Childlike needs (elasticated tie etc) Difficulties = 'Bad'	'Black Sheep' (difficulties marking her out as bad)
I moved around the country quite a lot so I guess when school gets quite serious, it's around GCSE time and then there were quite a lot of red flags being brought up about me in terms of organisation, in terms of getting my work done. (33)	'red flags'	Jargonises using medical terminology ('buy-in' to medical model?) Legitimising	Legitimising (jargonising)
I used to make a lot of silly mistakes in terms of grammar and spelling because this was kind of pre-computer time (35)	'silly mistakes'	Difficulties minimised (silly / pathetic), ascribed to a behaviour /choice (silly/behaviour)	Overhang (transference)

		Reflecting language used by others → Transference (overhang)	(negative self-talk)
My maths was really, really bad. I've always been really bad at adding, subtracting and just basic things, and I think as I used to…I've always been quite a…not self-conscious but I've also been conscious of other people and I've always been very conscious of knowing that there was something a bit different about the way I learned and the way I operated (39)	I've always been bad at...	'conscious of other people' → giving weight to other's perceptions → Self-conscious Negative self-talk...stuck in a script (repeated lots!) Difference…(? Relating to Black Sheep) …internalising this sense of Badness	Overhang (negative self-talk) Black Sheep (difficulties are present, and mark as different, but not aware of them / label yet) (Internalised Badness)
teachers used to get frustrated with me, the more I used to back off. So by the time I got to GCSE I kind of stopped working, so I got into a lot of trouble. (42)	Backed off...in response to teacher frustration.	Metaphor- distance between teacher (learning) and self (difficulty) → ? form of coping (possibly maladaptive)	Coping: distancing
My mum was a teacher at the school so she was actually in the meetings when they used to discuss me in her professional capacity so she came home and basically she and my sister would just teach me in my spare time (45)	Mum party to school meetings about difficulties	Family involvement, help But also sense of mum (and sister) being part of 'them' → the contrast adding to sense of Black Sheep	Black Sheep (contrast)
My sister spent a lot of time on my maths and proof-reading all my written work and kind of working through just basic things, how to divide things. Language is difficult for me and foreign languages are really difficult for me because they just don't mean anything, but numbers just, they don't click with me at all and the more stressed I get about all of this, the	Difficulties with language + numbers → stressed. Didn't click, very frustrated	Click- internal mechanism didn't align / work... Frustration – inwardly directed anger (internalised Badness)	Internalised Badness (part of Black Sheep) Internalised Badness

worse it gets, so I get very frustrated with that. (50)			(part of how Overhang is manifest)
But that was basically my mum literally shut me in my room to do my coursework and wouldn't let me out the house and made me revise, and at the last minute I had a stroke of luck. (56)	Attributing success to mum's help + luck	External locus of achievement (denying her capacity to achieve, abdicating agency to external 'forces of luck')	Denied Achievement (part of Internalised Badness)
I was really stubborn and decided to want to do AS Maths, and they refused to take me on the course because they said that I wasn't a good mathematician. (63)	'I was really stubborn'	? seen as +ve or –ve quality → self deprecating told wasn't good *again*…so her persistence framed negatively as stubbornness	Negative Self-Talk (part of Internalised Badness)
I think they relented from my mum's pressure and I very quickly found that I was really, really struggling and I'd get panic attacks before the lessons and I'd just sit in the back and kind of pretend to do my work because I didn't actually know what I was doing, so I'd just kind of write down patterns and numbers and stuff, and things like that, and just hope that no one noticed but they soon did and it was really embarrassing (67)	Didn't know what to do, so just drew patterns	Avoid discovery, or to belong to group by *Faking* a performance Hoped to avoid (? feared) discovery	Faking It (active part of something akin to Passing)
So I ended up having a really terrible year and I think I got an E in my maths AS Level. It didn't also help that my sister had now left home. (69)	Sister had left home- didn't help with exams	? partial attribution of failure to disruption of family support Failure as Terrible (Attributions of failure appear	Contextual Attribution (family disruption = context of attribution of failure externally…but complex process involving synchronous negativity – her failure as Terrible)

		contextual)	
I know that I struggled so badly with all the different work that I could never put my card in the box, so I'd just sit there and no one noticed me, but I literally sat there for two months, apparently, kind of just pretending to work (77)	Left behind and going unnoticed	Sense of child being left behind Lack of attention / awareness –Below Radar (? Part of passing…didn't raise alarm)	Below Radar (sense of neglect and being left behind…passive part of, or part of consequences of, Passing)
I think I was nine, I just stopped, apparently my reading age just completely stalled, and they started to get quite worried about me, and then I think that's when my mum really started to come back and teach me more because it just got to a stage that I just couldn't progress any further. It was really strange and they thought that I was just kind of misbehaving. (82)	'stalled' with reading and progress → interpreted as misbehaving	Stalled→ metaphor for mechanism / engine (cognitive engine?) Failure as a behaviour, as a choice...something to be consciously modified, and punished...	Stalled (difficulty & stumbling block) Misperception (failure as misbehaving)
I did history and I struggled more with history than I thought I would. I found it really hard to keep up and I know for instance I've always had this thing at school, you know when you had to read out segments of text in front of the class (86)	Reading text in front of class = challenge 'you know?'	Sense of seeking reassurance and validation through 'you know'(? Poor self-confidence)	Seeking Reassurance (part of Internalised Badness) [language throughout, 'you know' and 'kind of' implies a loosening of certainty and a lack of confidence, and seeking validation of perspective]
I'd be terrified of doing that because everyone would laugh at me because I'd apparently say the words in the wrong order and I'd lose my place, and I was always the last person to finish any text that we had to read. You know when they used to say, like, I'll give you two minutes to read this and then we'll do the question, and everyone would have finished and looking around	Terrified of reading aloud	'I'd apparently say' → loosening certainty around perspective Sense of her ('terrible') early childhood experiences being very significant to	Overhang As a consequence of overhang → poor confidence, and Internalised Badness, resulting in her

and I'd still be reading it for another couple of minutes, and it was just terrible and I felt so much pressure. (91)		her current perception of self → **Overhang**	discrediting / de-prioritising her perspective through 'loosening' the certainty of her recollections
So history was really difficult in terms of that, and I tried really, really hard and certainly that was the start of me trying to really overcompensate so I'd stay up all night to try and get my work done, and I got really tired and under the weather and I think I still ended up getting a B, and I used to find it really difficult in exams (95)	History was **really** difficult	Emphasis on difficulty by repetition (really, really) Compensation through ('over')working at night → covert, attempting to keep pace and ? Fake It	Faking It
I would never finish the exam questions because I'd get halfway through and I couldn't read fast enough and I couldn't process. I'd even try and make myself, just my eyes move faster, but it just wouldn't go in any faster, and I know in a lot of my mock exams, the teachers would say that I'd made silly mistakes because I just hadn't read part of the question and they couldn't understand why I hadn't read it (99)	Wasn't fast enough because 'I couldn't process' Told her mistakes were silly by teachers	Learning as *it* and trying to make herself *go* faster (mechanistic...like a car, racing) Jargonising (couldn't process) Disembodied- make eyes (part, not whole) move faster; 'couldn't process' (? Externalising 'fault' / difficulty / locus of control)	Jargonising (→ Legitimising) Disembodied Difficulty (attributing to parts of body,
I really, really didn't want to go to university. I think I found school so stressful in terms of not meeting my expectations and not meeting everyone else's expectations and I got really frustrated because I couldn't explain to them why I couldn't meet their expectations, and I just felt completely exhausted and	Stressed + ?fearful of HE	Perceived expectations (of others and system) caused *stress*	Perceived Expectations (causing **Stress** and Frustration)

drained (107)	Frustration at not meeting expectations		
I got kind of basically forced to go to university about a week before, and I wanted to go off to Ghana and find myself, and then university got a little bit better (111)	Felt forced into HE Wanted to find self	? lost something, wanted to *find self* (? had lost herself)	Lost Sense of Self (is Lost the right word? …maybe more like Loose, Ambiguous, Nebulous, or Opaque)
It's really weird but I always learn best when I'm in a passive role and no one's interacting with me and asking me to answer questions and things like that. I think I can tune out everything else that's going on and then if it's lectures it's auditory and visual but not written stuff, so a lot of the biochemistry, it was kind of models of amino acids and stuff like that, and I could kind of imagine how everything was moving and the enzymes were moving and that kind of thing, so I think that really helped me because I was moving away from text-heavy kinds of things and lots of people (118)	Is better suited to passive (transactional) learning Describes visuo-spatial aspects of learning: free to do during lectures (liked) [Reflection: describes learning as passive and lectures as helping her /move away from text' and affording her a sense of anonymity re: struggles…but ? is this actually moving away from *herself*?]	Learning as passive The way she learns = 'really weird' (echo of difference, black sheep)	Black Sheep (difference, weird way of learning)
But then I fell into bad habits in my second year because we had quite a packed schedule and we had some quick turnarounds so we had to do lab reports within two days of having done the experiment so I ended up having to stay up all night about three nights every week for about three months, and I got really, really ill because I was just completely crashed out and I was just working night and day, because I just couldn't	Working night + day to keep up = bad habits (emphasised by repetition of *really*)	Ways of Coping = keeping up (? related to a sense of Passing) seen as Bad Habits (coping as maladaptive)	Passing [ways of coping to keep up, keep flying under the radar…active aspect of Passing…but this is recognised as bad / maladaptive]

get through it fast enough and I couldn't understand why. (126)			
I started to get really frustrated with myself and I got really frustrated with myself when I was having to do calculations and they wouldn't work, then my friend would just show me and she'd be like it's simple and just… And then I think university just kind of… I think because it was less… I don't really know but I did do better at university than in school and I'm still not quite sure and I wonder whether it was because it was more practical based and, like I said, I could memorise what the lecturer was saying because that was in the days when my memory was still decent. (132)	Couldn't understand inability to cope → frustration (repeated) Comparison with able friend 'simple' When memory was 'still decent' (implies it is not anymore?)	Sense of frustration being grounded in not being able to understand difficulties (a factor, in combination with difficulties, rather than sole source) Frustration also borne out of social comparison (which is ? how perceived expectations are benchmarked)	Self Awareness [discrepancy = factor of frustration] (as Frustration is a recurring theme…maybe this should be the over-arching theme, with notions of self awareness, social comparison, and perceived expectations supporting it?)
and I just remember I was sitting on the train and just two pages would take me an hour to get through and I'd just get horrendously frustrated with myself and I just felt really annoyed because I was so motivated to do well and I couldn't get there, and everyone would say to me just make a plan, just say that you will do this, this and this on this day and get it done. It's just like I couldn't plan because I wouldn't know how long things would take and I knew that they would invariably take me a lot longer than I would be able to estimate. (141)	'just' tasks → frustrated at ability / speed not matching her motivation repeats 'just' to emphasise and deprecate	Sense of de-valuing or deprecating her sense of self through the repeated use of minimising language ('just') Frustration	Negative Self-Talk (Internalised Badness) [Deprecation of self, through minimising language] Frustration (self-awareness) […of difficulties and the relationship with discrepancy between motivation and achievement]
the finals were essay based, and it was just horrendous. I managed to scrape through because my second year	Scraping through on back of success	Sense of not fully / legitimately	Undermined Legitimate Belonging (from 'scraping through' →

marks were high so that was the end of my first degree. Then I went into research and I thought that would be better because I had a good grounding and things like that (147)	elsewhere	belonging due to 'scraping through' (is scraping somehow a factor that contributes to a sense of Passing?)	contributes to construction of difference within Black Sheep)
…that was the first time I really noticed for myself that my organisation was poor and my time management was poor, and it was just weird things about my estimation, like I don't seem to have a proper concept of time, like if I'm asked to estimate how long something is going to take me and I just can't estimate it. Apparently somebody told me that that could be due to one of my SpLDs but I don't know. But then it was obviously a lot of lab-based work so I kind of started to find it really hard (152)	Realised poor organisation due to poor concept of time. 'apparently' → disembodied memory / attribution of difficulty to SpLD [Reflection: I was surprised by how she jargonised with 'SpLDs' suggesting a 'buy-in' to the label at some level…does this ? somehow conflict with or ? help disembodied and distanced sense of difficulties]	'apparently' → weighting other's judgements, devaluing her own perceptions 'weird' confers sense of uncertainty, not quite knowing, as well as difference → different (Black Sheep)	Relates to: *the consequence of* ***overhang*** *→ poor confidence, and* ***Internalised Badness****, resulting in her* ***discrediting / de-prioritising her perspective*** *through linguistically 'loosening' the certainty of her recollections* Difference ('weird') → Black Sheep
I kind of started to find it really hard, kind of manipulating all the instruments and things like that, like with western blots it's really precise and I just couldn't get it right, and then I would find it really hard calculating on the end of the Gilson pipettes, (155)	Found really hard (repeated) → but: 'kind of' (? Uncertain)	Uncertainty in language here	Relates to: *the consequence of* ***overhang*** *→ poor confidence, and* ***Internalised Badness****, resulting in her* ***discrediting / de-prioritising her perspective*** *through linguistically 'loosening' the certainty of her recollections*
then my supervisor started getting annoyed with me because she couldn't understand why I couldn't do these things, and she thought that I was stupid. I just kind of started getting really panicky and my job ended	Other's misunderstandings lead to → (them / her) thinking she was stupid	Factors leading to Frustration (contextual judgement)	Misperception

up being a lot more stressful than I thought it would be. (158)	Judgement of others causing panic and stress	Misperception (thought she was stupid) → due to lack of awareness and insight…factoring into Expectations and subsequent Frustration	Frustration (perceived expectations)
It's not unusual for me to spend at least half an hour just going over one page (161)	Difference with reference to time and speed	Difference adding to construction of Black Sheep	*Difference* (adding to construction of Black Sheep)
but I've always had a problem with running on when I write and then I repeat something that I've already written because I can't seem to keep track of things. It's crazy. (165)	Difficulties are crazy	Crazy – conveys a similarly negative sense of difference as weird…	Difference (adding to the negativity within the construction of Black Sheep)
so my eyes were completely rested for a whole year, and I almost forgot what my issues were until I went back to do medicine. Then I've just found medicine really, really difficult to get through, far more difficult than my first degree and possibly even school, because on the Birmingham course, it's a lot of book-based self-taught learning and I struggled horrendously both in terms of getting through the material and retaining the information so I was trying to speed-read it. It just wouldn't go in, (174)	Year out = eyes 'rested' + forgot 'issues' Medicine = really really difficult (repeated for emphasis) Issue with speed ('it wouldn't go in')	'it wouldn't go in' → learning as ? filling a bucket referring to isolated body parts…this is strangely reminiscent of a distancing from inherent difficulties, attributing difficulty to individual organs or components….	Component-ing [within a later emerging theme of 'Defective Doctoring'…this sense of components being defective…this is a part of Partitioning, which arises later]
we used to have to do sessions where we would have to write on the whiteboard during our PBL session for the whole group and I just used to get such a…it's ridiculous because I'm a grown woman but I'd just get so panicky when I'd have to do that session for myself because I'd spell things incorrectly and I'd put everything in the wrong place like the sentences and things like that, and people would just kind of sharply point it out or snigger, and I just felt really self-	Panic due to *exposure*. Embarrassment 'ridiculous' as is a 'grown woman' (implication being that grown-ups can't feel panicked cf. ? children)	Exposure as ? fraud (fear that efforts to Fake It or Pass would be undone) A sense of holding on to the hurt of the event where peers 'sniggered' at her difficulties (?relating to Overhang)	Fear of Exposure (within and contributing to Faking It) Holding Hurt (continuing Overhang throughout lifespan)

conscious. (179)			
So I did pretty badly at medical school. I can't even remember what my mark was, but yes…because it was just basically book-based the whole way through and I just lost more and more confidence as I went through because I could see against my colleagues, as it were, that my knowledge base was just terrible, and it still is compared to everyone else, (183)	Did badly at medical school → Comparing self to others negatively	Social Comparison → driving decline in confidence and perception of poor knowledge performance. There is a sense that this is related to the theme of Frustration, in that the perception of others (their performance, their expectations, and wider expectations to 'keep up') drives both… There is also a sense of difference here: 'knowledge base' and speed of working is different from her peers (?related to *cognitive conformity*)	Social Comparison (this comes under Perceived Expectations, the link being provided by the expectation to 'keep pace') [Sense of Cognitive Conformity →] *difference* (within Black Sheep)
I just lost more and more confidence as I went through because I could see against my colleagues, as it were, that my knowledge base was just terrible, and it still is compared to everyone else, and when I come across other clinicians who are teaching me or now I'm working with them, they can't understand why I don't have the knowledge base, because I've had four years at medical school, and you can't make excuses (186)	Others don't understand difficulties. Difficulties interpreted by others as lack of knowledge. Can't make excuses in medicine (difficulties = ? excuse)	Social comparison is driving her reduced sense of self-confidence, with reference to skills and knowledge. How others (clinicians – powerful use of this label here, ascribing their judgement a certain degree of authority) see her…and lack of understanding.	Excuse [excuses are 'Bad' and you can't make 'excuses' in medicine → difficulties perceived as an excuse. Risk involved with label being perceived as an excuse. Potential for label to become a *reason* rather than excuse] Social Comparison (again, relating to Perceived Expectation, driving low confidence).

			Misperception (this feels related to the invocation of Social Comparison in this example)
I've tried lots of techniques for trying to kind of learn the information. I think the best ways that I've found to learn is, you know you can get the inverted contrast on your computer screen, I only learned about that last year and that really helps me. And then I bought ClaroRead about six months ago and that helped. But really there were no…we had maybe one or two lectures a week in the first year but they were kind of supplementary. (191)	Uses technology as assistive and facilitative of coping	'tried lots of techniques' → confers sense of desperation to continue to *keep pace* in order to Pass	Passing
They weren't like core material and we had a few lectures in the hospital trust but they weren't really to cover the core curriculum so it literally has just been book-based. (192)	Delivery of course in med school very self-directed	Self-directed learning, here, feels like a 'second best' to delivered content…inferring a sense of passivity in the learning process.	Passivity [there is a sense that this actually hints at a deeper trait: to be passive, or adopt a 'child' state (cf. transactional analysis) surrendering to authority / 'parent']
So it's just been really difficult and in terms of the clinical skills, I found that really horrendously difficult and very embarrassing too, because I feel in medicine, there's nowhere to hide, so when you go for teaching sessions, any knowledge deficits, any differences get immediately picked up on. (201)	Experience of difficulty as horrendous + embarrassing. Nowhere to hide in medicine.	Nowhere to hide → (relates to 'can't make excuses in medicine' …this also somehow relates to the fear of discovery, and therefore Faking It / Passing) Embarrassment alludes to a sense of fear	Fear of Exposure (Passing) + Excuse
and I don't know my right from my left, so I went to the left and I got a complete bashing from the consultant in front of everyone and he just formed a really bad opinion of me. And then I've been always told that I	Difficulty with L + R orientation.	Humiliation → shame and embarrassment at exposure (a **feared** consequence)	Misperception

look awkward and sometimes a bit more unfamiliar with how to do physical exams and that kind of thing compared to other people and they say, well, you obviously haven't practised very much, and I have. (208)	Humiliation and public judgement. Judgement implying lack of knowledge/effort.	Judgement based on inaccurate understanding / assumptions…erroneous, yet given weighting ('obviously')	Fear of Exposure (was 'outed')
It's just hard with motor planning and that kind of thing, and I find it very difficult in medicine, (209)	Motor skills planning challenging in medicine.	Jargonising [Reflection: is this jargonising an attempt to further legitimise her difficulties]	Jargonising
it's keeping that list in my head. I'm someone who it just kind of all comes together but doing things in specific orders is really tricky for me and that's another part of medicine that I found very challenging, because if you don't do it in the right way, then it's almost like there's no point to have done it. (213)	Sequence / order = difficult → it all just comes together…externalised / disembodied If you don't do it the 1 Right Way, no point in doing it (in vs. out group)	Can't do it 'the right way' in medicine = different / failure → some form of practical / skill-based conformity (*Conformity of Praxis*?)	Conformity of Praxis (difference created here → Black Sheep) [this doesn't feel like it is related to Passing, as it is her difficulty with *conforming* in this way that is marking her out as different]
I think last year because [Medical School] don't have an SpLD kind of focus group in the medical school, I think one of the pastoral leads just wanted to gauge about how they were doing, supporting med students, so I turned up to their informal meeting and I made a few suggestions and she said that they were interesting but nothing was ever done, so I went to kind of look into how… (220)	HE environment feigned interest → no action	Jargonising ('SpLD focus') HE strategies → perceived as Tokenistic dealing of issues of learners with difficulties	Jargonising Tokenistic (within Support)
because another thing is I think I've been told that this	Memory difficulties:	Somehow dyslexia is *separate* from	Partitioning (dyslexia as a separate

is dyslexia but it might just be me, but sometimes my memory is poorer, translating it from short-term to long-term memory is kind of more difficult so when I had bedside teaching and things like that (228)	'it might be dyslexia or it might just be me'	her *self* in this context. If dyslexia is a separate part – it isn't 'her' fault (= forgiveness), but if it isn't due to dyslexia, it is due to 'her' Again: 'been told' …ascribing weight to other's judgement, rather than her experience…reinforcing passivity	part) [here, this feels like a coping strategy, as it contextually confers the ability to forgive herself] → Power of Forgiveness (under Diagnosis & Label) Passivity [relates to the consequence of **overhang** → poor confidence, and **Internalised Badness**, resulting in her **discrediting / de-prioritising her perspective** through weighting others' judgement over her experience]
because I was really interested in the potential of having mentors, either from different years of med school or doctors who have SpLDs, I think it's really inspiring to know that you can actually progress in medicine, because I certainly have many times when I thought I just can't work in medicine with my kind of mix of issues (238)	Seeking inspiration of proof of possibility for dyslexic doctors to succeed. Wanted mentoring (from role models with SpLD)	Sense of desperation for reassurance: seeking a role model as proof that she can succeed and belong.	Seeking Reassurance (contributing to a sense of *legitimisation*) [within Legitimisation, but also Support….as a relation to coping – mentoring / role models for support *could have* helped]
I think when I was growing up, dyslexia didn't really seem to be on the horizon very much and I certainly didn't know anyone at school with dyslexia or anything like that, and certainly my mum says that people in education weren't that aware of it at that time, unless it was a profound issue. (259)	'below the radar' (as not a profound enough issue to be diagnosed earlier) Difficulties not identified as SpLD	*Below Radar* (sense of neglect and being left behind…passive part of, or part of consequences of, Passing, which she was able to do due to high levels of ability)	Below Radar [Passing (passive component ...afforded by high ability levels)]
I think when I started at Birmingham I was with another	Difficulties discovered through comparison	Reminiscent of the 'it's just me'	Partitioning [difficulties something

girl and she got diagnosed with dyslexia I think two months after we started, and I was in the same PBL group as her. We were just talking about the issues she'd been having and things like that, and I just thought that's like me but I just thought that was just me being kind of stupid, and kind of a birdbrain, like everyone used to say I was. (263)	with peer. Thought she was *just* a 'bird brain'	sentiment of partitioning…('just') Self-deprecating ('bird brain') → negative self talk.	else vs. 'just a bird brain'…i.e. 'just me'] Negative Self Talk (Internalised Badness)
So I thought about it a bit and then I decided to see…almost kind of self-analyse myself for a few months to see what came up and whether I was just making up symptoms or not. (265)	Delayed seeking assessment as wondered (? Feared) if she was 'making up' the difficulties	Fear of difficulties being 'just her'… risk in undertaking assessment.	Risk [in seeking Diagnosis → SpLD vs. 'just her'] (relation to Diagnosis & Label)
So about that time I'd started to learn to drive, I'd tried to learn to drive about three years before and I'd found it really difficult. It was like patting your head and doing your… Yes, and my instructor got so frustrated with me and I ended up giving up (268)	Others' frustration led to her 'giving up' learning to drive	Link to Frustration (other's frustration at not understanding her difficulties) but also Passivity (hinting at the earlier suggested trait: to be passive, or adopt a 'child' state (cf. transactional analysis) surrendering to authority / 'parent')	Frustration Passivity
Obviously because you can't see signs very quickly…you have to look at signs very quickly, I don't think I had time to look a long time and try and work it out for myself, so I found that I often couldn't read the signs probably and I'd mistake things. (275)	Speed of reading and thinking different + problematic (learning to drive)	Difficulties highlighting a sense of *Difference* (contributing to Black Sheep)	Difference (contributing to Black Sheep)
Another thing was I always thought it was me, and people, even my dad still makes fun of me, but I find it hard to pronounce words, or some words, and it's usually when there are two letters that are the same in the middle of a sentence or something, and I never ever thought about it. I just brushed it away (279)	Father jokes about phonological difficulties. Thought it was 'just her' and 'brushed it away'	Attributed difficulties to 'just her' before acquired of label / Dx …invoking metaphor: 'brushing off' dad's teasing. This feels somehow related to Partitioning: this is an example of 'her' vs. 'dyslexia'	Partitioning (coping) [prior to acquiring diagnosis, attributed difficulties to 'just her' …this changes post-diagnosis]
We started looking at my spelling more and we realised that my spelling was still quite an issue, just things like that. (285)	Looked at spelling more	(her + mum) searching for clues…a quest for understanding and an explanation	Seeking Understanding (within/ component of Seeking Reassurance)
[Medical School] they used to be really nasty and kind	Exams perceived as designed to prey on her	Feeling like a victim of tactics	Victim (within the Difference that

of make a play of…they kind of have two answers but just switch round some of the words to make a different answer and I just would get completely confused by that, and so I failed those exams (297)	SpLDs leading to failure	employed in assessments….	comprises Black Sheep)
then you have a reflection after your exams with your…I think it was like a mentor, and I said I honestly don't see how I can carry on in medicine because I'm just working so hard and I'm just not getting anywhere. She just said, well, it doesn't look like you're trying, it doesn't look like you're interested, and so medicine isn't for everyone, and I just thought I'm trying so hard. I know that there were these little things that are niggling away at me and I think I now know possibly what it might be. (302)	Told: 'medicine isn't for everyone'	Sense of being told that if she doesn't conform, she doesn't belong. Misperception ('doesn't look like you're trying') Also, sense of passivity here (no fight) in being 'told' something akin to 'if you can't stand the heat, get out of the kitchen'	Conformity [? Of Praxis, or is this a different variant?] (if you don't, you don't belong) Misperception Passivity
Maybe I should just be brave for once and actually say, actually I might have a problem. Would you mind checking this out? Rather than trying to struggle along as usual (304)	Admission / disclosure of difficulty requires bravery	Fear of Disclosure (due to how it / she will be perceived)	Fear of Disclosure (related to misperception, but also to Label & Diagnosis – as a barrier to coping)
Yes, so it was away from the med school so I felt quite safe and he said that I had really quite profound dyslexia, a significant amount of dyscalculia and some dyspraxia. (311)	Assessment of SpLD separated from medical school = safe Profound and significant dyslexia	Separate from profession = affords safety…confers sense of risk. Implies danger in medical school (+?wider profession) knowing – risk to group membership, risk to how she is perceived, and risk of being misperceived / misunderstood.	Safety (relates to Risk, which relates to Diagnosis & Label)
He said my visual processing speed is absolutely appalling, which is very heartening, and he said he thinks that how I got through my education to that part	Appalling processing speed = heartening (reassuring)	Sense of relief at external validation of difficulties (this feels like some sort of pay-off for the personal risk)	Validation (within Diagnosis & Label)

(313)			(this Validation is separate from, but contains Relief)
he said that my IQ was such that if people have these kinds of SpLDs, they find ways to compensate for them and struggle along rather than completely bottoming out academically, and he said also what really, really helped was having my sister and my mum because they'd been crucial in kind of getting me to progress and not give up and working through things. So that was kind of a real relief but it didn't solve the problem. (319)	IQ, mum, sister + perseverance got her through. IQ enabled compensation Dx = real relief [reflection: drawing on several labels for SpLD to ? illustrate *profound* and *significant* impact → ? legitimising]	This relates to Passing…she was able to fly **Below the Radar** because of her high IQ…but this left her vulnerable to feeling neglected.	Below the Radar (within Passing) [below radar = passive aspect of Passing. Faking it = active] Relief (within Validation, within Diagnosis & Label)
it was a relief because I'd always found things a struggle and I got so frustrated with myself academically-wise and I kind of felt torn because I took in what everyone kept saying to me that you're lazy, you're not trying, you're not achieving your potential, why don't you just try harder? (324)	Felt torn by effort vs. perception of results	RELIEF Frustration (self, due to social comparison + others' perceptions) 'took in what other ppl said' → relates to weighting others' judgements over her own perceptions → this passivity relates to the process of internalising the 'badness'	Relief (within Validation, within Diagnosis & Label) Misperception Frustration Passivity (within Internalised Badness) [here, the link between passivity

			and IB is becoming more visible]
, I don't get so, so incredibly mad at myself like I used to, in terms of I used to get so mad and angry with myself, (328)	Relief as Dx explains struggle + stops 'mad at myself'	Relief – but also a sense of forgiveness here → no longer angry at self	Relief + Forgiveness (Diagnosis & Label)
when I was a teenager I was like, I should just be a dancer or a hairdresser because I'm that thick that I just can't, you know, I can't do academic stuff, and I just had a terrible self image, especially compared to my sister, who's just crazily intelligent. (331)	'terrible self image' comparison with sister	Negative self-talk, very poor self-esteem / self-image here… social comparison (sister) AND linguistic uncertainty ('you know')	Negative Self-Talk (Internalised Badness) Social Comparison
I think I also had a real problem because everyone was asking why can't you do this? What's wrong? Why are you not trying? And yet I was trying but they wouldn't accept it so I started thinking to myself, why aren't I trying? Why am I lazy? And so I just got completely twisted up inside because I almost started to form a self image of what they thought of me, and it didn't kind of fit with actually what was going on inside me so it was kind of complete clash inside me. It was very strange. And I think the automatic response to that when I was younger before my diagnosis was when things got way too hard, I'd either totally, totally compensate and bottom out and get really, really ill or I'd just end up giving up because it just got a bit too much. (339)	Dx made it a real problem People say 'not trying' made her believe she wasn't Self-image formation clashing Before Dx would give up / 'bottom out'	Internalising misconceptions (lazy), but a sense of dissonance ('this didn't fit', 'it was very strange') but Dx ?helped clarify / make 'real' Difficulties → 'going on inside' her…a very embodied sense of her difficulties *being* her (NB: this is prior to Dx) [Reflection: ? suggesting that since Dx doesn't "bottom out" anymore? → notion of self-image and crisis of identity → internalised vs. eternalised / causing dissonance / clash]	Misconceptions → Internalised Badness (but **dissonance**) [conflicting sense of self] (Contextual) Embodied Difficulties [this seems related to the power of the Diagnosis & Label]
I don't think I would have carried on with my medicine	Dx allowed her to continue in medicine	Diagnosis as conveying sense of	Forgiveness (within Diagnosis &

degree if I hadn't had the diagnosis, purely because I'm probably being completely skewed in my perspective (341)		forgiveness, and permission to try…her diagnosis enabled her to re-centre her perspective	Label)
, it's kind of like the antithesis of what a dyslexic and somebody else with SpLDs needs to learn properly. (343)	Medical school = antithesis of how dyslexic people learn	Medical school being somehow antithetical to struggle and difficulty, which creates a sense of difference and not truly belonging ('sink or swim' / 'can't stand the heat, get out of the kitchen' kind of thing)	Difference (Black Sheep)
So that kind of kept me going, and also having that port of call at the SpLD place at the university which was away from medicine really helped because it was a completely safe neutral place that I could go and talk to people and they understood why. For instance, I had issues at med school because there were things like I found it terribly hard to keep within word counts, and I just used to spend ages and ages trying to cut things down and everything would be really convoluted and I'd get really mixed up and I used to get into trouble for that. Once I apparently incorrectly calculated the word count and it went for the medical…I don't know what they call it. (351)	Uni support (away from medical school) was safe, neutral and helpful	Reminiscent of the notion of vulnerability, and the sense that exposure / help-seeking within the medical establishment is perceived as *unsafe*.	Safety (relates to Risk, which relates to Diagnosis & Label) [this also relates to the notion of Risk in terms of seeking a diagnosis – not just risk to self in terms of exposure / 'just her' but also to being seen to seek / need support within medicine]
. Once I apparently incorrectly calculated the word count and it went for the medical…I don't know what they call it. **I: Fitness to practice?** R: It wasn't the fitness to practice but it was the examination board and they said that it was underhand behaviour or something and I said, I'm really sorry but I'm dyscalculic. I was trying to do it really quickly to get it in because it's a long story, but my friend's dad died the day before so I was rushing to get it in because she	Mistake with word count interpreted as 'underhand behaviour'	Misperception – miscalculation interpreted as underhand. There is a sense here that her mistake was dealt with harshly, and that she was either under-supported, or the feedback was couched in terms of suspicion… rather than seeking to understand…	Misperception [but this also speaks of a hegemony: authority unwilling to listen to defence / 'excuse' and quick to demonise]

hadn't been able to do her part of the work. (356)			
When I rush things, the numbers move around in my head, which incidentally is awful at the moment because I'm trying to learn bleep numbers and stuff, and the words get arranged differently. (359)	Difficulties with numbers affects recall of bleeps	Difficulties worse with rushing (context dependent exacerbation /manifestation / awareness)	Contextual Difficulties (= difference, part of Black Sheep)
And also the diagnosis hugely, hugely helped me with the extra time in the exams because, one, you get to be in a really nice, quiet room, which really helps me because I get distracted quite easily. Also not only do you have extra time but it's the huge release of pressure. (362)	Dx allowed extra time, release from pressure + helped defend 'underhand' behaviour	Diagnosis as bargaining chip for resources (extra time, separate room). Relief came from perceived 'release of pressure'	Bargaining (under Diagnosis & Label) Pressure (under Coping) [here, she talks about things that contribute to it, and to the 'release' of it]
because I know that I'm not going to be able to finish them and I'm always trying to race and race and race, and obviously when I race I make even more mistakes. (364)	Does exams 'knowing' not able to finish → rushes + makes mistakes	This is reminiscent of pressure, but also conveys a sense of **hopelessness** based on previous experience (? Learned hopelessness)	Pressure (within Coping) [describes 'knowing' will fail in certain context] [reflection: resisting the urge to make this fit within the pre-existing framework of Learned Hopelessness – but it does feel like there is a link]
Apparently I'm quite hard on myself so I don't accept excuses for myself or my behaviour or my work, so I needed someone externally to…it's terrible but I needed someone externally to give me a label and say look this is not your fault, it's a biological thing (371)	Doesn't accept 'excuses' for 'behaviour' (difficulties) Needs external validation of difficulties, and forgiveness	'apparently' – again, trusting other's judgements over her own, relating to Passivity Doesn't accept 'excuses' for her 'behaviour' – being hard on herself, some form of unforgiveness / punishment – this feels like it is related to the Negative Self-Talk as it is encompassed within a sense of low	Passivity Self-Compassion (LOW!!!) [relating to negative self-talk, but I think Self-Compassion is higher-order, and comprises notions of unforgiveness,

		self-compassion….	harsh self-judgement, exacting standards, and punishment- and Frustration]
You can get a bit frustrated because it's something you have to live with but you can't get frustrated and angry at yourself and your own competence, because it isn't incompetence, it's an SpLD, and that really helped me because it kind of legitimised things. (374)	Dx = not incompetence, it legitimises difficulties	Sense of compromise in 'something you have to live with'. Intellectualises 'can't get frustrated at self' (but does! – conflict & dissonance) as it 'isn't incompetence'	Compromise [→ embodied difference (but post-diagnosis)] Intellectualises for Forgiveness (within Diagnosis & Label)
It also gave other people a kind of reason why I was behaving the way I was and it's very, very rarely that I ever say to someone, oh, sorry, I think that might be my dyslexia. I don't think like that, because I really, really don't like to make excuses and I still feel that some people think of it as an excuse. But I know that that's what is happening inside me and I know that if I ever got into huge trouble in terms of someone saying this girl is just repeatedly being really, really stupid, I could say, hang on, this is what's happening, and then someone from outside would be like you can't do that to her because she's actually got an SpLD, it's not because she's just being slapdash or anything like that (381)	Label is helpful Doesn't like making excuses Doesn't disclose Dx due to perception of it as an excuse Label helps to challenge misconceptions of her performance	Refers to difficulties as 'behaviour' (reminiscent of 'birdbrain' and 'lazy' judgements) → negative self-talk / low Self Compassion 'can't do that' implying some socially / morally unacceptability of misattributing in relation to SpLD. Excuse: repeatedly refers to 'not making excuses' which conveys a sense of not quite letting herself off the hook, despite recognising difficulties. Has this feeling evolved from her having internalised the perception of other people think of it as an excuse	Self-Compassion (refers to difficulties as behaviour, akin to 'lazy', related to negative self talk and internalised badness) Misperception (misattribution is unacceptable in context of recognised label) Internalised Badness & Passivity undermining the power of the Diagnosis and Label through introducing self-doubt around 'excuses'
So I think it's made me less worried kind of about consequences and things (382)	Label = less worried about consequences	Implying has been very worried about consequences.	Diagnosis & Label (forgiveness & reassurance)

even though a lot of things are out of my control in terms of I can't operate as quickly and efficiently and precisely as other people in my profession, it's kind of given me a bit of a release and has also just…I don't know, I'm not explaining myself very well, am I? (385)	Performance 'out of her control' Dx gives 'release' (lots of self-doubt)	Social comparison somehow linked to distinct lack of agency ('I can't control'). Referring to *release* due to Dx (release of pressure) Again, within narrative, seeking reassurance and hinting at low self-esteem	Release (relating to Pressure, within Coping) Seeking Reassurance (part of Internalised Badness
, it's just… It's not a personality defect and I think I was always made to think that it was a personality defect and now I don't take my mistakes so personally if I can identify that they're to do with something to do with dyslexia or dyscalculia or dyspraxia (389)	Made to feel as if difficulties were a personality defect Mistakes *not* personal if linked to SpLD [?]	Somehow the label has the ability to distance the difficulty from her sense of self, almost a kind of de-embodiment	Distance (Diagnosis & Label) [different from forgiveness, but maybe a process that enables the forgiveness: de-embodiment]
I think by now I would have stopped doing medicine a long time ago (390)	If took mistakes personally, would have stopped medicine	The label has conferred ability to forgive self / afford herself a 'second chance'	Forgiveness (within Diagnosis & Label)
Certainly even in the last few months there have been times where I'm just like, I can't work in this profession because I look up in the index of the BNF for a drug that I need to look up really quickly because my consultant wants me to be fast and efficient on ward round, and do this TTO now, and I've looked up the page number and then I've gone to the page and then I've realised	Thought couldn't work in profession due to speed of work & difficulties	Sense of not being able to belong to the professional group due to not conforming to ways of working.	Conformity of Praxis

that my brain has rearranged the numbers in my head, and then I look like a daft fool (397)	Miss-remembered page numbers in the BNF Feels looks like a 'daft fool'	Contextual factors to difficulties Negative self-talk / self-perception → relating to poor self-compassion – seems harsh on herself for minor slip…)	Contextual Difficulties Self-Compassion
Then I can feel angry but I can feel a bit removed from that anger and I can let it go then I can come back ten minutes later and just say just carry on another day, whereas before I wouldn't have done that. I think I would have gone and hidden away in a research lab or something so…(400)	Dx removes her from anger (…at self, or at others for not understanding?)	'feel a bit removed' resonates with creation of distance from difficulties, facilitated by the diagnosis and label.	Distance (Diagnosis & Label) [here, the distance also refers to distance from emotional response, as well as distance from others' reactions…affording time for perspective to take effect]
Although she still worked with me an awful lot and helped teach me, it was very clear that my mum thought it was a personality defect and I didn't even tell her I was going for the dyslexia assessment until I'd had it done, because I think she would have thought that I was trying to make an excuse or something and I just think it would have been the most awful thing if I'd gone for the assessment and they'd said no, you don't have anything and she would have been like you're just trying to make excuses as usual. (408)	Mum helped her, but she felt judged by her 'personality defect' Worried would be seen as trying to make an excuse. Would have been **the most awful thing** I test was negative, and didn't have SpLD and *was* 'just making an excuse'	? overhang – the internalisation of her perception of her mother's judgement seems very related, in this example, to her self-harshness ('not wanting to make excuses') 'the most awful thing' – speaks of the personal risk involved in being tested for Dx	Overhang [related to (low!) Self-Compassion] Risk [in seeking Diagnosis → SpLD vs. 'just her'] (relation to Diagnosis & Label)
pretty much most teachers bar one or two that always used to say I was lazy and inattentive and sloppy and	Difficulties / others opinions reflected as	Misperception of difficulties as attitudinal ('not interested in work')	Misperception

not interested in my work and I didn't try and I wasn't committed. That all kind of gets reflected as character faults, especially as you get further on (411)	'character faults'	which she appears to have embodied as 'character faults' (but in this case, the 'faults' are not the difficulties, but the low self-compassion)	Embodied Character Faults (Self Compassion)
Then in terms of the dyspraxia, that's harder to shake off as like a personality thing, so I've always been told that I'm clumsy and uncoordinated and I don't learn things quickly and people used to say you must be really antisocial because you don't play contact sports and things like that (418)	Dyspraxia = harder to 'shake off' as 'personality thing' [NB: 'people used to say' and 'always been told' repeatedly used]	harder to 'shake off' as 'personality thing' → compared to ? dyslexia, implying there is a difference in ability for labels to confer 'distance' Passivity in her language creeping in again	Distance (Diagnosis & Label) [differential label functioning with regards to distance and forgiveness] Passivity
I used to absolutely love dance when I was a teenager but I actually had to give that up because the teachers just used to…it did get to the stage where they started to sneer at me and they wrote reports like she is not very naturally predisposed to dance and she has poor ability to pick dance routines and perform accurately and things like that. (423)	Used to love dance, but gave up as teacher said she was bad at it ('had to give it up' – felt compelled to)	Passivity, not only in language, but also in action → gave up something she loved because was told 'not naturally predisposed' This feels related to Overhang and as if it has contributed to her sense of low self-compassion/ esteem	Passivity [in action as well as language – surrendering agency to the judgement of others despite loving what she had been influenced to give up] Self-Compassion (within Overhang)
I would have loved to have done it properly but I had to give that up, and I can't even do classes now because they're like and to the right, and I go to the left and I just can't copy other people. The diagnosis helped me in terms of that too. It's helped me recognise that they are issues but they're issues I can get around or I deserve to get around, whereas before I think I thought	Had to give up dancing. Wanted to continue, but can't due to L-R confusion.	Passivity again ('had to') L-R confusion illustrates an early (and pre-medical) example of (non)Conformity of Praxis that resulted in her being *different* (and therefore a	Passivity Conformity of Praxis [here there is a link to Overhang…as this example is from earlier life, but the pattern is

I didn't deserve to get around them because it was obviously me just being really silly and stupid and not trying, (430)	Dx helps her feel like she **deserves** to 'get around' issues. [Reflection: somehow her Dx has allowed her to ? distance herself from her difficulties / mistakes, which has had an impact on resilience or coping in environment and enabled her to stay in profession…? Compromising / negotiating a sense of perfection/acceptance]	Black Sheep) Need for Dx to 'deserve' infers a very poor degree of self-compassion…requiring something externally approved to 'forgive'	recreated later/present day] Forgiveness (in Diagnosis & Label) [link with poor Self-Compassion through the need for this externally validated token of 'deserving']
whereas now I kind of problem-solve rather than just get angry, if that makes sense (431)	Awareness allows her to problem solve instead of get frustrated	Dx affords awareness which creates distance from anger, but also chance to problem-solve	Distance (under Diagnosis & Label) [here it allows distance from emotional response, and space to problem-solve = coping strategy]
, I definitely still have I think of myself as a poor medic and I feel like I'm taking someone's position. I feel like pretty much anyone could do my job better than I could. I feel like I'm taking up a space on the training programme that someone else could do much better than I could. (439)	Thinks of self as poor medic → taking someone else's place	This feels reminiscent of Impostership (related to a poor sense of self as undeserving, but also related to anxiety around 'Faking It' – waiting to be discovered)	Undeserving → Self Compassion Impostership → Faking It → Passing
I know I'm not the standard of other medics in terms of I'm not as fast and as efficient and I'm not as accurate as other people, so in terms of my job at the moment, when I get in at eight, I have up to an hour to review the patients' notes and go through them. There are certain things I have to check up on and I have to fill out forms. I have to read through the history of what's happened, then print out all the blood results, check the x-rays, tick all the admission documents and make sure all the prescribing is correct and things like that,	Slow = not the same standard of other medics. Feels different (? Substandard) cf. other medics.	Slowness isn't consistent with legitimate / equivalent membership – doesn't conform, and is aware, and compensates through preparing etc… and awaiting discovery…there is also a sense of this being 'penance' – having to make up, and earn (? As is underserving) her place through additional work.	Conformity of Praxis [non-conformity covered up through active attempts to cope / Fake It through preparing covertly] Underserving [relating to Self-Compassion and Internalised

and then I'm expected to memorise all that stuff in my head as well, so I can present it on ward round. I find, like this morning I was incredibly stressed because somebody interrupted me for 20 minutes and then another person interrupted me for ten minutes and I just knew the morning was going to be a car crash then because I think my reading speed is much slower than other people's so my consultant called me in for a mid-placement review and he said he doesn't think I'm lazy but he thinks I'm inefficient. He says he can't understand why jobs take me so long to do. (451)	Prepares as means of coping Struggles with interruptions Supervisor thought she was inefficient rather than lazy. Supervisor couldn't understand why she was slower	Misperception Insight & Understanding (which informs Misperception)	Badness] Misperception Insight & Understanding [informing Misperception]
The one thing I find really difficult is ECGs. I'm really bad at pattern recognition and I can't manipulate things in my head. I can't rotate things, so that is really difficult. I find it really difficult to remember…I find it really hard to calculate the heart rates, you know, when you have to count the number of squares and divide the number by 300 (457)	'really bad' at pattern recognition and manipulation and recall	Embodies her difficulties here → internalising this badness as something intrinsic to self…contradicts the distance afforded by the diagnosis & label	Embodiment [relating to de-embodiment…which appears to be contextual (dependent on at-time insight) in terms of how it affords 'forgiveness']
everyone went round and you had to present the ECG and calculate the heart rate, and I said I'm really sorry, I can't calculate the heart rate, I would need a calculator, and everyone looked at me and the instructor just looked at me in disgust and said, you should be able to do it in your head. That was just really embarrassing	Embarrassed in group when couldn't calculate heart rate in head. [Reflection: such a lot of negative self-perception and self-talk…incredibly sad and	Exposure elicited sense of shame (through embarrassment) as highlighted difference (Black Sheep)	Exposure [undermining efforts to Pass] → Shame [reinforcing *Difference*, which contributes to construction of Black Sheep]

(462)	mostly framed in terms of what she has perceived others have said / thought about her]		
like if you can't do that, there's only one reason why and that's because you're not trying and you're stupid. That is really funny because you'd think that people would be aware nowadays that these people that obviously look like everyone else but they do have these things that they struggle with. I didn't want to bring it up at all but on my transfer of the information form from med school they put down that I had dyslexia and whatnot, so I had to see the foundation programme director about it, just as a standard protocol thing, and he said you need to inform your clinical supervisor (481)	Judged from school → only reason for struggle = 'stupidity' 'Really funny' that judgement of difficulties as stupidity persists nowadays	Passivity in weighting others' judgement Overhang (significance of this experience carried forward) has resulted in Internalised Badness (of 'stupidity' – as it is 'really funny' that misperception persists, but her perception / attribution of others' misperception also constructs this, which is based on IB)	Passivity [this appears to give more power to Misperceptions, and is therefore related] Overhang (from Misperceptions) → Internalised Badness
, I said at the end, this is just…I kind of belittled it because I don't want to make excuses because he's the kind of person who won't stand for anyone making excuses. (485)	Belittled difficulties Afraid of making excuses	Felt the need to minimise (belittle) her experience of struggle, to *conform* with expectations, and through own fear of making excuses	Excuse [excuses are 'Bad' and you can't make 'excuses' in medicine] Minimised Difficulty (to fit within *Conformity* [or sense of Passing])
So I just said thank you very much, your feedback after all that stuff, telling me that I was going to sink in respiratory and stuff like that, I had such an easy job and I should just be enjoying it as a holiday type thing rather than a proper FY job, and I said by the way, the foundation director just told me that you need to know that I have dyslexia, dyscalculia and dyspraxia and he just said, what do you want me to do about that? And I was just like, nothing, and just walked out, and I think…I don't know…I've never actually talked to people about	Warned would 'sink' in respiratory medicine Felt like was seen to be in an 'easy' (and therefore not 'proper') job.	There is a sense of passivity expressed through *thanking* someone for negative judgement…(?a form of learned helplessness) which feels related to her low self-regard (esteem/compassion) Passivity through acting (rather than ?	Passivity Self-Compassion Disclosure (this would be within

it, so I don't really know how aware people are of what dyslexia and dyscalculia, how they actually manifest, because I just thought, oh, well, maybe because he's a kind of supervisor, (493)	Told to disclose Supervisor: what do you want me to do about it?	choosing to act) on advice to disclose (NB: disclosure appeared to relate to negative outcome here) Apathy ('what do you want me to do about it') on part of others…?mirrored by her ('nothing')	Diagnosis & Label) Apathy (self & others) in response to Label (related to Diagnosis & Label) [but this also feels to contribute to Passivity on Amanda's part and feels like an abrogation of Educator's responsibilities]
I just thought, oh, well, maybe because he's a kind of supervisor, he might have an idea and he might be like, oh, is that why she takes a long time to read notes and that kind of thing and makes mistakes, and sometimes get the sodium levels for one patient mixed up with the other and that kind of thing, but nothing clicked. (495)	Thought supervisor would have insight into difficulties / SpLDs	A sense of being let-down by the Educator's lack of understanding (leading to Misperception)	Let-Down [as a consequence of Misunderstanding (which is within Misperception)]
when I started out I was really, really worried about and I got quite terrified in the first couple of weeks was prescribing because the funny long names, they kind of get jumbled in my head but particularly calculating dosages and TTOs correctly and that kind of thing, especially when you have to do it under time pressure. (502)	Terrified of prescribing because of 'funny' long names + time pressure Potential for mistakes	A sense of heightened worry (some would be expected, but she is *really, really* worried and *terrified* which feels related to her anticipation of difficulties (and potential errors) with drug names etc.)	Apprehension [understanding of difficulties leads to heightened anxiety about potential for contextual errors…which would possibly bridge Faking It (active passing) with Coping through prompting double-checking strategies]
I notice that I do make more mistakes than I should do, so then I have to go and check things out several times and I found it really difficult… I do still find it really difficult at times because I would like to have time and space to be able to sit there and just work it out for myself to just check that I've done it properly, but often people are rushing me and expecting me to do things at their speed and some people get really impatient, and I	Still makes mistakes	Apprehension (as above) but here there is a relationship with pressure (perceived through needing to 'keep up appearances' to conform (coping	

do worry that one day I'm going to make a big mistake (507)	Double checks things People rush her, preventing checking Worries about potential for 'big mistakes' [reflection: does still find it difficult ? emphasising expectation on self that would improve / difficulties would fade with time / in 1 year]	with interruptions is perceived as conforming)	Conformity of Praxis [driving perceived pressure, which stresses coping strategies beyond their ability to 'keep up']

Amanda - Self Characterisation Sketches: *Coding Notes*

1. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
Tell me if I'm going wrong when I do this. **I: Well, as I said, there is no right or wrong, so I shall tell you nothing of the sort.** R: This is going to look really weird. (546)	Uncertainty + Frames her action as 'weird'	seeking reassurance and validation	Seeking Reassurance (part of Internalised Badness, reinforced by 'weird')

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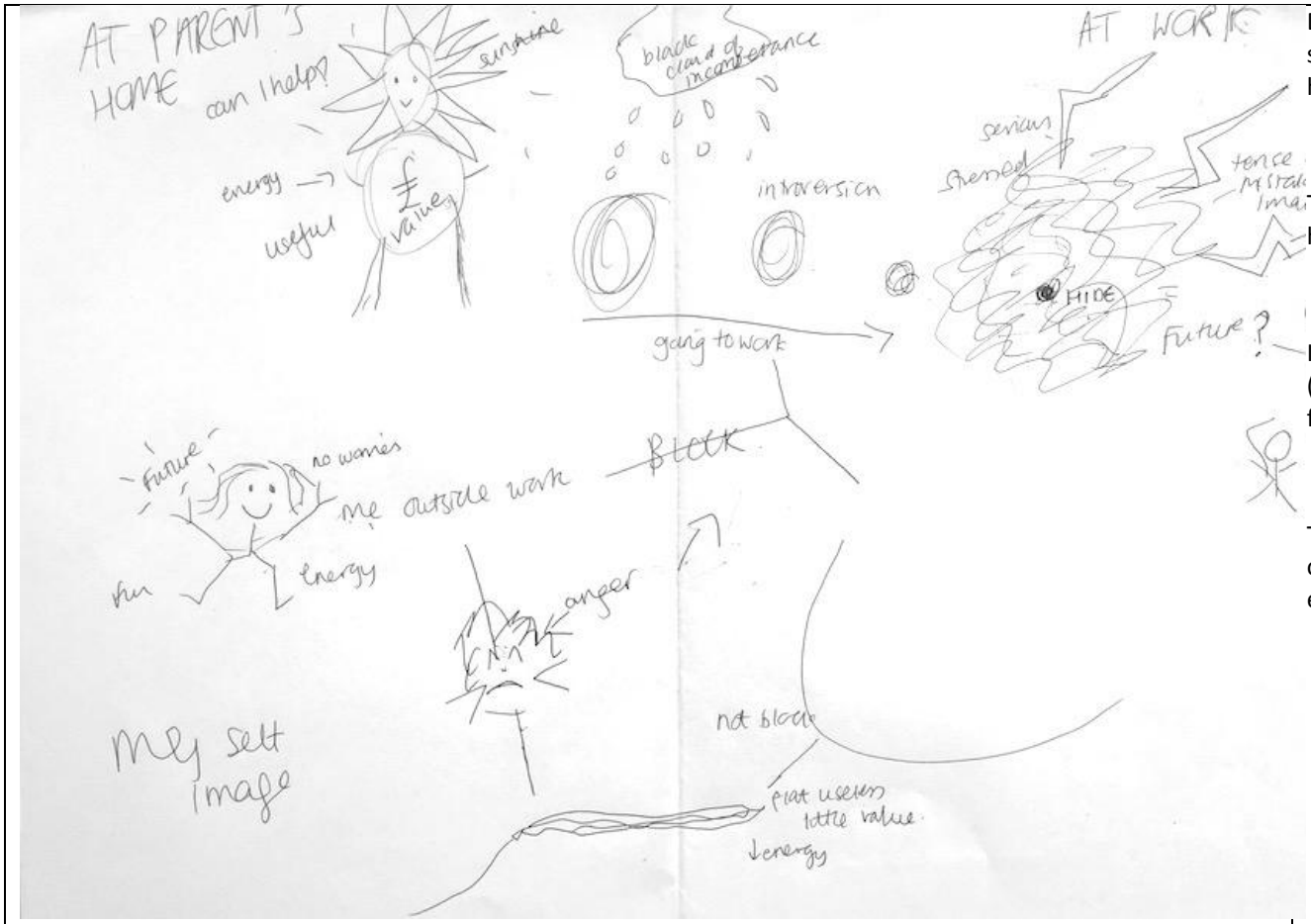
<td colspan="3"> 
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<td>Drew an all-encompassing representation of how she feels a friend, and supervisor, would perceive her, as well as her self-image.

This image shows relationships nad tension between her working life, and life outside of work.

Interfacing with work invokes images of black clouds (‘of incompetence’), uncertainty with regards to the future (?), chaos (squiggly lines), stress, and anger.

The is contrasted by the images representing herself outside of work: both of which bare a smile, have energy, and a sense of happiness and fun.</td>
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<td>at work, this is how I think my supervisors think of me, so basically this is kind of a little bit about how I see myself, so this is my journey into work, so I feel like I get smaller when I get into work, because I feel me outside, I’m a much bigger person. I’m more colourful, I feel more confident, I feel more valued and I feel like I have more value (562)</td>
<td>[?How others see us is projection of how we see ourselves]

Feels less of a person when in work.</td>
<td>Devalued in work as doesn’t feel legitimately belongs, or her true self recognised (consequence of Faking It)</td>
<td>Value (devalued as a consequence of Faking It) [fitting in makes her feel a smaller, less confident, less valued person]</td>
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	Feels has more value outside of work.		
when I go into work I feel that I become much less of a person. I feel like I scrunch up inside because I'm just waiting for the next mistake I make or the next defect in my doctoring skills (564)	Her perception of her mistakes make her feel scrunched up. Mistakes = defects in doctoring skills	Devalued (as above) Mistakes make her feel scrunched up – crumpled (under pressure of trying to conform) tarnished	Value (***de***valued within Faking It) Pressure (within Faking It)
or is perceived as being sub-par and then I feel that they think that when I go into work, I'm just this huge mass of fluff and like a dustball because everything's confused and disorganised and things aren't done correctly and these are kind of lightning bolts that come out and they affect the rest of the department because of, say, if I'm in Majors, my patient takes 25 per cent longer because it takes me longer to read the notes of the previous admission and that kind of thing and to get the bloods and stuff like that, and to document everything. So I feel then that starts to affect them so all this fur kind of comes off on them, then I feel that I'm a burden to the department (572)	'defects' percieved as fluff / dust. Fluff = burden, which rubs (bolts) off onto other colleauges.	Sub-par= doesn't feel equal (?legitimate) team member, of lower value (relates to *devalued*) Sense of concern that her difficulties would burden team.	Value [***de***valued different facet: her it isn't just being perceived as of lesser value, but of feeling like warrants this due to being sub-par] Burden (within Black Sheep)
I feel like I'm a much happier and sunnier person when I'm outside work and I feel that I give more happiness to people (575)	Sunnier, happier + more valuable outside of work.	Context-dependent nature of self-value. Non-conformity in work = lesser person	Context (within Value) [+ve outside of work]
I feel I can contribute and I am of more value to them when I'm outside. I	Can contribute more outside of work	Reinforces notion of	Context (within Value)

feel like I almost have a negative effect at work. I would say that this has got 1000 times worse since my mid-placement appraisal because of the feedback I got. I wasn't happy with my performance (578)	= more valuable. Negative effect at work. Feedback impacted further on performance.	context-dependent nature of self-value. Internalising the 'badness' from the feedback → poor self-esteem and performance	[+ve outside of work] Internalised Badness Self-Compassion [unable to balance/attenuate negativity of feedback]
I wondered whether there was still a bit of an element of me being a junior doctor and it's my first job and you just have to put up with you just being a bit incompetent and then later on you kind of start to meet your expectations, but his kind of feedback really jolted me down. I talked to quite a lot of other people because I'm close to another staff grade. She's really nice. She's Dr [SMITH] and she said to me that when the middle grades used to do my job, it used to take them as long to do it as it does me, and that my clinical supervisor isn't, you know, kind of the nicest and most empathetic person, and not to take it to heart, and I just wonder whether all my SpLDs just make me take everything to heart a bit more than I should do. (587)	Criticism externally discredited by colleauge. Her SpLDs make her more sensitive / vulnerable to –ve feedback Doubts insight, so can't ignore critique for fear it is accurate.	Here, seeking reassurance externally, but also element of not focusing (bulk of narrative is –ve) on +ve feedback → weighting to *negative* perceptions of others …this appears more to be re: Black Sheep than specific to SpLD	weighting to *negative* perceptions of others → Self-Compassion & Overhang → Internalising the Badness
I have different self images depending on where I am. So at work I have a very different self image. I would say my self image is not the same as my friends and family. I don't know how to draw it but I find I see myself as a clumsy person and accident-prone (594)	How sees self is context-dependent. Sees self as clumsy person	Context-dependency of self-concept articulated here. She has internalised *negativity* here ('clumsy' feels pejorative)	Context (within Value) [+ve] Internalised Badness
my self image kind of has two elements, so if I block out what happens at work, so if I have a weekend off and I just block everything out then I'm a very different person from if I don't block out what happens at work and how I feel at work and how I feel that people think of me at work (604)	Very different self-image if 'blocks out' self-at-work.	Context-dependency of +ve value is dependent on active 'blocking' out of work → partitioning	Value [not only dependent on context, but active effort to **partition** negative

		identity (her-as-doctor vs. her-outside-of-work)	aspect of identity – linking partitioning as a coping strategy]
I: As a doctor? R: Yes, I feel like a deflated balloon, if I don't block it out and I almost kind of like…I don't feel like a proper person, because I feel like if I can't do my job properly I've always wanted to help people and I've always wanted to be of value and if I can't be of value and I can't help people then I'm not a proper member of society (609)	As doctor, feels like a deflated balloon. Self-at-work = self-as-doctor = defective and of low value to society	Metaphor / image of deflated balloon: defective, deflated, empty, useless – without value	Value [contextuality – as Dr, deflated]
it's kind of difficult to just isolate my self image because I think my self image has always had a huge input from how other people perceive me and I certainly have always been told that I take too much from everyone else. I'm like a sponge so I draw up other people's emotions and how people respond to me and I take it to heart, so these aren't pure self images because I'm not really sure that I have a self-image of myself in isolation. (616)	Framing her sensitivity as *greed* (?) Cannot isolate other's perceptions of her from how she now perceives herself	Sensitivity-as-greed seems to be a very negative interpretation: negative self-talk Passivity has lead to contamination of self-perception	Negative Self-Talk Passivity [has led to internalised badness and negative self-talk, contributing to low self-compassion/concept]
So I have always been told that I'm accident-prone, from when I was a very little girl, I was always getting into scrapes just because I'd mis-planned things and I'd fall over and knock things over and I'd smash my mum's favourite vase and I wouldn't mean to at all, but I was told that it was intentional and I was kind of not taking care and I was being clumsy (621)	Always been told was clumsy. Accidents were her *fault* from childhood.	Passivity (always been told, must be true) Accepting *fault* for accidents → a sense of helplessness here	Passivity [which, in this example, also involves a sense of being helpless: if told, must be true, and therefore accepts fault]
So I've always thought of myself like that, and as I got older my friends kind of thought of it in a fond way, that was just part of me because I was a bit dippy and zany and that kind of thing when I was younger. So they kind of expected of me as they were really good friends, they loved every part of me	Because others loved her clumsiness, she accepted and assimilated it into her self-image.	There is a sense of this 'love' being an *acceptance* or *expectation* of Others → through passivity	Passivity [again, helplessness to the expectations of others, incorporates into

so I accepted it and that became part of my self image (625)		incorporates into self-image	'accepted' image of self]
since being diagnosed, I think that might have slightly changed my self image, so I kind of separated that a little bit. For instance, certainly my dad finds it really hard to understand that that's not me being intentionally like that and it's not possibly part of my personality, it's a biological thing. I think I get slightly more upset when he makes fun when I mispronounce a word because I insert things in the middle of words and stuff. (631)	Dad doesn't see SpLD as biological – so when he 'makes fun' it upsets her more.	Conditionality of acceptance = if biological. SpLD not 'biological'…therefore ? 'just me' and not worthy of forgiveness	Conditional Acceptance (Diagnosis & Label) [relates to conceptualisation of SpLD and the embodiment)
I've started to reject part of that, part of my self image that I'd formed from everyone around me saying I was accident-prone and clumsy and that kind of thing, and a bit weird and a bit, as they used to say, un-PC way, ten years ago a bit blonde, you know, messing up how I'd say things and calculations and not being able to manage my money properly because I couldn't add things up and it would just not make sense to me. (636)	Dx helps her *reject* part of self-image that she is at fault.	**Rejecting** the acceptance-through-passivity…yet still identifying as 'weird' (Black Sheep)	Conditional Rejection [of acceptance-through-passivity, but still identified within Black Sheep]
I think I've actually changed quite a lot as a person in the last couple of years, and until you said that to me, I hadn't really thought of it that way (637)	Realisation and self-awareness facilitated through interview	A sense of the interview process being therapeutic, but also of her seeking opportunities to continue to make sense of her experiences…seeking validation and reassurance.	Self-Awareness (within Validation, within Diagnosis & Label)
when I was at secondary school being a doctor was the last thing that I considered I would ever be able to do because you have to be sensible and practical and not get into scrapes all the time unintentionally and I was the exact opposite of that so… (640)	Not sensible or practical enough to consider being a Dr	Had already internalised negativity by secondary school – therefore 'not good enough'	Internalised Badness (resulting in Negative Self-Talk)
I would say now I see myself as someone who tries and tries her hardest and I see myself as…it's not the right word…kind of like a truthful person and I was always very sceptical about myself before because I thought that I was trying my hardest and I thought I had the best intentions and people would say you're not trying, you're being lazy or you obviously didn't have good	Now sees herself as truthful (? Because of being a Dr)…whereas used to be skeptical of self as thought worked hard, but told	Internalised negative feedback, and acceptance (through passivity) have led to self-doubt	Self Doubt (as a consequence of Passivity + Internalised Badness complex)

intentions because why on earth would someone do something as ridiculous as that and smash that kind of thing (655)	otherwise.		
so if I transition, like often, say, when a weekend starts, I go from here and I get really angry at myself and also my supervisors, whereas before my diagnosis I would always just get angry at myself and now it's split and some of it is at my supervisors. (661)	Since Dx directs frustration at educators *as well as self*.	Frustration – in this sense it feels like it is conditionally (on Dx) directed at others *too*	Frustration (context and conditionally directed at self & others)
I will get really angry about everything that's happened and why, and why can't things be better, and then I'll transition to this during the weekend. (663)	Gets angry at self and educators at work, transitions to happy when away from work	Accepts an embodied sense of responsibility for difficulties – so inwardly directs Frustration / anger	Directionality of anger (Frustration) influenced by Acceptance-through-Passivity
with my dyspraxia I'd find it difficult to type in the correct order, especially when I'm doing it for long periods of time, so that really slows me down, so I've just recently bought a dictation thing and it's an absolute dream, and my stress levels are like reducing a lot. (676)	Adaptation has helped reduce stress levels	Describing a coping strategy, has adapted (due to self-awareness) which reduces stress/pressure	Adaptation (within Coping) [this feels different from Faking It, as it appears to be described as a personal means of her coping with *herself* rather than for others around her]
I always have the best of intentions and I do work every evening but it's snail pace especially after the whole day, and just things pile up and pile up and pile up and my FY director was just like you haven't done enough reflections (678)	Speed of working impairs ability to keep up with expectations of reflective work	Invoking animal metaphor. Misperception of quantity implying lack of input.	Misperception (output instead of process)
Every time I find a way round one of these issues I get more hope and hope is always something that anyone has, it's what carries you on through life, (683)	Adaptations give her hope to carry on through life	Hope: this gives a sense of desperation – clinging on to small gains to help 'carry' her on 'through life'	Desperation & Hope (coping – both a driving force, but also somehow grounds it to the sense of negativity held within Black Sheep)

Appendix 7: Coding notes for Brian

coding notes

Brian- initial interview

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
So my interview for medical school was with the Sub-Dean, "These are your marks, these are the marks of the people who got in, do something else" (laughter) and that was it that was my interview. So I said, "Right you, I'll prove that I, you know, I can do it" and I did very well, I worked my backside off. In that first year I only got very good marks and did get into medical school but never got A's again except when I found out what my blood group was (36)	Worked hard to get into med school + 'I'll prove…I can do it'	*prove himself* to mocking doubters…a sense of confrontation with authority figure driving motivation assumption operating here is that he doesn't belong, and that he won't succeed. 'I can do it' = determination → achieved goal	Motivation
trying to answer the question for myself, "Why didn't this come up before?" and it said, you know, "Bruce doesn't get the results that his effort should be producing in maths and reading" but I don't remember any	<u>Questioning</u> why diagnosis wasn't made earlier as signs were there	Effort in ≠ results out (a disparity between the two) …but this wasn't picked up on in	Disparity

specific assistance or anything at school. (52)		terms of alluding to an earlier diagnosis questioning of late diagnosis → conveys sense of regret (later expresses anger) and missed opportunities…but also creates image of child being left / neglected…feels unfair	Missed Opportunities
. I had a tutor when I was at High School for physics and maths because I couldn't, I just couldn't get on with them and I needed them; they were, they were important subjects for, for medical school. (54)	Failure to achieve.	Repeating 'couldn't' → frustration + absoluteness of barrier Laughter → irony, now working in field of difficulty Again…a clue that was missed → evoking sense of missed opportunities	Frustration Missed Opportunities
So and I did pass but I found those very, very difficult and I still find those very difficult numbers which, you know is a problem in epidemiology (57)	Passed, but found maths very difficult	Conditional pass (contingent on struggle) – qualifying / attenuating success with *but* and follow-up with how this impacts negatively now…	Achievement [using achievement instead of 'passing' due to duality of meaning] (within Achievement: Conditionality, and Attenuating)

the only other sort of clue in the background was that my parents or my father particularly didn't feel able to support me. My parents didn't know what to do with me because I showed an interest in things academic and they couldn't help me with my homework. My dad, I knew he didn't have a qualification but I didn't know until my dyslexia came out that he'd never passed an exam in his life (62)	Family weren't able to help academically, but supported as best they could Suspected Dad had dyslexia.	Comparison: 'dad's not stupid'...but (similar) difficulties give appearance? Compared to? Clues in background → missed Again, a sense of missed opportunities and having missed out.	Missed Opportunities [in here, there is also a sense of environmental factors leading to him slipping through the net)
my dad's not stupid I suspect he's probably dyslexic and you know my parents' solution to deal with my academic bent was to buy me at great cost a full volume of Encyclopaedia Britannica (laughs) (65)	Laughter (at help parents provided)	Humour / irony (at sense of futility or missed opportunity) …but his parents were doing the best they could, and he acknowledges this ('at great cost')	Missed Opportunities [environment not meeting needs]
I knew I was slow at reading and that continues because I find it very, very tiring and you know, finding out about the dyslexia has since explained a lot; it explains why I take so long to finish a novel because, you know, I'm lucky if I can read a chapter before I'm exhausted, you know. (72)	Diagnosis explained as difficulty with reading, slow	Repeats 'very' tiring 'finding out' has 'explained' a lot → discovery and explanation Label as illuminating, explanatory	Effects of Dyslexia [attributed difficulties: reading related fatigue] Power of Label [label as illuminating]
in academic work obviously quite a bit of reading is important and I get very	'than it should'	Phrase is repeated – emphasises significance: Judgement,	Frustration

frustrated with writing that isn't clear and you know it takes me longer than it should. It's always taken me longer than it should to read other people's work and get the meaning from it. (76)		comparison to peers / expectations (that he applies himself…internalised norms) **Frustration** Sense of struggle, with relation to reading and processing info.	Judgement & Pressure [against internalised norms] Struggle
that had been the case for so long that I didn't even recognise that that's what was happening until you know it was pointed out. In fact I, I didn't even, I didn't expect the diagnosis, I was … when I got told because I wasn't expecting that as an outcome of the assessment, as an academic trainee I was supposed to be smart (82)	As an academic ***supposed*** to be 'smart' so didn't expect diagnosis	Dyslexia associated with stupidity → stigma, reflects self-image Expectations (supposed) Somehow *not* 'smart' (supposed to be)	Pre-judgement & Pre-conceptions [that dyslexia + doctor = incompatible] (within Judgement) Relationship to Stigma (also in Judgement)
so when I didn't pass my part A exam which everyone thought I would sail through I got referred, probably prematurely, to have an educational occupational psychology assessment. (84)	Didn't meet expectations --? Suspected SpLD and referred	Expectations on self, as well as from others (system – exams, persons – supervisor)…but this didn't add up (disparity) triggering suspicion	Disparity & Trigger [due to expectations placed on him by self + others] (within judgement)
. My expectation was that they were going to tell me that my attitude was all wrong and I needed to change my	My expectation was that the test was going to tell me to change my attitude	Attitude- within-person = 'all wrong… voluntary (?) problem, sense of blaming failure on self. Self-attribution / extending	Extended Responsibility (within judgement)

attitude towards the exam (85)		responsibility	
actually my results were apparently quite conclusive and I was very polarised so I broke the ceiling on some of the tests visual manipulation and things like that and then I was down on the 19th and 15th population centile for other things and, you know, some of the tests I was just astounded, I just couldn't do and there was one where he was making word sounds but not, not actual words and asking me to repeat them back to him and I just couldn't do it at all. (91)	Astounded: difficulties defined by inability, detected phonological deficit	Apparently = uncertainty (disbelief that could ? do well) polarised: good vs. bad…	Disbelief (within self, within judgement) [disbelief in own abilities…Astounded = quite a strong word, not just indicating surprise, but here an element of suspicion at an objective marker of abilities]
then I was floored by the fact that he said I was dyslexic and all I knew about dyslexia was that it's a learning disability (laughter). (95)	'floored' by diagnosis – associated dyslexia with *disability* Laughter- humour	Laughter- ? rejecting / minimalizing / using humour to reframe perspective Metaphor- floored, as in knocked over (combat with self / other)	Disbelief (within self, in judgement)
So I got a second opinion from a dyslexia specialist tutor with a view to doing some work to helping my chances in the exam. It was really her that convinced me that he was right with the assessment. (97)	Sought second opinion (needed convincing)	Sense of mistrust and disbelief…but here, disbelief is at idea of having 'disability' rather than performing well in some tests…creating a strong sense of difference between perceived struggle and perceived disability	Disbelief (within self) [different – disbelief at notion of 'disability'…maybe (as disability crops up a fair bit) Disability should be a constituent component of this subtheme]

Well I don't know whether it's a cultural difference or a temporal difference that's more important because certainly when I was at school we didn't have ADHD and things, and, and I see a parallel between ADHD and particularly adult ADHD and dyslexia in that you get the sense that it's sort of something that became in vogue. Previously it didn't appear to exist and then it became in vogue (113)	'didn't have dyslexia when he was at school' Dyslexia ~/= ADHD = vogue	Temporal nature of diagnosis, difficulties, cultural construction and acceptance - - - - - Questioning validity of construct / diagnosis, vs. awareness of difficulty	Temporality (within Diagnosis) Questioning (links to Disability, which I think bridges with Judgement)
I don't paint them quite with the same brush in that, you know, my own view is that certainly some ADHD is an excuse for misbehaving children and I'm a bit dubious about the existence of adult ADHD but, you know, the jury's out. (116)	'The jury's out on ADHD...but less so on dyslexia'	Comparative validity Hierarchy of difficulties, labels, disabilities	Comparative Validity (within Hierarchy, within Diagnosis)
Dyslexia I think just wasn't recognised when I was at school. I don't remember ever hearing about it. (120)	Lack of recognition	Not seen/heard → hidden, visibility as a condition of recognition and ? acceptance Temporality	Visibility (linking to missed opportunities, within Diagnosis) Temporality (Diagnosis)
and I had quite a close relationship with one particular teacher who was a form teacher and a biology teacher	Even 'interested' teachers didn't identify difficulties	This speaks of visibility, missed opportunities and interaction with an orientation to caring for	Condition of Identification (within Disability) [links with

and he was quite encouraging me, wanted me to become a biologist and at no point did, did anything like that come up with him and he would have been of all my teachers the one that had the most interest in me and probably in the best position to have identified any particular learning difficulty if it had come to mind. (126)	(disinterested teachers ('all others') wouldn't stand a chance)	learners as a condition of identification (of difficulties rather than diagnosing, but this would go within Diagnosis)	visibility and a new concept of *orientation to caring*- which feels related to **commitment**, which is something he refers to in CIRs about needing to be very committed to be able to overcome difficulties…maybe need to be committed to spot them too]
, I was already quite developed in terms of my compensation so that people didn't recognise it or I think it possibly it was the case that the people who were teaching me just weren't familiar with it (130)	Quite developed in compensatory strategies	Compensation → people didn't recognise (masked difficulties)…also, here he is *owning* his compensation, and at the same time taking responsibility for *missed opportunities* in a way	Masking (within Coping) [this links to coping **and** Missed Opportunities, and speaks of agency and ownership]
the question that's come up for me is had I been aware, had my teachers been aware what might have been? (132)	What if his teachers had picked it up earlier?	Hypothecating alternative histories / futures based on Missed Opportunities…sense of remorse	Hypothecated Alternatives (within Missed Opportunities)
Had it been recognised in childhood would I have had to have struggled the way I did and I've had to work very hard to get where I am so I kind of initially actually after the diagnosis felt a little bit of resentment at the fact	Resentment at not having been spotted earlier	Resentment at 'missed' difficulties – could have struggled less…	Resentment (within Missed Opportunities)

that it had been missed or not recognised which I suppose is understandable (135)			
the knowledge of it might have not so much improved me academic performance but for me I think what I maybe have missed out on is the fact that I was too hard and too strict on myself and I blamed myself and thought I should be better and got angry at myself for not being able to do what I thought I should be able to do. (140)	Knowing Dx may not have changed performance, but may have helped him not blame self	Revisiting the notion of hypothecated alternatives → the knowledge of the diagnosis may not have changed much at all, or if he had changed, he would not have achieved what he did… but still a sense of anger at being left to blame himself…	Hypothecated Alternatives [may not have changed / achieved as much] (within Missed Opportunities) Resentment (within Missed Opportunities)
You know the only time I got threatened with the strap in school was because I couldn't recite my times table and I can't to this day. I just could not learn them and you know I'd like to go back to that teacher and give them a good shake and say, you know, "This is probably because I don't have the memory span to, you know, to learn these things and can't work with numbers" although I don't have dyscalculia. (145)	Couldn't do times tables, wants to go back to tell teacher his memory couldn't learn that way. Doesn't have dyscalculia	A sense of historical anger…since learning of Dx, knowledge of learning *difference* (and 'acceptability') of this crease sense of anger at previous authoritarian figure who was unfair in their expectations	Retribution (within Hypothecated Alternatives) [drawing on the sense of re-writing historical actions in light of new knowledge]
So yes I think it was mainly actually resentment that I could have had an easier path had I known about it	Resentment as missed opportunity for easier path, but ? would he have achieved	Explains resentment is because her was deprived of the chance of being *easier* on himself…but there	Resentment (within Missed Opportunities)

because I would have been easier on myself and instead of putting all the additional pressure on me that I did I could have had an easier time of it but then of course it could be argued that I might not have achieved what I've achieved had I given myself permission not to do as well. (151)	same if was easier.	is tension here between being easier (and a sense of 'letting himself off the hook') and achieving (striving onward) what he did…	
So what I don't want to do is to say that sort of every, you know, difficult social interaction or failure to deliver a piece of work or whatever's all because I'm dyslexic; (163)	Doesn't want to say every little thing is because of dyslexia	Sense of not wanting to use diagnosis as an excuse	Excuse (within Diagnosis…possibly relating to Power of Label) [fear of diagnosis being seen as an excuse attenuates Power of Label]
you know you have to make allowances for me and this is wrapped up in this whole question as to whether or not you declare it or not, you know is it a disability? (165)	Is dyslexia a disability?	Tension created here between what it means to him, and how he feels it is constructed by others → disagrees with disability component	Tension (within Questioning within Diagnosis) [questioning meaning, and exploring tensions between his and other's construction]
it was difficult to apply for an extra 25% time to take my exam when I thought I should be capable, as capable as anybody else; I didn't feel disabled but the public health part A exam was a two day handwritten exam which requires you to be very	Struggled to ask for extra time, didn't feel had a disability, but his thinking & writing doesn't work in the conditions expected to work in.	Barrier was internal perception of expectations…should be as capable' as others...this interacts with his perception of other's construction of label as disability (i.e. he isn't disabled, therefore not	Barrier (within Adjustment, which is within Diagnosis…this may bridge diagnosis with Coping)

linear and, you know, answer in order and make your points in order. I don't write that way, I don't think that way. My thinking's all over the place. (170)		deserving of extra time)…	
If I'm starting to write a paper I might put down a word that's going to be part of the conclusion first and then it's all over the place and then I reorganise it later and probably reorganise it several times before I'm happy that it's in the sequence that I want it to be in and obviously you can't do that in a handwritten exam situation. (174)	Writing is all over the place.	There is a sense of owned deliberation in the action here…it is *him* (in an embodied sense) that is executing the action of poor writing…it is therefore *his fault*	Extended Responsibility [taking ownership of errors, but implying he is to blame…it is his *fault*]
I passed my exam on the third attempt and I did no more topic-specific revision because, the first time I had been incredibly systematic and I'd gone through and I'd revised everything that was in the syllabus and I'd made index cards with bullet points and diagrams on them so I had those (179)	Passed exams on 3rd attempt, put in lots of extra work	Sense of disparity and unfairness…effort in, again, not equating to results out…this speaks of an internalised expectation that it *should* be equal…	Disparity [feel this is now related to Expectations….]
So the focus with this dyslexia tutor was on ways to beat the exam. So just with a few technique changes my, my part, my mark went up eleven marks with absolutely no new knowledge	Beating the exam with technique not knowledge	A sense of being inducted into the rules of engagement…how to 'game' the exams in a 'dyslexic way'… now has a diagnosis, there are a set of conventions to learn:	Dyslexic Conventions [rules of engagement] (bridging Coping with Diagnosis)

which was enough to pass because unfortunately I had missed by one percent the first two times (laughter). (183)		techniques for exams, permission for self…	
it was only, you know, it was only just a fail but still and yes I felt angry that I had to go through all of that and had messed up what had been planned for me in this current post because I got hung up and tried to pass the exams for so long (187)	Hung up on passing exams, just failed = angry	Very focussed on externally determined measure of 'goodness' or 'acceptance'….interaction with pressure of training trajectory (again, external)…this feels like it fits within judgement → feeding into his self-judgement and expectations of self	Pressure [applied through self-expectations and self-judgement] (within Judgement…somehow linked to Self, Expectations and Judgement)
. So dyslexia's no doubt caused damage but it's also my best friend in that it's responsible for all of the things that I'm really good at, you know, people want to mind map, people want something creative out of the box thinking, joining dots that other people haven't joined. I can do that and I'm sure that the reason I can do that is because I'm dyslexic and I think different from people who aren't. (192)	Dyslexia has caused damage, but able to think and work differently, which helps others	Damage of Dyslexia: imagery of leaving a path of destruction and devastation (although this feels a little too strong…)	Damage of Dyslexia (within Diagnosis) [possibly relating to The Power of Dyslexia – as there is a sense that this is 2 sides of the same coin]
I guess you all have, we all have a self-image and I didn't like the thought that my self-image included having a learning disability because to me my	Diagnosis damaged self image- is disability compatible with future in academia?	Damage of dyslexia – links to self, judgement and expectations, as has (historically) been hard on self…but also, the actual	Damage of Dyslexia (within Diagnosis) [linking to Self – momentary altered perception of

academic ability was quite core to who I am and being told that you're dyslexic my initial reaction was that self-image was undermined by having a learning disability so I was concerned that, I suppose that that might damage my chances of going further in academia as a sort of, you know, gut reaction (205)		connotations of label itself (associated with disability) – self-stigmatising, because he then felt this was incompatible, over-riding his positive self-regard and historical achievements, to suggest he would no longer be able to get certain jobs etc…	self…some of which does not appear to be entirely transient]
what does this mean in terms of declaring, you know have you got a disability for exams and things and you know I am because I'm coming to the end of my training you know four months to run in the process of applying for things and, you know, do I or don't I tick the box because what if they give me a test to, you know read a guideline and prepare a PowerPoint presentation; well that's going to take me a little bit more time than it might take someone who is much more efficient at reading. (211)	What does it mean in terms of declaring a diagnosis in future job applications?	Fear of stigmatisation and prejudice based on label alone…tension between disclosure (resulting in prejudice) and fear of performance being affected by pressures unmitigated by potential reasonable adjustments… Also, disability is, somehow constructed as a simple box to tick…	Disclosure [tension] (within Diagnosis)
in that case dyslexia might be a disadvantage but I suspect that other people are prejudiced against dyslexia on the basis that they don't know what it means either. (215)	Suspect other people prejudice about dyslexia based on poor understanding.	Disadvantage of dyslexia is from difficulties AND prejudice → on-going damage, whether it exists or not, it is the perception that is damaging to self.	Damage of Dyslexia [historical and anterograde]

		Assumed stigma (within Stigma [which would include self-stigmatising]…within Disclosure, within Diagnosis)	Assumed stigma (within Stigma [which would include self-stigmatising]…within Disclosure, within Diagnosis)
you know if someone sees on an application that you've ticked a box that says you've declared a learning disability is that going to lower you, rightly or wrongly, it might mean the difference between being the preferred candidate or not. (217)	Ticking 'disability box' may make you less preferable a candidate	This speaks of the non-neutral act of ticking a 'simple' box, in which you become disabled on form, and in fact – through either impairment or discrimination…the act of box-ticking itself can, therefore, become disabling…	Disablement (within Disability) Fear…[does this relate to pre-judging…for, as he worries of other's pre-judgement of him, he is also pre-judging other's actions]
So I think the damage that I fear is that being too open about it might prejudice people against me and I know for a fact from talking to other dyslexics there does seem to be some prejudice certainly in surgical training where I've got a friend who is completely closed off about it and then won't mention it to anyone because of the fear of being looked down upon by her colleagues primarily. (222)	Fear being too open about diagnosis. Colleague fearful of being looked down upon	The fear of consequences from disclosure… informed by peer / community experience…sense of Community (shared traits) here Experience has contextuality: worse in certain specialties Some friends are 'completely	Within Stigma: fear of hypothecated consequences, peer anecdotes → becoming fact, secrecy Community (from Diagnosis)

		closed off'- secrecy...	
Whether that's justified I can't say but I can imagine it being the case quite easily but you know I know of a few other people that have dyslexia in public health and funnily enough when I did my Ebola screening shift at Birmingham Airport, I'm not sure if I told you but the two other people that were on before me both were dyslexic and we had a conversation about dyslexia, you know I thought that was good. (227)	Can't justify view, but can imagine discrimination Enjoyed talking with dyslexic colleagues	Acknowledgement that perception of stigma may be speculative, but there is a sense of having internalised sufficient experience and social norms (within medical profession) to create a strong belief (you *know* I *know* of… - use of 'know' indicating a sense of truth and fact)	Community (within Diagnosis) Speculation (within Stigma)
So I think for some people it's because it … the difficulty with it is it can mean many things, you know, it's a spectrum and that some people it means that they have minor difficulties that they can fully compensate for which is typically my case and for other people it's much more what I thought it was all about which is, you know, word salad (laughter) and you know people that are illiterate or come across as being illiterate even if they're not (234)	Dyslexia is a spectrum, with some able to fully compensate, and others not.	Recognition that diagnostic label means many different things to different people and this contribute to misunderstandings / confusion / lack of clarity that lead to prejudice. Dyslexia as a spectrum of severity.	Severity [here there is reflection of it being a spectrum, but also an acknowledgement that the severity of his dyslexia interacts with other traits, such as other abilities, to allow him to compensate] Confusion [plurality of meanings] (within Power of Label)
so I think, you know, some people	Role models needed to	The notion of needing a champion	Champion (linking to

probably still have that mind as that's what they think being dyslexic means so I think it's good to have role models like, I don't know, isn't Tom Cruise is supposed to be dyslexic and various other people that, that people, the general public can say, "Oh they're dyslexic, oh I, you know I didn't realise you could be successful, you know and be dyslexic" or whether that's justified I don't know but my perception is that there are probably certainly people out there that think of dyslexia in the same way that I did when I got the diagnosis and didn't really know anything about it (241)	disprove generalised misperception of people with dyslexia	a publicly-facing image to challenge misperceptions, and demonstrate to him (and peers within community) that success is achievable	community, within Diagnosis – also linking prejudice [through *challenge/disabuse*])
lumping it in with learning disabilities is not a good thing but then I read an essay, I can't remember the name and the title of it but it basically said dyslexia is a learning difference rather than a learning difficulty and more than anything else, more than any other information that I had that's what sort of made the difference for me in terms of being able to accept it and see it as a, as something that had pros and cons rather than just all negative; rather than just a potentially	Lumping in with disabilities is not a 'good thing'…seeing it as a difference rather than disability was helpful	A sense of being pigeon-holed into a generic, ill-fitting category…which is bad: unhelpful, unkind, unpleasant… Seeing it as a 'difference' rather than 'difficulty' helped him *accept* the diagnosis: in essence, this softens the damage and disabling component of the label	Pigeon-holing (within Power of Label) [negative connotation] Plurality (within Power of Label) – [there is a sense of him using that plurality to create a flexibility about what the label means to him to

damaging label (247)			manipulate the way he feels about it]
I have another colleague who's dyslexic who will tell you that she's dyslexic whether you've asked about dyslexia or not and she's quite sort of in your face with it and it's kind of like she uses it as a label to explain how she comes across as a, you know, I think she, she puts more weight on it that it perhaps deserves. So I tend to be, I suppose a bit more modest about it and if it comes out in the conversation then I'll not deny it and I'll be quite willing to talk about it but I'm not going to meet new people and say (255)	Colleague discloses a lot, he does so less	There is a sense that he disapproves of the way his colleague discloses a lot…as if it is not 'socially acceptable' within their 'community' ('quite sort of in your face' – implies negativity, as if it is seen as confrontational, or obnoxious). 'She puts more weight on it than it perhaps deserves' → caution around over-attribution (a reoccurring theme in his narrative) but also implies direct disagreement with her attribution and ?understanding	Conventions (within Community, under Diagnosis) Tension & Disagreement (within Plurality …linking Community)
It's not something that I would necessarily want to put out there for fear of uninformed people making wrong judgments if that makes any sense (258)	Non-disclosure for fear of uninformed views	Fear of pre-hypothecated misinformed views and prejudice	Fear (within prejudice) [linking

. The reality is I think, you know in medicine we're as prejudiced as everyone else in life and to some extent I think it can be a little worse on medicine because generally we're all high fliers, high achievers and you know people have the expectation a doctor should be able to read information quickly, digest it and write you know a perfectly structured clinic letter (272)	Medics are as prejudice as everyone else, if not worse	Acknowledging prejudice within own community (medical = 1 of many communities) …a sense of hypocrisy created by disparate social comparison...but supposition that this would then be turned internally, within community…	Internalised Hypocrisy (linking community (medical) with prejudice)
whatever it is and you know if you can't do that, if you seem less than above average to have less than above average literary skills that somehow you're getting into medicine was a mistake (274)	Getting into medicine may seem a mistake	Sense of misconception leading to discovery of impostorship…fear that his group-membership will be exposed as illegitimate, but also a sense that this would be inaccurately attributed to poor literacy	Impostorship (within Community (medical)…linking with Fear, and combining Exposure within Disclosure)
it's become less of a problem to me once I passed that exam because I don't ever intend to take any exams ever again and if they ask me to retake my driving test I'll just stop driving (laughter) because I am just done with exams. (280)	Done with exams	Exams / tests constructed as hurdles…once leaped over, nothing in way…implies difficulties only problematic around such times (which conflicts with narrative elsewhere, where he explains that it does have many little reminders of daily impact) – does this reflect denial, or an over-emphasis of the importance of summative	Assessments [construed as an object of over-emphasis, but also a point at which effects of dyslexia elsewhere can be denied]

		assessments?	
. I think the main thing that is done for me is given the historic permission to have struggled and that's the most important thing. To a lesser extent it takes the pressure off me going forward in that if I can't get something done by a deadline I hope I won't beat myself up about it as much as I might have previously (284)	Historic permission to have struggled	'historic permission' – the notion that permission is needed to be 'allowed' to be different…conveying a sense of transgressing, disobeying, or being wrong… 'lesser extent' re: pressure = ?less important than ? feeling 'allowed'	Historic Permission (within Forgiveness & Permission, within Diagnosis / Power of Label) [speaks of a retrospective apology, soothing and acceptance]
you know if I'm reading lots of bids at the moment which are quite hard to get your head around and you have to very carefully and slowly and I'm kind of thinking, well, you know they didn't, half of them didn't meet the deadline for handing them in so (laughter) should I really bust a gut trying to meet the deadline for commenting on them all when in fairness there hasn't been the amount of time that was thought necessary for a non-dyslexic person to make a response so if the fact that I need an extra bit of time to do it, you know should I feel bad about that (291)	Should I 'bust a gut' to meet a deadline	Metaphor: bust a gut = physical harm through exertion, meeting targets that perceives as external (but, in fact, rather than being explicitly stated, these are internalised through socialisation and have been applied to self, by self) Social Comparison at play here, but used to benchmark (he is doing better cf. others) → but doesn't sufficiently reassure him…something here about the power of social comparison to drive negative self-image (v.	Effort-In Social Comparison (within Judgement) [strong –ve, weak +ve driver]

		powerful) but weak at driving positive self-regard…	
if the fact that I need an extra bit of time to do it, you know should I feel bad about that, well probably not but you know, me being me I'll still bust a gut to try to meet the deadline.(292)	Probably still will try	Again, this refers to the fact that he is not quite forgiving / giving permission to self (letting himself off the hook) fully…a sense that he knows he could relax expectations, but still wants to prove himself…	Forgiveness & Permission [conflict]
So I think it does give, it does relieve the pressure that I might put on myself slightly going forward but it's mainly more a case of being able to look back and say, you know, "Oh so that's why I couldn't learn my times table" or you know, "That's why I didn't like reading aloud in class at school" which is something I remember actually you know I mentioned, I've only just remembered that. (298)	Diagnosis does relieve self-applied pressure a bit	Contradicting above, as says relieves pressure (maybe conveying sense of relief, even if he doesn't relax expectations)	Forgiveness & Permission [conflict]
. I used to hate that because I'd fumble you know trying to read aloud. I can read, I have no problem reading and understanding but you know my difficulty is more specific to words and reading speed and retaining the meaning for any length of time. (301)	Used to hate reading aloud, specific nature of difficulty	Used to = ? doesn't hate it anymore? Illustrating temporality of competence and confidence. Sense of overhang from these experiences	Overhang [+ temporality]

you know I think it has explained quite a few things and as closer to the point of diagnosis it's not been happening particularly immediately but nearer the time to when I was diagnosed practically everything that was coming up and it wasn't just me it was also my wife saying, "Oh I wonder if the reason you had difficulty doing that was because of your dyslexia" or something (307)	Has started to notice things that he could attribute to dyslexia	Retrospectively attributing things to dyslexia to explain difference, a sense of applying forgiveness for difficulties.	Retrospective Attribution (linking Diagnosis and Forgiveness and Hypothecated)
does it explain my relationship with my mother-in-law, well I very much doubt it but it's all been suggested so this is what I mean about, you know, the tendency is to possibly attribute it to too much (310)	Cautious about risk of over-attribution	Drawing on extreme example, but then hints at tenuous possibility. Not fear, but aversion and caution towards over-attributing, as if to do so would be both unwise and breaking an unspoken convention	Over-Attribution
. Is it a part of who I am, yes I mean it's not something you could carve off and it probably does, you know, shape a lot of what I do and what I think but in a pretty subtle way so I actually deliberately try to resist blaming dyslexia for everything and instead of looking at what it might have not given me or the extra challenges that it's given me I try to focus on the more positive aspects and, you know, the things I mentioned about, you know,	Dyslexia is part of who he is	'part' suggests discrete, but can't 'carve off' hints at integral and intertwined. 'deliberately resist' *blaming* → agency, and blame suggests *fault* couching outcome of *difference* in negative terms…it is something wrong. The contradicts his attempts at positive reframing	Part Blame (within conflict within Reframing)

creative, being creative and visual manipulation and stuff like that. (316)			
I mean I've completed General Practice training and unless something terribly unexpected crops up in the next few months I'll complete Public Health training. I've written three books when my English teacher you know didn't think I'd (laughter) pass the English exam at school and you know I've, I've, I'm good at working with computers, I taught myself to write bits of code and PHP and you know code websites and things. People look at me and they see me very much as a generalist, a very broad base skillset so you know I, I'm probably that because I've had to adapt and had to look for different ways to do things and I should feel proud to be able to do all those different things and to have been able to adapted to them rather than feeling apologetic because I've got this label which in my case hasn't been a disability mostly. (328)	Has achieved so much, and thinks differently, possibly because of the dyslexia	Describing positive attributes that he associates with dyslexia…almost as a means of self-soothing / bargaining to counteract the negativity I've go this label = this *thing* is a label = disembodied sense of diagnosis In my case hasn't been a disability mostly = *mostly* = implies it has in part (cf. reference to contextualised disablement in relation to job application etc)	self-bargain (within Reframing) Disembodied Contextualised disablement
you know, the Public Health exam that I had trouble with yes I hated that; it's a good thing that it came up. Had I	Glad to have failed the exam to be subsequently diagnosed	Reframing exam failure	Reframing

not had that, had I not … of course you always want to pass an exam but if I had passed that exam on the first sitting we wouldn't be having this conversation because nobody would know that I had this dyslexic aspect to me. I certainly wouldn't know and I'd probably be, you know, as hard as I was before on myself without that knowledge. (335)		Describing trigger for diagnosis – this is one of a series of previously un-noticed potential triggers that went missed (so links Missed Opportunities with Diagnosis)	Trigger
So you know in retrospect it's a good thing to have failed an exam because that led to a sequence of events that gave me more self-knowledge than I had before. I mean at the time I did do a little bit of reading and looking around and particularly looking to see if there was anything about dyslexia and medicine to see if it would explain … I guess I was looking for things to explain actively as sort of a part of a drive for self-awareness but that didn't last for terribly long because I think I quickly realised that hang on a minute, you know, you're in danger of attributing too much to dyslexia here (342)	failing the exam = good in order to be subsequently diagnosed danger of over-attribution	Reframing 'danger of attributing too much'→ danger of being seen as making excuses: fear of being seen to make excuses, implying sense of blame and fault …difference between explanation (this is why it happened) vs. excuse (it's not my fault)…one seeks to create understanding, the other seeks to shift responsibility. He illustrates both here, and his seeking to explain, and 'drive for self-awareness' speaks of his desire to retain responsibility in order to	Reframing Over-attribution

		change and improve…	
I think that's when I sort of, you know, became properly aware that it, of the, the very different nature it is in different people and you know there are people that you get emails from that you sort of think "Could they be dyslexic?" because they're, you know, their emails are what I had historically thought emails from dyslexics might be, completely confused you know, no punctuation, transposition of words, all sorts of things and I thought, "Well you know if you can't actually read what they're trying to write" you know, "They might be dyslexic" and I'm not like that but then that's because I have all these sort of virtually compulsive checking behaviours (351)	Recognises difficulties in others, which helps him realise he has strategies (compulsive checking behaviours)	Insight gained from experience → recognition in others, and a tolerance of difference in performance by tentatively attributing it to similar difficulties he has experienced	Attribution [insight from own experiences affords him ability to tentatively attribute difficulties in others to similar experiences he has had]
it's extremely rare that I'll just write out an email and send it without reading what I've written and sometimes when I do I've said funny things but a complete wrong word, you know. So I, I mean I have software on my computer, before I	Has software to help checking strategies, as if checks himself – he reads what he thinks should be there	Has drawn on supportive strategies since before Dx…the contextualises diagnosis as about recognition rather than initiating development of support strategies…it also speaks of his abilities → significant enough to enable him to put in	Coping (relating to diagnosis) [strategies employed before diagnosis, use of technology, not all difficulties mitigated]

had the diagnosis I had the software on my Mac that checks my spelling and grammar and everything I type and I rely on it and without the autocorrect there's quite a bit that I don't pick up even when I re-read things because I have a habit and my wife says this all the time, of seeing what I think should be there rather than what's there. (361)		place strategies to mitigate difficulties …but they don't mitigate everything: e.g. he still reads what he thinks should be there	
I guess I feel a little bit of regret that I didn't have a life in that certainly at medical school everything was around the work and I would, I would go to lectures and then I would come home from lectures and once I had attended to basic biological functions like eating I would work and I didn't go out and didn't meet people and just sat at my desk and I did that for the whole six years that I was at medical school and I think the reason that I did that is because I wasn't efficient there's a lot of volume of work to get through and you know (383)	Had to work hard at medical school, didn't go out and have fun	Describing a sense of missing out and 'being unfair' due to disparity (c.f judgment of self vs. others) and investment in his study via employed coping strategies (over-learning / over-working)	Disparity (relating to judgement) [disquiet, unfair, unhappy]
the saying that learning medicine's like trying to drink from a fire hose; I think that's very, very true. (385)	learning medicine's like trying to drink from a fire hose	Sense of being drowned through invocation of metaphor → if he doesn't drink at fast enough rate /	Sink or Swim in relation to coping (fear driving over-learning/ over-

		swim, he will drown / sink	working)
because I know that other colleagues who were at medical school with me did have a social life and did go out and do things and did live I was probably conscious of the fact well, you know, why is it that I have to spend all this time trying to stay on top of the work and I think it was probably because I was that bit slower at doing the reading, at writing the coursework, you know and I suppose … (398)	Saw colleagues have fun, highlighted the amount of extra work he had to put in	Social comparison against snapshot of colleagues, feeding into sense of disparity through his over-working	Social Comparison [linking to Disparity]
I don't remember terribly much about GP training to be honest but a lot of it was about talking to people rather than writing things down for them so I suppose it might not have become all that much manifest and the way I studied for General Practice was very different than the way I studied for Public Health because in General Practice we had a revision group and we divided up the work and we all presented bits of the syllabus back to each other and it was much more sort of interactive, you know, group learning type of environment whereas Public Health has been a go on your	GP training v. different from PH training, and didn't manifest difficulties	Contextuality of difficulties: learning and working environment. Interestingly, later narrative highlights that his difficulties around sense of self, and confidence were more problematic in GP (hence he left) but his on-the-job literacy-related-difficulties (superficial Sx of dyslexia in adults) are more manifest in public health	Contextuality of Difficulties (within diagnosis (maybe this should be Difficulties & Diagnosis)

own largely (405)			
the whole question of entering into medical school at possibly had I known about it at school would my school marks have been better, would I have had to have proved myself in that first intermediate year or not, I don't know but I think probably the only time until that part A exam in my medical career that it could have been a problem was getting through medical school and I mean I didn't fail any exams at medical school; I didn't do well, I was very much an average student but my, my peer group, the people I hung out with were generally the smarter end of the class (419)	Was an average student at medical school	A sense here that he is saying he was 'ok' compared to others…but this doesn't feel like an acknowledgement, it feels self-deprecating: average used negatively ('not good enough') rather than as reassurance.	Reframing [differential use of language → positive potential converted into deprecation]
so I'm just joining dots here and I'm just thinking that I wonder if that's what's contributed to my self-view of not being up to it, you know, not being as good as my peers. That view has certainly continued in that you know I look at my … when I was a GP I was looking at other people who were working GP's thinking that, you know, "I'm just a salary doctor" or "I'm not as clinically competent or as good as my colleagues" but it was only me	Comparing self unfavourably to peers, but recognises it is himself doing that, not peers / patients	This represents a strong example of where he has developed such a negative sense of self, that he is projecting it onto others…which he has acknowledged, but this doesn't soften the injury to self	Self [confidence and regard so negative, projecting onto others…reinforcing internalised belief of 'not good enough']

saying, that; it wasn't the patients and it wasn't my colleagues saying that and to some extent I continue to do that even in my Public Health career (428)			
I do know a lot, I've had a lot of experience and I know people look to me when, you know, they want advice or they think, you know "[Brian] will know this, [Brian] will know that" so they have a completely different self-view of me whereas my view is that I'm not as good as these guys. (432)	People look up to him	Recognising that has positive attributes (' I do know a lot') and that this is valued externally 'people look up to me') but he doesn't *believe* it ('I'm not as good as these guys').	As above → sense of self so negative now that cannot believe positive regard
Whether that's to do with dyslexia or whether that's a more generic, you know, aspect of personality I couldn't say but I wouldn't be surprised if a subconscious awareness of dyslexia didn't at least play a part in shaping that inferiority complex that I have. (437)	Possibility for dyslexia to unconsciously shape his inferiority complex	Separation of dyslexia: dyslexia vs. part of personality but thinks dyslexia does play a role: subconscious (so this is a *part* of his *subconscious self)*	Partitioning [dyslexia is partitioned and apportioned contextually: either separate, and disembodied, or separate-but-embodied at a subconscious level]
Yes, that as a new insight for me; I hadn't thought on it before but I think it could … so that I'm in danger of attributing everything to dyslexia again. (438)	In danger of over-attributing	Danger with reference to over-attribution (again)…speaking of fear	Attribution
I basically thought that after ten years	Left previous career in GP	Such a strong example: his	Self

I should feel comfortable doing the job; I should, I should have the confidence to know that I could do the job. When the objective evidence is there, you know, I got good feedback from patients, I hadn't cocked up but I still felt that I didn't have as much right to be there as my GP colleagues because I wasn't up to their standard. (479)	because didn't feel was as good as peers	negative sense of self was so significant, here (despite objective evidence proving otherwise) that he left and changed career	
I think that's clearly bigger than dyslexia in terms of a sort of self-image problem but I, I don't know, I wonder if all along there was this unvoiced concern or insight, a subconscious realisation that there wasn't something quite right (laughter) in terms of, you know, my supposed academic ability and you know whether the fact that to work out a dose of Morphine and special care when I was a junior doctor or something I would have to, you know, do it all on paper and get it checked and go over it again just to be sure that I wasn't going to give a baby (laughter) the wrong dose of Morphine because I didn't trust myself (488)	Couldn't trust self throughout career, manifesting by working out and double-checking morphine etc	Trust (within Self) so poor, which leads to anxieties (bad) but also checking strategies (good, potentially)	Trust (within Self) linking to Coping

I suppose that's probably quite a good expression actually talking about, you know, the level of self-trust because I don't always trust myself with certain things and maybe that does stem from the fact that I know I have a propensity to make mistakes or to overlook things that might not necessarily be overlooked by someone who's not dyslexic although of course I wasn't blaming dyslexia at the time I just thought it was some inherent character flaw (493)	Low self-trust, blamed as character flaw before knew had dyslexia	Discussing in relation to label, suggests may feel it is somehow linked… 'I know I have a propensity to make mistakes… 'wasn't blaming dyslexia at the time' (?is now) Trust: very poor self-trust	Attribution [highlights the contextual, and temporal aspect of it] Trust (within Self)
I mean I don't see certainly now I don't see dyslexia as being a character flaw because on balance although it maybe have caused me some problems it's, I do think it's part of what's driven me, it's part of what has made me strive to continually improve and I might not have had that same conviction had I not had something to struggle against if that makes any sense (500)	Needed dyslexia to work against to drive him forward	A *need* for dyslexia: the label, or the difficulty? Temporality of diagnosis and retrospective attribution would suggest it was the *difficulty* (+ drive) that was needed, rather than the label	Drive (within Difficulty)
because I think you can, you can have like an internal coach if you were and I guess you know my internal coach could have been the dyslexia telling me that you've got to work just that	Dyslexia is his internal coach motivating him to work harder.	Dyslexia conceptualised as a separate entity driving him (drawing on metaphor of a sports coach) but this discrete and somehow separate entity exists	Internal Coach (within Drive, within Diagnosis)

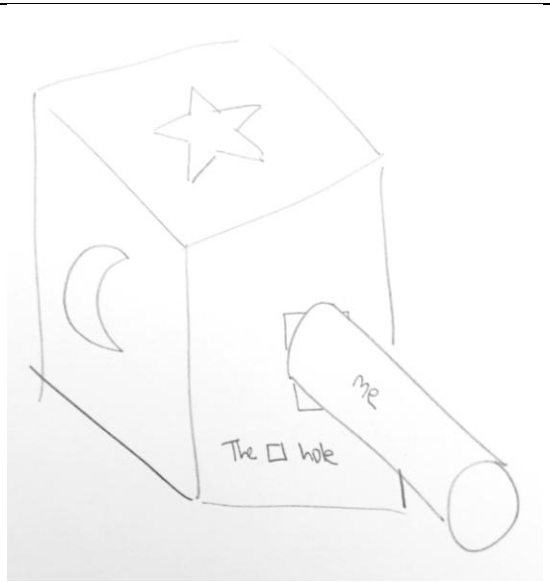
bit harder, you know, you've got to put that much extra time and this isn't quite as it should be because I don't know about you but I certainly think that there seems to be a relationship between and certainly in my case dyslexia and perfectionist tendencies. (506)		*within* him (internal). This appears to give agency to this entity…but the relationship here is not one of surrender, it is of a *developmental* relationship that contains respect…	
I don't know if that necessarily applies to all dyslexics but that would be an interesting thing to look at because if you're dyslexic, even if you're not aware of it and you have all of these sort of checking behaviours, you know which is, you know perfectionism it would make sense that there might be a relationship and I am systematic, people know that, people do see me as a perfectionist. (510)	? is this the same for other dyslexics checking behaviours & perfectionism	Perfectionism and neurosis → anxiety… Acknowledging variation within community Dyslexia (with / without Dx and awareness) drives checking behaviours… this locates the cause of these behaviours in the discrete (but ? integral) entity of dyslexia [but in reality, it is likely to be a consequence of internal-locus difficulties with environmental factors (e.g. orthography) **and** feedback]	Attribution Perfectionism (within Drive) Dyslexia as Discrete Entity …(within dyslexia)
If I wasn't as under-confident in what I'm doing as I have been, you know,	Confidence and ? perfectionist tendencies…and	Attributing lack of confidence (in turn been attributed to dyslexia) as	Perfectionsim (link to

maybe they wouldn't have that perception, maybe I would come across as a little bit more laid back, speculation but there's another line of research for you (laughter) is there a relationship between diagnosis of dyslexia and perfectionist tendencies? (515)	relationship with dyslexia	reason for others' perception of him as perfectionist…couching that in negative terms (with polarity to 'laid back')	Dyslexia)

Self-Characterisation Sketch

1. How *you* see *yourself*. How all of the bits of you and your life fit together.

Transcript Text (line numbers)	**Descriptive Coding (notes)**	**Interpretative Coding (notes)**	**Emerging Theme**

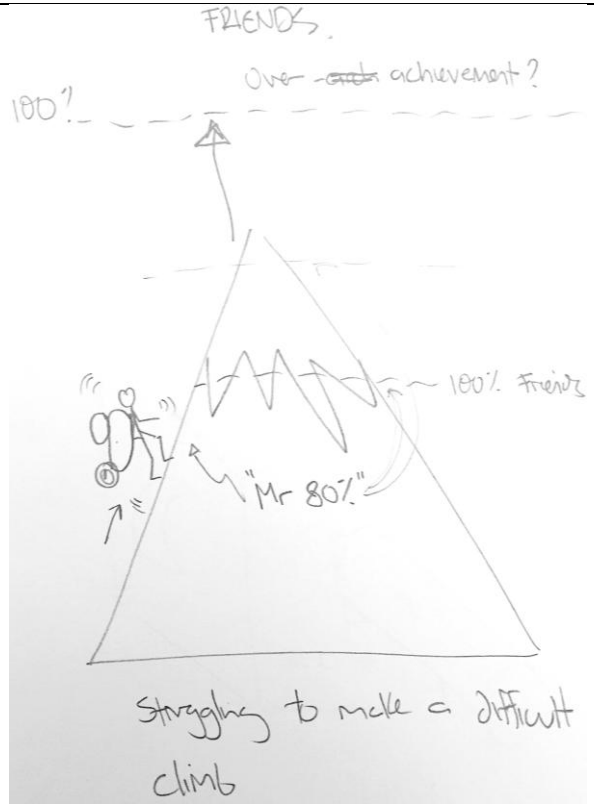
	A child-like toy box with shapes in the sides. He is represented as a round peg trying to get into a square hole.	Doesn't feel like he fits in	Misfit (within Difference)
The round peg trying to fit into the square hole. Of course there would be other shapes (laughter) just for completeness but I think in a nutshell that's me. I know I think, I think it's supposed to be a square peg trying to fit a round hole actually but for some reason I'm a round peg trying to fit a square hole (laughter). (588)	Sees himself as different, even from square peg in round hole metaphor	Not only does he not fit in with the box, he also doesn't fit-in with the normal convention of the metaphor (square peg in a round hole)	Misfit (within Difference)
I think that's been me all along really. It's never been smooth; whatever I've tried to do has always come with complications so you know things like getting into medical school against the grain, you know being told by the Dean to, "Plan another career, you're not going to get in", trying to do General Practice when I couldn't, you know, the	Never smooth / right place & right time	A sense of 'bad luck' conveyed by the 'right place at the right time' …there is an implied social comparison here – 'I was never' suggests others, or at least some others, are…	Bad Luck (within difference)

right permissions it wasn't, you know, I wasn't the right person in the right place at the right time for that (597)			
I did apply for General Practice training in New Zealand and didn't get on the training programme for a variety of reasons and I found this training programme very, very difficult as an academic trainee, I wouldn't do it again; it's too demanding because you know it's a five year full time training programme for regular trainees and I'm half time on the training programme in four years so I get two years equivalent to do a five year training programme and I was supposed to have registered to do a PhD on top of that in the programme which is just ridiculous. (605)	Academic programme too challenging to balance alongside training and service provision	Ridiculous – sense of pressure from unreasonable expectations placed upon him	Pressure (within Expectations)
they have recognised now at the Deanery that that's a problem and they're talking about extending academic trainee tenures to six years (laughter) which will make a huge difference because it's been hell trying to fit all the service work, the teaching, the research which was a bit of a fizzer you know into the one role and has had consequences for my personal life and my relationship with my wife which is primarily why I look forward to being a trainee. (611)	Deanery recognised and plan to change training pathway	This reinforces the notion of the above being unreasonable…for it to subsequently changed) Having an impact on family life (relationship with wife)	Pressure (Expectations) [unreasonable]
that was easy (laughter) because that's, that's kind of the self-image that I carry around in my	It is the self-image he carriers around in his head	Self-image construed as a physical, tangible, object: carried around *inside head* –	Physicality

head (614)		head itself being construed as an object…e.g. suitcase	

2. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**

	Image of him struggling to climb up a mountain, with a heavy burden, at 'his' 80% mark, and what his friends would consider 100%, but striving to get to 'over-achievement' level		
that I think my friends view me as an achiever that I'm always trying to go further, get higher, do more. Sometimes I've quite a bit of baggage (laughter) or you know there's not an easy climb and I can't really illustrate struggling too easily other than perhaps uncertain footing. (626)	Friends see as over-achiever, but someone who struggles	'always' trying to get further / higher / more implies a restlessness, a sense of never being 'good enough'…so the struggle is not *just* the extra work to get there, and the work to mitigate his difficulties, but the struggle against his demons (low self-	Struggle

		esteem etc)	
"Struggling to make a difficult climb" because I think they, they are aware, you know they do see me struggle, I complain (laughter) possibly too much. (628)	Struggling making climb difficult	'complain possibly too much' → feels guilt at externalising experience of struggle, at struggling (itself) …a sense of being undeserving of sympathy	Underserving (within Self)
yes I suppose that's certainly been the case in terms of my medical career; in terms of making this sort of relevant to being a doctor or being in meds and I think, you know, in terms of climbing and getting high enough my friends would probably say that I'm actually aiming for here and that, you know, whereas their, their 100% might be to reach the snow line and that, you know their 120% might be to get to the summit but my 100% (laughter) is up there and that's been said to me a number of times and I'm constantly being told to pull back and do less (635)	Aiming for 120%	Holding a different target for himself → holding himself to different standards…this doesn't feel like it is because he feels he is *better* than others, but because he has to somehow prove himself, or has to go through struggle – as if he deserves it	Prove Self (within Self….may include/supersede Good Enough)
as a result of this, tried largely unsuccessfully to be Mr 80% (laughter) and that Mr 80% is supposed to get me to where my friend's expectations are rather than, you know, where my expectations are. So that's probably a fairly apt analogy in terms of how I think people that know me see me in medicine in terms of what I'm trying to do and the effort that I put in to get	Friends try to convince him to be 'Mr 80%'	'tried largely unsuccessfully' reinforcing the sense of struggle: putting in effort (tried) but with inadequate outcome (unsuccessfully) …has internalised this narrative – which applies pressure to self, construing	Pressure

there. (645)		efforts negatively	

3. How a *critical* other, someone who knows you very well, and is *critical* sees you.

Transcript Text (line numbers)	**Descriptive Coding (notes)**	**Interpretative Coding (notes)**	**Emerging Theme**

	Boss (critical other) sees him as a blank page / 'space for rent' but a space that is without use – waste of space.		
My boss sees me as a waste of space. Him and I don't see eye to eye. I'm interested in teaching, he's purely driven by research and sees teaching as a distraction from doing research and appointed me really because he wanted to turn me into a researcher to sustain the very active research group that's here and I took the job because I was	Boss sees him as waste of space	He feels as if he is seen as being without value, as not contributing to environment, as being a 'waste' to the 'space' of the immediate community (e.g. research team)… he has	Self (sense of self and value)

offered the opportunity to explore teaching, research and service work, you know to do the training. (633)		internalised this	
I thought my personality would have meant that I was a good research candidate that I could be, you know I could follow up a lead, I could be very systematic about it and so on. It turns out I hate research and having never given an iota of thought to teaching other people because I didn't think I could do it, I didn't think I had any foundation to teach other people from because I wasn't good enough you know I wasn't the academic, I wasn't the top of the class but it turns out that I actually have some talent for teaching and I think that talent stems from having difficulty learning and the care and attention I put into presenting information (671)	Personality clash – not a good researcher, but a good teacher	Qualities of 'goodness' for something are construed as personality trait…sense of disappointment in self. Describes affinity to teaching, but undermines this with 'didn't think I had the foundation' for it → reinforcing notion of negative sense of self and confidence	Self (sense of self confidence, and abilities)
all of the things that make me a good teacher because I now have a personal stake in learning, I understand that people can have difficulties, I can appeal to people who need information processed in different ways so it's not just a case of, you know, here's some text, read and digest but I, when I lecture my lectures are very visual so I draw bespoke diagrams, you know I don't just take things out of books and things I do my own diagram. (678)	Good teacher as has personal stake in understanding and supporting people with difficulties	Speaks of insight gained from experience, and motivation….but this motivation appears to be borne out of a sense of proving self → he was 'wronged' by the educational systems he went through, and he wants to correct this through role modelling…	Insight (from Diagnosis) Self (positive self-regard)

		Also, in doing so, he identifies as a 'Good Teacher' which is a rare example of *positive* self-regard	
So I'm not saying that other people don't do that but I'm just saying that it seems to come more naturally to me to do that and I see the students connect with it. (691)	Not saying others don't do it, but more natural for him	Dyslexia contributing to a more natural sense of working in graphic ways when teaching…	Attribute (within Dyslexia)
So in terms of me as a medical teacher the fact that my boss sees me like that doesn't really bother me (laughter) because it's the very fact that I don't fit into what he values that makes me fit better as a medical teacher, yes, so I'm going to call that 'waste of space' and then but much better than him (laughter) as medical teacher because of the strengths dyslexia (696)	Doesn't fit boss's values, but this makes him a good teacher	Not fitting in with *one* thing (boss's research group), helps him be better (and fit in) with *another* (community of medical educators)…a positive reframe on the waste of space	Reframe

Critical Incident Reflection: 1

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
that she wouldn't have had a clue how to have approached that. So I wondered if that was a positive instance of some of the skills that I've	Dyslexia's positive influence on creativity	'I wonder' – in search of positive examples…actively search, taking agency for reframing	Reframing [counteracts Damage of Dyslexia]

developed as a result of being dyslexic enabling me to undertake a task like that, that others might find difficult (12)			
So that's a positive example to start, and I certainly think the visual side of things has enabled me to learn and to commit things to memory that won't go in otherwise, and I do like doing things visually. And I enjoy the creative process of making things visual, whether that's down to dyslexia or not, I don't know (17)	Visual side of things enabled to learn better	Positive self-regard, seeking positive examples of impact of dyslexia (counteracting the Damage of Dyslexia) – but is tentative in this attribution	Tentative Attribution Reframing

Critical Incident Reflection: 2

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
I was just writing an e-mail to a colleague who's driving to Glasgow tomorrow and advised her to take walking foots and a sleeping back, meaning walking boots and a sleeping bag, of course. Quite funny! But again, thankfully I check things before I send them, so I didn't get caught out by that one. (24)	Slips in email	Quite a firm attribution here (note how the majority of tentative attributions are for positive things) Finds humour in his slips, this somehow softens it – he does not sound self-deprecating here…so not internalised as a 'big failure'….but more as a 'soft slip'	Attribution Scale of Error

Critical Incident Reflection: 3

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
. For the umpteenth time I've tried typing document with a transposition of the 'e' and the 'n' so DOCUMNET, I do that frequently. It's annoying because document is actually a word that I know how to spell, but for me, a very common transposition for some reason. (31)	Error in typing the word *document*	Annoyed at small slip – annoyance borne out of knowing how to spell word (the implication being that the slip suggests he doesn't) and the frequency with which it happens (common)	Annoyance (with frequency & dissonance as elements…although dissonance used elsewhere for theme heading)
So I'm in the process of writing a report at the moment and I guess things like that slow me down, probably not appreciably, it's more the frustration that gets me of doing something that I know is wrong but somehow I seem unable to avoid it. So I guess that's a small example of dyslexia getting in the way of the day job. (34)	Writing report, taking very long time, frustrated	Frustration borne out of time taken (disparity between input and output) and that this extra effort is likely to go unnoticed… Getting in the way of the day job → dyslexia is conceptualised as a physical barrier	Frustration (with disparity and imperception as elements) Dyslexia (as physical barrier / obstacle)
Not an especially important one, but it's all the little things that add up. I guess for people who have dyslexia it's all of those little things rather than big things that get on their wick. (36)	Not important, but little things add up	Acknowledgement of scale of issue (perhaps a nod to externally perceived triviality…which would be internalising societal expectations that a grown man could cope with this minor thing)	Gestalt (within Damage of Dyslexia)

		…but simultaneously illustrating that 'little things add up' → gestalt of insults damage confidence	

Critical Incident Reflection: 4

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
Just want to make a general reflection on my work over the course of this last week. I had a couple of projects that I was working on; assessment of some investment bids and an audit of bone marrow transplant compliance, compliance with commissioning criteria. They were both quite complex pieces of work and I think I did them well. I do think it took me far, far too long or rather I invested far too much time in both pieces of work, particularly the assessment of bids. How much of that it is down to dyslexia? I don't know, but I do think that reading through the bids was slower than it should have been, trying to retain in my mind the information that was in the bids was difficult, so it caused me to have to go back again and again and again to look for the	Invested far too much time in getting reports done	Frustration again borne out of dissonance between time in and output, but also there is a sense of this resulting in fear – that he would be externally perceived as inefficient…and that this would impact on overall view of work (perhaps this is why he offers the 'I think I did them well' tentative justification)	Frustration Judgement (perceived external expectations → driving fear)

information (49)			
although dyslexia doesn't get in the way of me being able to do the job, it definitely does slow down my general productivity, but at the same time it also have benefits in that the checking and rechecking behaviour is probably an important mechanism by which I quality assure my work, which, who knows, maybe I wouldn't do if I didn't have a suspicion that I'd missed things (55)	Dyslexia doesn't get in the way of job, but does slow him down	Denial of obstacle of dyslexia (as has just previously given examples of where it does get in way)	Conflict (between denial and attribution)
So that was probably a benefit and I have learned techniques as I have gone along to try and shortcut the process a little in that I've got quite good at hunting out just the specific information that I might need, (59)	Benefit of dyslexia → learned techniques	Positive attributes: softened (made tentative) through 'probably' and 'quite'	Tentative Attribution
I think I've certainly been aware of the dyslexia in the background, but have been reliant on my well established coping mechanisms to try and offset that. But it, nevertheless, is frustrating that it should take me as long as it did to have completed this work (66)	Aware of dyslexia in background	Dyslexia conceptualised as a discrete, but pervasive 'background' force… Coping mechanisms well-established (tentative: to try) over time… Frustration: borne out of time taken, and expectations on self	Dyslexia (background) Coping Frustration

Critical Incident Reflection: 5

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
. I do sometimes do some interesting word substitutions. I have made a few just recently, but the one I'm looking at at the moment is I've tried to write sub-group presentation but have written sub-ground presentation and that's quite a typical inadvertent word substitution, where the word is similar but not quite what I wanted (73)	Error in typing	'interesting' → sense of intrigue, as if seeking to understand it. 'made a few recently' → suggestive of frequency Similarity	Difficulties (seeking to understand, frequent)
this is the reason that I read e-mails through a couple of times before I send them, because I'll very often pick up things like that, or sometimes completely missing words and it's a little embarrassing to find those after you've sent the e-mail (77)	Re-reads emails	Coping strategy – to re-read. Acknowledges that he does successfully pick them up. Embarrassing: sense of shame borne out of simple slips	Coping Shame

Critical Incident Reflection: 6

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
I'm really struggling to motivate myself	Struggling to motivate self with	Difficulty → harder to motivate	Difficulty

to get some reading done; several papers that I have to summarise for a piece of work on Hepatitis B virus. It takes me a long time to extract the information and I had to keep going back to the papers, which I suppose is dyslexia making itself known in that I can't retain a lot of information in my head, so there's that constant fetching, which is a real time factor, not a time waster, but it certainly increases the time that it takes to get anything done and it's very, very frustrating (88)	reading	when it is reading-related task, 'Dyslexia making itself known' → dyslexia as some kind of animal / beast / predator lurking in the dark	Dyslexia
this because I constantly feel, even though I'm aware now that I have dyslexia, I constantly feel that I should be more productive, that I should be more efficient. (90)	Constantly feels should be more productive	Sense that (now) has knowledge of dyslexia, should be able to mitigate it more effectively → expectations change → constantly keeping ahead of his abilities.	Expectations (contingent on knowledge of Dx, has changed to overtake his coping strategies)
it's not other people who are bashing me but it's the self bashing that I do and I wonder to what extent other people with dyslexia do, because a lot of the medics tend to be quite hard on themselves and it's quite possible that the type of personality that goes into medicine combined with dyslexia means that you beat up on yourself a	It is self-bashing that he does	Acknowledgement of self-oriented negativity…is this 'personality' or 'dyslexia' → dyslexia contrived as separate	Dyslexia (separate) Self (Judgement)

bit more than is probably healthy (96)			
Certainly the diagnosis gave me some level of permission to at least understand what was going on, but I don't seem to have been terribly successful in taking that to the next step, (99)	Dx – permission to understand what was going on	Needs a Dx to gain permission to understand…this understanding is somehow contrived as being within someone's/something's gift, requiring justification to bestow…	Power of Dyslexia (permission)
while accepting that there are issues, I'm still aspiring to be non-dyslexic in terms of my performance. And I guess that's probably understandable, but you don't want to blame everything for dyslexia and you don't want to it to be your excuse for everything, but it doesn't seem to be quite right to pretend that it doesn't exist either (103)	Aspiring to be non-dyslexic in terms of performance.	Despite acknowledgement of the pervasive traits of dyslexia, and his compensatory strategies, he is 'aspiring to be non-dyslexic' …this implies that he both dislikes dyslexia, but also seeks to be normal, to fit-in (reminiscent of round peg in square hole)	Dyslexia (dislikes – linking to Self) Fit-In

Critical Incident Reflection: 7

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
I decided that I'd stick the essay that I wrote for my PG Dip on Dyslexia in Medicine on to my website, edited to remove personal references. Can't	Concerned his essay may reveal dyslexic identity publically	Fear of disclosure, but in a public way – both in terms of the open-ness of the medium of sharing, but also in terms of the public	Disclosure

help but wonder if that was a wise decision in that with the stigma or at least potential for stigma, is it a good idea to be so public about the fact that you do have or might have dyslexia, will other people, particularly potential employers, read it and think ah oh, based on ignorance and not knowing exactly what dyslexia is. But is it a good idea to put that out there for other people to be potentially biased by the information? (113)		reaction …somehow breeching ome sort of code…	

Critical Incident Reflection: 8

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
I went for an interview today and on the train on the way there was reading through the covering letter that I submitted, and of course, spotted a couple of mistakes. Interestingly, substitutions very similar words, my and by, switched around a couple of times. Hopefully they'll forgive those, the sort of mistakes that anybody could make;	Cover letter for job interview had spelling slips, hopes they will forgive him	'hopefully they'll forgive' → small slip requires forgiveness…despite (or because) they're 'the sort of mistakes that anybody could make' …loosening attribution	Tentative Attribution Judgement (requiring forgiveness)

you probably don't have to be dyslexic (121)			
I suppose the other thing that came up was when they were asking me about my motivation to teach; whether I should bring up dyslexia as something that gives me a personal stake in teaching, and I decided that the risk of harm exceeded the potential benefit and chose not to mention that. But it does say in CV that I've an interest in it, so I suppose if they wanted to they could have asked me about it (127)	Motivation to teach related to dyslexia – concerned about discussing it	Fear of disclosure and consequences – risk to new job	Disclosure
The reason for not mentioning it or putting it in their face really is that I guess you expect other people to react adversely and think well we don't want this person then if they can't read or write properly, because you just don't know how ignorant other people can be about dyslexia and whether they realise that it is a spectrum and that there are dyslexic people out there who can read and write perfectly well (133)	Didn't disclose re: his interest in dyslexia, as wondered if they would react adversely	'how ignorant other people can be about dyslexia…' → quite a strong word, distain for the lack of understanding, fear of consequence	Prejudice (distain for lack of understanding and fear of ignorance)
maybe just a little bit slower and perhaps a little more prone to making	A bit slower, but not illiterate	Decided not to disclose (kept it	Disclosure

the odd mistake. But that certainly doesn't make us illiterate. (135)…I kept that to myself (137)		to myself) 'Certainly doesn't make us illiterate' implies the impression that some perceive it does	Stigma

Critical Incident Reflection: 9

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
They did characterise dyslexics as sometimes having difficulties with verbal expression, I can understand how that might relate to sequencing things mentally before you open your mouth. I'm not convinced I have a particular problem with that (144)	Characterised dyslexics as difficulty with verbal expression	Others (they) characterising, and this resonates with him – although he is only tentative about it (I can understand)	Difficulty
Receiving information though, particularly on the telephone, is an issue and I certainly don't really like being on call by telephone partly because I really find it quite stressful taking the messages, you don't have the visual clues or cues from watching someone's mouth movements. So when they are giving you things like phone numbers particularly and	Discussing profiles of difficulties in dyslexic adults: receiving info. on telephone etc. He recognises this in himself	Recalling information told re: dyslexia and linking to personal experience – historical attribution, but there is tentativeness there too: sometimes, can be. Embarrassing → shame	Attribution Shame

addresses and other details, it can be difficult for me to get it down in the right sequence and sometimes I pause to think about the spelling and by then the speaker has moved on and then I start losing it and have to stop them and ask them to repeat, which is a little bit embarrassing. (153)			
And to some extent, the same sort of thing happens with leaving voice messages. Sometimes I write myself little notes if I'm anticipating that I might have to do that, so that I get out what I mean to get out and in the right order, otherwise I end up sounding a little bit blithering and repeating myself. I obviously don't want to make a bad impression by sounding like an idiot. (159)	Difficulty with leaving voice messages	Fear of making a bad impression, driving anxieties	Fear (within difficulties / linking to judgement)

Critical Incident Reflection: 10

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
There was a bit of discussion about behavioural responses to dyslexia and the suggestion that we tend to be a bit disorganised. I certainly don't think that's applicable to myself, as	Dyslexics tend to be more disorganised	'I certainly don't think that is applicable to me' = very strong (certain) denial, controlling attribution	Control (within Tentative Attribution)

that's one of my strengths, it's one of my main mitigation strategies is to be organised. (171)			
Distraction; certainly. Personally, that's a big issue for me. I find it very, very difficult sometimes to stay focused on a task that needs to be done, whether I'm writing a report or whatever and I wondered to what extent that linked into sort of ADHD type symptoms I think we talked about before when we met (176)	Struggles with easily distracted	'big issue' in terms of consequence, how frequent, or how intrusive and frustrating it is	Difficulty
Dyslexics can be characterised as prone to over-activity. Quite how you distinguish between over-activity and distraction I'm not sure. But not having a still mind can be certainly a barrier to my getting the work done (180)	Over-active mind	Again, loosening attribution here – but reflects on similarities	Tentative Attribution
It was also said that we can be impulsive. Again, I think I buck the trend there because I tend to be quite deliberate and planned in my approach to things, but there you go (183)	Dyslexics as impulsive, but doesn't think he is	Controlling attribution	Control (within Tentative Attribution)
Anxiety about promotion and not getting pleasure from success. That's	Described anxiety re: promotion etc, resonates with him – prefers		

quite interesting because I could be quite senior by now. I'm smart, I'm well qualified, I've got a lot of experience, but I don't want to get noticed. I'm quite happy to be sort of the background person or sort of middle level without being the tall poppy, and maybe that's partly because I fear additional pressure. I don't want to be put in the position of having to cope with more demands because I'm afraid of not being able to cope with that, exceeding my ability to mitigate in the effects of dyslexia, I suppose. (191)	to be in background	'I don't want to get noticed' → fear of being noticed if good / bad…happy being 'background person' 'Tall Poppy' metaphor – noticeable, but delicate, vulnerable → fear of vulnerabilities Afraid his coping strategies won't effectively mitigate his dyslexia	Fear (within Judgement, and linking Damage of Dyslexia)
And I guess that must be true for quite a lot of dyslexics in medicine as that we might feel that we have a role to play but we don't want to be overstretched for fear of breaking the mechanisms that we've come to depend on to prevent the dyslexia	Dyslexics in medicine feel they have a role to play, but don't want to be over-stretched	'fear of breaking' → Fragility of coping mechanisms, potential for them to break, potential for mistakes to have significant consequences	Fear Coping (fragility, fear)

from coming to the fore. (196)			

Critical Incident Reflection: 11

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
I'm sorry if I've already mentioned this, but I've forgotten if I did or not. Important point: that in medicine you definitely need to be a committed learner. I don't think you could have an ordinary level of commitment and overcome dyslexia successfully because you need to work that bit harder to achieve no greater gain than those who aren't dyslexic. And sometimes you work very hard and your efforts perhaps don't result in commensurate recognition or marks or whatever. But that's something to celebrate rather than hide from. (205)	Can't have an ordinary level of commitment and overcome dyslexia	A sense of needing to *have* exceptional drive and resilience to cope→ this is what *he* needed as he went through such tough times… Disparity between effort and output	Resilience (within Coping) Disparity
And I think being a highly committed learner as a trainee is probably more crucial to us as dyslexics than it might be for some of our colleagues. (208)	High level of commitment is most crucial.	Commitment more important to dyslexic learners cf. others... a sense of imposing an expectation here: one he put on himself, that he is projecting	Expectation

		onto others	

Critical Incident Reflection: 12

Transcript Text **(line numbers)**	**Descriptive Coding** **(notes)**	**Interpretative Coding** **(notes)**	**Emerging Theme**
no dyslexic incidents to report really, no critical events that it, but some reflections to pass on regarding an event I attended yesterday which was for educators in the East Midlands on supporting trainees with dyslexia. So I thought it was quite good that they made the point that how dyslexia can be manifest is influenced by the environmental context, so things like personal motivation, emotional issues, sometimes sensory impairment and certainly the opportunities that we have as trainees, which can be quite different (218)	Found good that organisation discussing how to support dyslexic trainees	Positive regard re: support suggests an assumption that they wouldn't…reflecting the fears that influence concerns around Disclosure	Disclosure (fears – projected, rather than actual)
And all those things in combination are very, very difficult to tease out from the effects of dyslexia on the training environment. And I can certainly see how in my own motivation and emotional state and opportunities have fluxed over the years and I certainly think it's probably had quite an influence on how and when dyslexia has been an issue for me (223)	Difficult to tease out effects of dyslexia, although can see impact on motivation and emotional state	Acknowledgement of difficulty of identifying which specific aspects of difficulty are related to dyslexia → this links to Tentative Attribution, as it is his appreciation of this that underlies (at least *in part*) the need to be tentative.	Tentative Attribution (complexity)

They talked about the need for having specialist teaching and I think that's optional really in that yes, it should be available, but often by the time you get to this stage you've developed the skills you need, and perhaps all you need is a little bit of affirmation but you're probably already more expert than the specialist teacher at overcoming your personal experience of dyslexia (229)	Becoming experts in own strategies, need support as means of affirmation	Need for affirmation → for what, for being 'good enough', to assuage sense of fault	Self [needing affirmation as antidote to self blame]
On the other hand, I think you do need to be a very committed learner in that you can't be a dyslexic trainee and not have probably an extra level of commitment to overcome the problem. You have to work that bit harder to achieve not necessarily a better end point (233)	Need to be committed learner to overcome difficulties	Projecting his expectations of commitment again	Expectations

Appendix 8: Coding notes for Liz

Liz- coding notes

Initial Interview

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
... an important thing to know about me is that my entire family is dyslexic which I think is very helpful and I've been quite lucky that I've got all that support (25)	Whole family is dyslexic Been lucky	**Lucky** to be in supporting & understanding family (strong sense of being *in*) Recognising importance of support	Luck Belonging Support
the person who is affected the most is my sister who's older than me and when she went to school she really struggled in mainstream school and they didn't know what was wrong with her (28)	Sister most affected Didn't know what was 'wrong' with her	Dyslexia construed as something 'wrong' and amiss before her…creating sense of difference from wider social group	Difference
the school didn't support her but my parents who are teachers were able to tap into resources and support her and because she had that horrible, horrible experience it kind of made things a bit easier for me because by the time I got to school my parents were on guard and looking out for it and from a really early age I've always been kind of in the top set for maths and science and kind	Because sister went through horrible time, parents knew what to look out for. She had support, and did well in science and maths.	Recognised the warning signs, parents 'on guard' (guarding against what? Failure, stigma, being let-down by system) Parent's teacher background = insiders, able to 'tap in' to resources.	On-Guard (within support) Insider support (within support)

of relatively high achiever in my class but I've always struggled with English and I was always in the bottom set, always struggled with spelling and so forth but my parents knew what it was and they knew how to deal with it (39)		Always 'kind of' and 'relatively' (sense of uncertainty and social comparison) – reflecting lack of confidence in judgement on abilities cf. peers	Social Comparison (within Difference) Confidence
so I think my kind of course through school was relatively easy compared to my sister (40)	Course through school relatively easy	Parental support and 'on guard' helped ease her journey through school cf. sibling – sense of luck	Luck
both my other brother, well both my brother and my other sister have also since being diagnosed with dyslexia when they was, I think my sister when she was college and my brother when he was at university and then although he's never been formally diagnosed we think we can now recognise the features in my dad as well. (44)	older siblings and dad have dyslexia	Sense of all sharing in experience and label – community and in-group	Belonging
So it looks like he gave it to us (laughter) thanks dad and I think that has made it easier and also because my family are all teachers and my brother and my sister who is dyslexic is now a teacher she kind of specialises in disability, learning disabilities and so she's been immensely helpful (49)	Jokes about dad 'giving' dyslexia to her. Family very supportive	Dyslexia (it, not 'difficulties, but 'disease') is constructed as something 'given' and passed on…biological…genetic …embodied Family v. helpful with background in teaching	Embodied Dyslexia Support (which, here seems to fit within Belonging – family)
and I think life would have been very different if they hadn't have been there but it did have even with all of that it does have a profound effect and	Life would have been different without support.	Needed the support in order to maintain the trajectory…a sense of attributing her	Support (need recognised) Reattribution (of success

struggled with spelling in particular and at college as well I have to like ... I mean I think kind of it's fair to say that I'm probably kind of a high achiever compared to my peers at college but there was stuff that I really struggled with (54)	Was high achiever, but still struggled with things.	success to the external support Did well- sense of self as high achiever … but recognised dyslexia still had 'profound' effect on her (spelling)	to support – links with Luck) Self (achievement)
I had to have extra tuition for chemistry but also I went to such a big college that I was able to sneak into biology lessons unnoticed and I went to every single biology lesson throughout the course of my two years at college I went to twice and just kind of snuck in and sat at the back and that meant that a subject that I was really struggling with I had the time to absorb the information and to learn it and then I'd just go and sit in the lesson again and it would reinforce the information (59)	Snuck into biology lessons to duplicate the learning.	A sense of sneaking in covertly, to avoid discovery, in order to keep up with expectations for desired trajectory [this doesn't feel like 'passing', as she is more acting to address her recognised difficulties for herself, rather than to match peer group]	Covert (within Coping, which would also include Support – related to Belonging)
Yes they didn't even know the students in their class and it wasn't until like when I had one term left to go that they actually realised I was turning up to too many lessons and then I got found out, they just kind of turned a blind eye and let me carry on. (77)	Got discovered, but teachers 'turned a blind eye'	Sense of her coping strategy being illicit ('a blind eye') and requiring some form of exception to 'allow' or 'accommodate' her learning style (conveying a sense of difference and like she should be 'grateful' to be allowed to work harder)	Difference Exception (bridging difference with Coping)
So I really had to really kind of, I think, go above and beyond to get the grades that I needed to	Had to go above and beyond to get into university	Above and beyond what? Superficially: her peers, but	Hurdle (within Belgoning)

get into university (79)		also: her own routinized learning, the capacity within her immediate family support…a sense of uni/medical school being out of usual reach for 'them', as if dyslexics wouldn't belong Also, above: over a hurdle…the grades being this hurdle	
when you get to university the work gets harder and there's less support and the university way of learning is less geared for people with dyslexia (80)	University much harder for people with dyslexia	Ways of learning, context-dependency of support	Context (within Support)
in my first year I really struggled and I just scraped through the exams and then I kind of when I like learnt how to learn in the university and the dyslexic way things got a lot better and by the end of my fifth year I was kind of coming around like the middle of the class in the end of year exams. (84)	Struggled, but adapted	'scraped through' = 'only just'…minimising achievement, fear is less legitimate 'dyslexic way' = ownership, community of learning (in a particular way) Active adaptation, requires *struggle*…	Scraped Through [inferring inferior passing & belonging] Dyslexic Way [inferring specific practices within community of learning] Struggle & Adaptation (encompasses Support)
I kind of learnt to deal with it but again that was my family helped me with that, he provided me with loads of different coloured paper and loads of pens and I did loads of drawing and then I'd	Family helped. Post-graduation becomes a struggle again	'kind of' – not certain…'but again, that was my family' – shifting 'locus of luck' and success to family	Conflicted Locus (this sits alongside luck, insider support, and self – within Support)

say probably since graduating that's when I started to struggle with it a bit more again (87)		support…whilst saying 'I did…I'd say…I started' = *her* action	
so I've now sat my MRCP Part One and Part Two and my Part One I sat it for the first time at the end of FY two and I revised solidly for six months and then I failed it and I'm sure that that has something to do with the dyslexia and then I sat it again in CT one and again I worked so hard like I must have been working for perhaps six months in the lead up to the exam and that was how I passed it but only just (95)	Failed MRCP part 1 first time. Passed re-sit 'only just'	Solid work, resulting in failure = massive sense of disappointment…this is of dominant significance, reflected in the prevalence in her narrative → this *failure* means more than just an exam, it speaks of failing to achieve, to keep up, to demonstrate legitimate belonging	Failure
It's very difficult to know because people without dyslexia they have different abilities and it's difficult to know if the dyslexia is playing a part or not but I just couldn't see how you could work so hard for six months and then fail and then work so hard again for six months and only just pass (99)	Uncertain if failure due to dyslexia, but cannot see how effort in would result in failure otherwise	Uncertainty about impact of dyslexia → a tentative resistance to 'blame' it, owning the failure. Simultaneously, hinting at disbelief at the notion this difference didn't contribute…	Tentative Attribution Ownership (within Failure)
then I did my Part Two and I passed by quite a long way but I think the Part Two is more, I don't know if you know much about the exams but the Part Two is very kind of clinical based whereas the Part One is your basic sciences, your A Level stuff and I just couldn't do it whereas the Part Two which is the stuff that you come across in every day and you learn from your experiences	Smashed it in the part 2 MCRP	'smashed it' = strong sense of destroying the hurdle….but 'kind of' introduces uncertainty that attenuates that sense of …this 'doesn't quite add up' = suspicion, of success but also of dyslexia's involvement in failure	'Doesn't Quite Add Up' (within Tentative Attribution) Hurdle [smashed it – metaphor for destroying hurdles] (within Belonging)

like I kind of smashed it (laughter) and that in itself doesn't really quite add up. (104)			
So I think it probably was the dyslexia (106)	(doesn't quite add up) so think it was dyslexia	'I think' and 'probably' = uncertain / tentative attribution	Tentative Attribution
I've started revising for the PACES, for PACES now but like the books, the textbooks that you buy off the internet they are not geared towards dyslexic learners at all in any way; it is literally just kind of white paper, written words and lists, bullet points, stuff that is just not helpful at all and that really, I really struggle (110)	Revising for next exam, resources challenging for dyslexics	'not geared towards dyslexic learners' – reminiscent of The Dyslexic Way	Dyslexic Way (fits within Belonging)
there's so much information that if you take all the time to do kind of brainstorms and draw pictures and all of this you just won't cover all the material. So I think now is when I'm starting to struggle a little bit more there. (112)	So much information to cover, struggling	Overload of information and work → can't keep up, invokes an image of a child being left behind, conveying sense of vulnerability and fear	Overload (feeds into Struggle & Adaptation) [this feels like it fits into Struggle rather than Hurdle, because it is something she is working on to overcome, and there is a sense of pace-related difficulty, rather than a solid 'brick wall' to be smashed]
this isn't really to do with education but I have a real problem with telling the time. Like I cannot ... like digital watches are fine but telling the time I really struggle with which is ridiculous and quite often I'll, like I'll just turn up late because I think it's like I've thought, I've looked	Struggles with telling the time → makes her late	'a real problem' (implication: other problems aren't 'real'?...as well as "this is very significant")…'happens all the time' conveys sense of prevalence.	Hierarchy of Problems (some are more 'real' than others)

at the clock and I think, "Oh I've got about 45 minutes" and then I just turn up late and that happens like all the time. (124)			
One thing that I've kind of really missed in my neurology rotation because they ask for really weird and wonderful blood tests all the time you have to kind of there's all the different blood bottles that they go in and I've done investigations like time and time and time and time again and then I'll be asked to do it again and I cannot remember the colour bottle that it goes in. Like I just can't remember even though I've done it like five times before (129)	Struggles to remember	'just' can't remember → sense of frustration, but also perception of task being minimalized and simple, making her difficulty seem even more frustrating and pathetic	Frustration [within this, there is a sense of minimalized difficulty, almost exacerbating sense of self-frustration]
, just kind of trying to learn on the ward rounds and learning clinics whether the consultants are telling you information and you just can't take it in. (134)	Can't take all the information in	'kind of trying' = ?not really, or ?uncertainty (re: efficacy) 'just can't take it in' = minimalizing difficulty, contrast → frustration	Struggle & Adaptation [uncertainty of effort…also conveys sense of 'show' of effort, and also sense of uncertainty around belonging] Frustration
... I think I have quite good kind of communication skills with the patients. I think I can relate quite well to the patients and I think part of that is the dyslexia because firstly it's coming from a kind of a different perspective learning in a different way not, not list fashion, not bullet points but kind of thinking very visually	Dyslexia helps communication with patients	Has something good = attribute….but 'I think' and 'kind of' = uncertainty…she doesn't appear to believe / be certain in her strengths, or her ability to 'claim' them	Tentative Attribution [this is relating to +ve, rather than the diagnosis + difficulties]

and kind of thinking outside the box and I think that really helps relate to patients even, even if they're going through difficulties that are completely different to, you know, working with dyslexia (145)			
the dyslexia helps me think outside the box I think and just kind of be creative I think maybe with how I approach problems which again I mean I don't know, I'm, I'm, I don't really know as much about dyslexia as like my sister does and I don't know whether that's dyslexia or whether that's me and part of my personality but I think I'm able to approach things from kind of sometimes a different perspective (152)	Thinks outside the box Not sure if it is dyslexia or part of her personality	'I think' and 'just kind of' = uncertainty → tentative, but attributing qualities 'to dyslexia' rather than to self. Dyslexia vs. **<u>part</u>** of personality – disembodied dyslexia…separate from her.	Tentative Attribution Conflict (within Embodied Dyslexia) [contextuality of embodiment…in context of attribute – disembodies and partitions]
and I just wonder if you could tell me a bit about both sort of instances where you found out that you had dyslexia, both the sort of the informal one and then the later formal one? R: I mean the, the informal one I think I was kind of too young for it to be upsetting or anything. I think I just, we just kind of always assumed that I had it because I think it was even like it was probably even earlier than ten like in, when I was in year three which is kind of when I was seven or eight years old I remember I was in the bottom set (169)	Informally recognised as dyslexic in early primary school. Too young to be upset by it. Expected	Anticipation of difficulties and diagnosis aided transition of identity from 'he' to 'her-with-dyslexia'… too young to be upset, implies recognition that process is painful / upsetting…	Anticipation (linking Diagnosis to Belonging and/or Adaptation)
I didn't even remember a set time when we said, "Oh you probably have dyslexia" I think it was	Formal assessment was a hurdle to extra time in exams	A sense here that the label was 'academic' and less	Diagnosis [softening importance, academic, for

just always a given that I had it and by the time we got, by the time I got to college like we were all, you know, there was no question about it we just knew that I had it and to be perfectly honest the reason why I got formally diagnosed is because we thought I needed the extra time in exams. (175)		important, purely a means to an end (resource access)	resource access]
I've always been really open about it to my friends, open about it until I started working as a doctor and since I've been working as a doctor I have never ever told anybody that I've ever worked with that I had dyslexia and I make a point of kind of keeping it very quiet. (183)	Used to be very open about dyslexia, now keeps secret as doctor	Disclosure → was open, now secretive…sense of wanting to avoid hurt and suspicion (of not being 'good enough').	Disclosure
I was very open with it up until the point that I graduated. (184)	Graduation = threshold of secrecy	Was open re: Dx, now not….turning point	Threshold of Secrecy (within Disclosure)
people had really bad stories there and people really struggled and then there were, there were big issues and so there I was an incredibly high achiever compared to everybody else and yet I had this label of dyslexia and other people do not understand that because they can't understand how a high achiever can also have dyslexia but I didn't really, I didn't really experience any animosity there because I wasn't getting any benefits from being dyslexic. (198)	People weren't mean about her dyslexia in secondary school because she wasn't 'benefitting' from diagnosis	Hostility towards diagnosis contingent on perception of 'benefit' from label… Sense of 'benefit' from label being unfair in high achievers…only low achievers (? 'visibly' struggling) learners worthy of benefit	Conditional Benefit (within Diagnosis, linking to Difference) [contains notions of worthiness, and visibility of struggle]
When I went to college and I started getting extra time then people were, then people were nasty about it and I remember when I did my exams in the first year of college they put all of the people	In College, peers didn't understand and behaved in intimidating ways when she got extra time in exams.	Sense of being persecuted for being (visibly) treated differently…'rewarded' for (hidden) difficulties resulting in	Conditional Benefit (within Diagnosis, linking to Difference) [dissonance between visibility of

with extra time on the front row of this massive exam hall which is just such a stupid thing to do and then when they started letting the other people go they ... you would literally like I'd have to close my exam paper because people would be stood around me waiting to go and get their bags like literally stood all around me and I was meant to be doing an exam. (204)		hostile treatment by peers	struggle (success) and access to resources (extra time) results in hostility]
So that extra time I didn't have anyway because I just had to close the exam paper and people were so kind of furious that I had extra time over them that people would like kick your chair as the go past and like bump into you and that sort of thing (208)	Didn't get to use extra time due to peer behaviour	Sense of being defeated….hostile peer-treatment was successful in circumventing her reasonable adjustments	Defeat (within Conditional Benefit)
minimali	Got separate room, and possibly had better exam experience cf. peers	Separated = better (hiding benefit from view)…but strong sense of guilt and undeserving coming through ('perhaps shouldn't have')	Guilt (within conditional benefit)
at university when I was with, when I was put with other people who were also high achievers like people used to say to me that "I can tell you're dyslexic." So I think it became more obvious when I was more stressed and more pushed that people all around me could tell and so people were kind of a bit kinder about it at university. (218)	Her dyslexia became obvious to peers at uni, when she became stressed, but they were kind	Sense of contextuality of visibility of difficulties: when in lower-achievement peer group, less obvious, in higher-achieving peer group, was more apparent…	Contextual Visibility (within Difference)
the thing that really infuriated me at uni though was that when we were kind of in the fourth year	Friend got diagnosed with dyslexia too. This made her feel odd.	A sense of rules and conditions to group membership (tribal)	Tribalism & Transgression (within Belonging)

doing our fourth year exams we had our finals at the end of fourth year so that's when we were under the massive, massive amount of pressure and all of us in my house, I lived with all medics and we were all working extremely hard and we were all struggling because it's, it's a fourth year medical exams and like everybody struggles whether you're dyslexic or not it's hard to do and because all of, all of us were struggling my entire house then decided that they must be dyslexic too. So they all kind of went and got kind of privately assessed and like most of them were not dyslexic but then one, like my best friend then got diagnosed as being dyslexic but just she hadn't, she hadn't struggled at all up until that point and then she started having kind of extra time as well and it sounds really, really stupid that I find that I have negative feelings towards that because that doesn't really make me any better than the people who are having negative feelings towards me when I was having extra time but I just, I found that a bit odd (234)	She doesn't feel like she should feel odd about it, but she does	which have been contravened by her friend (Tara) – NB: this made her cry, very emotional…sense of personal hurt and being let-down.	
... I think on a rational level like I know from my sister that about 17% of the population has dyslexia whether it's diagnosed or not or that's what she tells me and so the chances are that there probably was several people at university	Probably several people undiagnosed at uni	Rationalising *against* her feelings…sense of guilt to the Tribalism conveyed in previous excerpt…recognition that it is not a ?productive stance /	Rationalisation (within Tribalism & Transgression)

who weren't diagnosed, who didn't, who it only became apparent when they were at university but then on the other hand like that friend of mine she was absolutely fine until fourth year and I would have thought that it would manifest earlier than that but maybe she has kind of mild form of dyslexia and I think probably the thing that really frustrated me is that I've had to work extremely hard to get into medical school and then to get through medical school and then to carry on the other side and everybody works very hard, I'm not trying to down play anybody else but definitely some people have to work harder than others and I was somebody who had to work harder than others. (252)	Hard to get in, but harder than others for some She had to work extremely hard to get into medical school.	feeling …but also rationalises *for* her feelings on basis of having put work in, having ?earned the right to be protective of membership to this group – has to be earned through suffering, and Tara ?hasn't suffered enough yet…	
Like even at college going to two biology lessons every day for like two years, having private tuition, all of this so I think ... and the other thing that happened is at the same time I got my, for some reason I had to have another psychological assessment and I can't remember why, like the other one had run out or something and that psychological assessment found that I was dyslexic but that I was finding ways to cope with my dyslexia so my extra time in the exam was reduced from fifteen minutes every year to ten minutes every hour and at the same time my friend who had seemed to kind of get through	Had to work harder to get in to uni Her original assessment 'ran out' so needed a new one Because was found to be using coping strategies, her extra time was reduced	Earned, through suffering and hard work, group membership (Belonging)… …sense of disposability of validity of psychological assessments (ran out, no longer valid, no good)….it is time-bound… Sense of being recognised as having capability to cope within re-assessment…but this	Rationalisation (within Tribalism) [Membership earned through struggle] Conditionality of Diagnosis (within diagnosis) [time-bound, contextual validity, disposable] Punishment (within Contextual Visibility) [here the punishment is not

university like easier than me then got fifteen minutes per hour (261)		resulted in punishment (resources removed)	from peers, but from those charged with looking after her- punishment is for coping, not for invisibility of difficulty]
, I had really kind of mixed emotions; I had resentment but then on the on the other hand I had these feelings like, "Well you're just as bad as other people if you have resentment against her being diagnosed as being dyslexic." (264)	Mixed emotions about her friend's diagnosis	Rationalising the tribalism (against – recognising 'just as bad as other people' – resists identifying with *her* persecutors…Contextual Visibility)	Rationalising [this appears to link to Contextual Visibility]
I think the reason why I'm struggling with it at the moment is because I think at university there was a finite amount of knowledge that you were expected to know and even though there was a lot of it, it was finite and the, the curriculum was very clear of what we had to know for the exams and so I had time to, to make revision notes in a way that is good for me and I still use them, I still use those revision notes like even when I'm revising for these exams because they, they were really helpful and they were really good for me and the problem with now is that I don't have the same amount of free time as you have when you're a student. (279)	Approaches to learning / coping strategies don't work any more, as no time	Speaks of dynamic, and contextual nature of Dyslexic Ways: they need to change (adapt) according to environment	Bridges: Dyslexic Ways *with* Adaptation
. There's no diagrams, there's no pictures, there's no colour at all, nothing, not even like the chapter title or anything and it is very, very bullet	Information presented in bland way, no time to draw + colour, therefore can't learn	Appears to create conditions which comply, or not, with Dyslexic Way…	Conditionality (Dyslexic Way)

point and the other thing that they do is they try and cram so much information onto one page which other people might like but that's no good for me and I think the reason why I'm struggling is because there's so much information that I can't learn it in the way that's good for me. Like I just don't have time to do brainstorms, to use pretty colours to, you know, draw pictures; I just don't have time to do it and therefore I can't, I can't learn it (291)			
the main reason why I don't share it now is because I am sure, positive, that other people have a negative impression of people with dyslexia to the point that they don't think that people with dyslexia should even be doctors (326)	Doesn't disclose Ppl with dyslexia shouldn't be Drs	Speaks of reasons for non-disclosure: avoidance of negativity. Sense of persecution, and suspicion → shouldn't belong	Disclosure Persecution (within Belonging) [appears to link with Conditional Visibility]
not that they should not be doctors but that they don't realise that people with dyslexia can achieve to become doctors and so I think people would be surprised about it (328)	Surprise at Dr having dyslexia	Surprise speaks of assumption that dyslexics cannot achieve group membership	Links with Persecution
So I'd already been kind of a doctor with dyslexia for a year and when he started his FY one he was really struggling and I think he was really struggling because it is really hard to become to an FY one doctor but he blamed his dyslexia for the reason why he was struggling and he made the decision to tell his consultant and his team that he was dyslexic and that he thought that this was interfering with his ability to be a doctor and	Dyslexic colleague blamed difficulties on dyslexia, told team and they no doubt him. Angry at this, as it casts doubt on all doctors with dyslexia – wrong impression to give	'kind of a doctor' = uncertainty regarding sense of self but also in term so sense of belonging (to professional group) Sense of contravention of rules of Dyslexic Way (not way of learning, but way of *being* within community)…letting the	Uncertainty (within Self) Tribalism & Transgression [letting down the community by contravening Dyslexic

so they started kind of double checking all his work and everything and it infuriated ... I was so angry with him when he told me because that is such the wrong impression to give of people with dyslexia and to have, to encourage this belief that doctors with dyslexia are less capable than doctors without dyslexia is just rubbish because every doctor has difficulties; it might not be a named learning difficulty but everybody has difficulties and if he can't cope with his dyslexia then that's actually a reflection on him as opposed to his, as opposed to people with dyslexia, their capabilities (343)		community down…unspoken rules to ensure community not brought into disrepute or suspicion.	Way]
, I've made the decision that I never ever want my team to judge my abilities on my dyslexia. I want them to judge my abilities on how they see me and how they perceive me and anything, any negative impact that my dyslexia has on me I make up for. (346)	Won't disclose, wants to be judged on abilities	Active decision (agency) not to disclose → choosing what she wants to be judged by (element of inevitability of judgement)…Judgement Management	Judgement Management (within Disclosure)
So this problem with remembering the blood bottles, if I have to say biochemistry and find out again or if I, if I forget some information I need to look it up like I do let dyslexia have a negative impact on me and I only take the positives of it. So it's just, it's just really important that people don't know that I have it. (351)	Forgets info, has to ask for help → lets dyslexia have negative impact.	'I do let dyslexia have a negative impact'→ sense of choice, of agency, in how impact is interpreted: is this an attempt to retain sense of control over something she doesn't actually she feels she has control of?	Exerting Agency (within Adaptation in Struggle & Adaptation) [a way of adapting is to take control through struggle…if you can control it, you can change it]
So yes, it's just to stop any negative misconceptions really. (352)	Doesn't disclose to avoid misconceptions	Controlling perception through managing disclosures	Judgement Management (Disclosure)

I've never told anybody which sounds quite crazy because I'm actually and I perhaps tell people more about my than I should (laughter) so I'm always impressed myself that I've never ever told anybody that I've worked with that I have it and this was even like, this is even my peers so like when I was an FY one the fellow FY one who was on my firm with me I got really, you know, you bond with people that you're an FY one with in your first rotation and I was really good friends with her for a year, two years, I don't, I'm not really in contact with her anymore because she moved but I never told her. I've, you know, there's people who I've become very close to in my work and I've never told any of them and it's just so important to me that people don't find out just because, just because I want to be judged on my abilities as opposed to for anything else. (366)	Gets close to people but doesn't disclose	Change in contextuality of disclosure (a sense of being close to someone usually qualifying them to know diagnosis, but now not → sense of remorse, loss of aspect of connection, but essential to management)	Judgement Management (Disclosure) [this conveys a sense of remorse over need to manage, and also challenges thresholds]
, I think in university it made work harder for me and it made revision harder for me but I think I had a really good way of adapting and dealing with this and I think the attitudes that I had from people were on the whole quite positive. (393)	Dyslexia made uni work harder, but adapted, and positive attitudes	'it' made work harder for me → disembodying dyslexia …'I had a good way' = taking ownership of her adaptive actions	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodies to take agency] (links to adaptation) Exerting Agency (within Adaptation in Struggle & Adaptation) [a way of

			adapting is to take control through struggle]
I didn't really like people were kind of pissed off that I had extra time but apart from that I didn't have any negative beliefs about the dyslexia (395)	Didn't like when people got pissed off at her having extra time in exams	Sense of trying to avoid (didn't like them being 'pissed off') persecution (but implies that they were 'pissed off') at visible 'benefits' to diagnosis	Conditional Benefit (within Diagnosis, linking to Difference) [resources = visible benefit = persecuted]
I really do think it's made being a doctor harder not just the exams but just ... well I mean like every day we work on stuff that we've learnt like everything we do at work is a test of our knowledge, everything whether you're clerking a patient or you know you're seeing a patient with chest pain or whatever it's all on stuff that you've learnt before and I just feel that, that I have to kind of ... like a piece of information has to be told to me like time and time and time and time again before I can remember that information and I think that is holding me back and you get other people who are told things once and they just somehow manage to retain that information (403)	Dyslexia makes being a doctor harder. Dyslexia holding her back Has to receive info. again & again cf. peers who seem to get it immediately.	'harder' recognises it is hard, but dyslexia more so than 'baseline' → illustrates with example of memory difficulties disembodied sense of dyslexia, giving it agency over her – something that is physically holding her back.	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodies to give *it* agency over her, surrendering power: holding her back in situation where dyslexia makes it *harder* to be Dr]
So I think that's, that's where it's really held me back and that's where I get really frustrated like I feel confident in my abilities as a doctor in terms of my communication skills. My practical skills I think I'm quite good in my practical skills. It is purely my knowledge that I feel immensely	Dyslexia has held her back Confident in abilities but not in knowledge. Can overcome difficulties	Frustration: dissonance between confidence in abilities, and uncertainty in knowledge 'not a problem can't	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodies to give power: Has Held her Back] →[leads to] **Frustration**

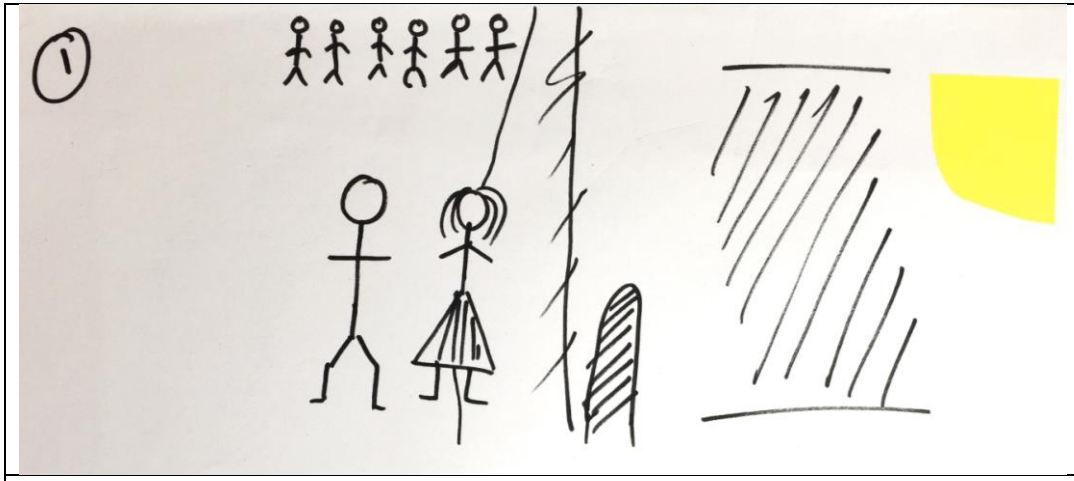
under-confident in and I think my dyslexia has played a big part in that but that's just, you know that's not a problem that I can't overcome. (409)		overcome' → phrasing agency in a negative sense here…as if uncertain about ability to exert agency in taking control to overcome…	Dissonance [between Confidence in Abilities, and Uncertainty in Knowledge](leads to low Confidence → bridges Struggle with Confidence) Exerting Agency [*uncertainty*]
Like the only thing, the only things that you can't look up is when a patient's kind of having an anaphylactic reaction pretty much everything else in medicine you can, you can look up like if you have five minutes to look it up on the internet or get out the Oxford Handbook or whatever. (413)	Can't look up certain things in medicine, but others you have time for.	Speaks of a conditionality around accommodating different strategies / approaches to coping.	Conditionality of Coping (within Struggle and Adaptation) [very environmentally focussed – it is the medical environment that enables]
So everything else you can look up and I think actually the reason why I love medicine is because it is more an art form and it's a practical skill ... it's a mixture of practical skills, a mixture of communication skills; it's a mixture of just having the right motivation and having your heart in it and the knowledge just makes up a kind of a smaller part of it. It's very important but it's not the be all and end all (419)	Knowledge in medicine is not the 'be all and end all'	Medicine is a mixture – dynamic, speaks of a hope for inclusion and acceptance: the *environment* and *work* should enable, **but** the community ?don't…	Environmental [would feed into conditionality, but this also speaks of nature of environment being at odds with nature of community…challenges orthodoxy]
a lot of people can't do the communication. A lot of people aren't in it for the right reasons. A lot	Some people can't do communication, or practical things.	Recognition that doctors have different skill profiles…but	Defending Difference (within Difference)

of people can't do the practical things so they have to work on that, I have to work on knowledge. (421)		there is a sense of her justifying her difference, excusing it (NB: not making 'excuses' but excuse in an apologetic sense)	
I'd say that it's made me more under-confident in my knowledge like I, because even when I, even when I have the knowledge and the knowledge isn't a problem I'm not confident in the knowledge and that makes it seem like I don't have the knowledge or makes me feel like I don't have the knowledge. (435)	Dyslexia affects confidence in knowledge – even when knows something, problems with confidence makes it seem like she doesn't	Uncertainty in knowledge, but here she is explaining that there are external validators of her knowledge (being adequate) but *'it' dyslexia* (disembodiment) undermines her judgement	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodies to give power: Has Held her Back] →[leads to] **Low Confidence & Uncertainty**
So I think that's played a part but then again everybody has problems with their confidence who even when they're not dyslexic so it's always kind of, it's always ... because I've never not been dyslexic I don't quite know what it's like to not be dyslexic but I think, so I think there are issues for my confidence just like everybody has issues with confidence but I think I probably do have issues. I think, I think that I'm a more imaginative, colourful person (laughter) for it (440)	Everyone has issues with confidence, but possibly she has more issues because of her dyslexia	Sense of normalising her difficulties, or minimising them- not to 'blend in' but to avoid over-focused sympathy (as if she doesn't deserve it)	Minimalizing [to avoid compassion greed] (within Difference)

Self-Characterisation Sketch

1. How *you* see *yourself*. How all of the bits of you and your life fit together.

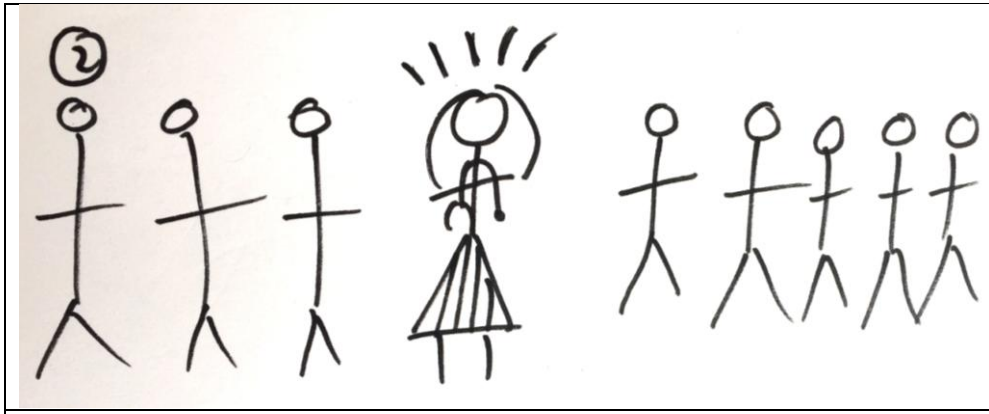
Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]
The other thing I don't know, I genuinely don't know if this is anything to do with my dyslexia or not but I really struggle with my speech. So I had to have like speech therapy lessons when I was younger because I couldn't, I couldn't talk. I think I just learnt to talk very, very late on and then I don't, I don't, I haven't really asked my parents about it but then when I was talking it was very difficult to work out what I was saying and I still to this day like have a lisp and I think sometimes my speech is a bit slurred and I have no idea if that's connected to dyslexia or not (510)	Has had speech difficulties	[reflexive note: difficult to not jump to link between this and phonological processing difficulties that are central to Dx of dyslexia] 'I have' = embodied difficulties…but 'I just learnt to' = minimising difference	Difference (linking with Embodiment)

	How she sees herself: A revised line dividing her self between her partner + family, and the tunnel (with light at the end) that represents medicine.	Split between Family and Career…two different *parts* to self	Partitioning self
This is me. An excellent representation I think. I think that's probably it for number one. **I: Okay.** R: I'll label it number one. So this is the light at the end of the tunnel. **I: Okay.** R: And this is medicine and medicine is very separate. (535)	Light at the end of the tunnel	Sense of medicine being a dangerous and gloomy (fear) journey through a dark tunnel.	Environment (medical career as fear-inspiring)
I should have drawn this line kind of going half way through me like that and get rid of that because it's very integral to me but at the moment it's separate from the rest of my life and I want to ... I kind of think that life would be a lot easier when I'm more senior so that's the light and then this is difficulties to overcome (539)	Medicine = part of her, but a separate part	Integral, yet a discrete part	Partitioning of self
this is difficulties to overcome to get to the light and not necessarily dyslexia but just kind of difficulties in medicine, passing exams, getting publications and audits and then I guess dyslexia ties into all of that but I don't see dyslexia as a barrier in itself as everything else and this is my partner because he's very important and then that's my family (542)	Difficulties to overcome: dyslexia part of it, but not insurmountable	Dyslexia contrived as an externalised component to hurdles	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodied

			component of medical hurdles]
I don't really think that there's any other like it sounds quite sad but I don't think there's any other bits of my life because since I started medicine I couldn't do anything else. (547)	No other bits to her life	Medicine as displacing 'other bits' of her life… taking over	Medicine Displaces

2. How a *sympathetic* friend, someone who knows you very well (perhaps better than anyone else could) and is understanding and *sympathetic* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]

		How a friend would see her: surrounded by patients, wearing her stethoscope.	Stethoscope = token of doctorness, because she *loves* medicine, because she *is* a doctor (NB: in *their* eyes, cf. how sees self)	Token of Doctornes [contextuality]
so I was thinking about my best friend Tara who is the person who was diagnosed with dyslexia in fourth year and this is how I think she sees me; I think she sees me as a bit of a stress head so this is all the stress that's coming out. (576)		View from Tara, sees her as a stress head	Stress head (hence the lines coming from hear head 'coming out')…externaisation of struggle	Struggle & Adaptation [externalised to the extent where peers can see]
Although I think she…she's very stressed as well. So I think she'd probably say that I'm no stressed than any other doctor but that I am quite stressed and that doctors are quite stressed but I think these are all my patients (laughter). I'm wearing a stethoscope because I think she appreciates that I'm doing a job that I really love doing (583)		All doctors stressed, but doing hob she lives	Patients (focus of her job and job-related-identity) are significant to her, and this. NB: she has made no reference to the stress being visible to them	Struggle & Adaptation [visibility to those 'in the know'…dyslexic peer - ? to other Dr peers too?...not to patients]
Yes I think I probably kind of said it all. I think my friends probably see me as somebody who is very caring. Is that big headed to say that?(589)	Seen as very caring	Uncertainty and discomfort with attribution of positive traits (caring) to self…as if she is undeserving, ? given her difficulties	Deserving appears in several other themes [guilt re: resource allocation, minimising difficulty to avoid compassion greed]	
wanting to achieve good things as a doctor and I mean I see that very ... like I		Stethoscope integral	Separation speaks of	Partitioning

think the reason why I drew a stethoscope on there instead of there is that I think they see it as a very integral part of my personality whereas I think it probably was at university but now it is a very integral part of my personality but I've had to separate it a little bit just because it's so hard. (597)	to identity, but has had to separate medicine a bit.	partitioning that aspect of her life and identity	
I was thinking about drawing Drew, he's my partner because I see, I think they do see me as very kind of like very one and the same with him. I think my friends see that too but I don't know. I decided against it. I don't know why. Maybe because I didn't like I met Drew after uni so I didn't, I didn't know him as well. (605)	Partner important, but not as integral as met him after uni	Integrity to sense of self dependent on conditions (e.g. time)…if Drew is not yet integral, what else isn't *yet*…with the implication that it may become?	Conditionality of Self

3. How a *critical* other, someone who knows you very well, and is *critical* sees you.

Transcript Text (line numbers) or **Image**	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organisation into clusters / core themes) [double hermeneutic]

	How a critical other ('just work colleagues') would see her: fewer people around her, tokens of her professional identity (stethoscope and syringe) balancing notes and computer work, with her knowledge being represented as lower cf. others… consultant (not short, standing far away) observing from a distance	Tokens of Doctorness Balancing Act: balancing notes, computer work, practical tasks Stress Head (visible to ? peers)	Tokens of Doctorness Pressure (Balancing) Struggle & Adaptation [visibility to those 'in the know'…dyslexic peer - ? to other Dr peers too?...not to patients]
Okay so this is me balancing a lot at work so like notes and taking blood and writing EDSs because I think they probably see me as quite organised and somebody who kind of gets the job done and if they email or ask me to do something then I'll do it. (631)	Seen as organised	Balancing Act: balancing notes, computer work, practical tasks Externally seen as 'quite organised'	Pressure (Balancing) Struggle & Adaptation [visibility to others → 'quite organised'…sense of uncertainty in *quite*]
So I think they see me as organised and I think in, I think probably in, on balance, I think I'm probably seen as a good doctor and I think this is a patient	Seen as amiable and 'probably a good	Amiability conveys sense of *needing* to	Uncertainty (within

who's happy because I think I tend to ... with most patients I tend to get on quite well and then this is a member of staff, any member of staff, probably the nurses and the most prominent who are quite happy because I tend to get on with the nurses (635)	doctor'	get on well with others. 'probably' = uncertainty, undermining confidence in role	Self)…seems to be distinct from other emergences here: in this instance it is more about her sense of medical-self, rather than with regards to other aspects of self (e.g. difficulty)
then I think they probably see me as being somebody who's stressed and then I think they probably see me as somebody who's knowledge is perhaps not bad but maybe nothing like definitely not outstanding and maybe kind of a little bit less than average but I don't know how to draw that. (639)	Seen as stressed and knowledge 'not bad but…less than average'	External reference to knowledge: she is 'good enough' but doesn't feel she is / agree with this judgement.	Confidence [judgement – not trusting others' suggestion she is 'good enough' and not trusting her abilities] (in Self)
Maybe I could have a consultant ... oh I don't know what that is and then you can have like a bar chart of like this is trainee number one (laughter) who's got really good knowledge and then this is trainee number two who's got kind of average knowledge and then I'm probably here and then maybe you'd have like a really struggling doctor who's like number four. (647)	Knowledge seen as less than average	A real sense of self-directed disappointment, that she (her knowledge) isn't performing better	Self (disappointment directed at self)
I think people see me as stressed but that I get things done. I think as a general rule I'm an asset to the team I think (656)	Asset to the team	Externality of 'stress'	Visibility (within Struggle &

		Asset to team = positive contribution, legitimising membership → belonging	Adaptation) Belonging [bargaining for belonging to other group]
I think you could argue that things take me longer so that would perhaps affect the fact of balancing a lot at one time and also stress levels as well (665)	Takes longer, balances more	Taking longer affects balancing act...'things take me longer' is distant and disembodied (cf. e.g.: it takes *me* longer)	Pressure Conflict (Disembodied) [this time it is *difficulties* not dyslexia that is disembodied]
So these were my notes from university and these, this is what I passed my degree on. So nothing else, just like what's contained in here; so as a general rule if I found something really difficult I use an A3 sheet so these are the things I really struggled with and they're all kind of, kind of brainstorms and like pictures as well. It's amazing how long this takes. That's why I can't do it for my exams because it just takes up so much time but I still use these to revise from (681)	Proud of revision notes, brainstorms got her through degree	Sense of ownership over approach to revision & study… time taken is a trade-off	Ownership (Adaptation) Trade-Off (time)
if I'm asked questions now I can see this picture and I, I can, I do it by colour so I can tell like the hormone in the system but what colour and then I can actually remember the colour and I can remember where the arrows go. (692)	Can recall based on colour and image	'I can' = reinforces sense of ownership, internalising that adaptation	Ownership [internalised sense of adaptation]
Yes and then like obviously induction is green and inhibition is red naturally. This is all, this is, the reason why this looks so bad is because this is my MRCP revision. (696)	MRCP revision not as colourful	Contrast between pre-and post-graduate work: tipping point in	Tipping-Point (within coping)

		coping.	
Because she's, she like genuinely thought that she had hyperthyroidism so this is my drawing of Tara and then all the symptoms of hyperthyroidism I can kind of associate with her. (707)	drew friend (Tara) who thought she had disease to remember facts	Describing a strategy to humanise information	Adaptation [humanising info. as means of Coping] (feeding into Coping)
these notes are from the beginning of third year so these white notes was when I was just learning how to learn in a dyslexic way so that's why it's on white paper (713)	Used white paper to revise when was just learning to learn in a dyslexic way	Referring to The Dyslexic Way in terms of approach to learning- didn't have it 'right' at first (implying *one* right way)	Dyslexic Way
I was just kind of starting to figure out how to do it and that's why I actually tried to draw and that's me how it actually looks which is the wrong way to try and learn anatomy. So that's when I was kind of like learning that this is how I learn and then I kind of went a bit crazy on it and this is the psych stuff and like, yes, and that's why I think that's why I find haematology really difficult because I can't picture haematology (718)	Can't draw haematology, so finds difficult	Conditionality of coping strategies – some things/subjects will lend themselves to it, others won't	Conditionality (within Adaptation)
oncology is kind of very easy to picture and you know it's just so yes I'm very proud of these notes and then if you compare that to the crap that we have to deal with now. (724)	Crap has to deal with now (MRCP)	Current work –not compatible with Trade-Off… 'crap *we* have to deal with' implies community (sense of Belonging) but also sense of burden, almost intentionally applied to group	Trade-Off (within Adaptation) Belonging [sense of belonging to a community within medicine here - ?struggling trainees, or all those revising

			MRCP]
I tried to like colour in so I tried to colour code the different kind of areas so I still know that my respiratory is blue and I kind of I try to do that where it is still just so much information that I just couldn't do it basically and it just didn't work very well and like the (727)	Couldn't colour in all info for MRCP	Conditionality of coping strategy- works well for some, but Trade-Off (time)	Conditionality (adaptation) Trade-Off
so the first time I sat the exam I just spent six months learning from this book which just didn't happen and then the second time I sat the exam I learnt just from doing the questions and even then, even after like a year I followed, admittedly I had a year off in between but a year in total of working solidly I only just passed my last couple of marks whereas as my Part Two like I sailed through (731)	Scraped through part 1 of MRCP (2nd time) but sailed through the second part.	Scraped – reminiscent of 'Doesn't Quite Add Up' (cf. Tentative Attribution) but in this sense it also sounds like an 'only just' legitimation of group membership	Scraping By (within Belonging) [bare legitimation] Doesn't Quite Add Up [sense of disbelief at disparity]
Everything is just lists and I just don't know how I'm going to be able to do that at all. So I'm going to have to try and find out a way (738)	Will have to find a way	Sense of taking ownership and responsibility for adaptation	Ownership (Adaptation)
but it's still very like grey and not very inspiring which is why I really like the Oxford Handbook because it gives you kind of little stories and antidotes (754)	Needs stories and anecdotes ('antidotes')	Alluding to huminising means of adapting	Adaptation [humanising info. as means of Coping] (feeding into Coping)
That's the difference but like at least when I was at uni I could from the books that I had I could make these notes whereas from these books I can't. (759)	Now her old approach to revision doesn't work	Something here about work out-pacing her ability to adapt…but also conditionality & contextuality of her	Conditionality (within Adaptation) [in this sense, this conditionality refers to context

		adaptations	& pace]

Critical Incident Technique Reflections: 1

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
A massive part of being an SHO is getting through your membership exams. I think most SHOs would agree with me that it is a huge weight on all of us and when you don't have membership you feel very much trapped and very much uncertain of your future (5)	Massive part of SHO is to pass exams - trapped	'feel very much trapped' = lack of choice and agency, metaphor speaks of suffering and imprisonment…but 'us' and a collective 'you' speaks of community	Trapped (within medicine and training trajectory) Community (Belonging)
All my life I feel that I have had to put much more time and effort into every exam that I sit compared to the average student, and in the past I have been able to do this. But when revising for membership, when I am already working full time and the exams are so much harder than any other exam we have ever sat, it gets a lot more difficult to put in the extra time. (8)	Always had to put more work in, which is harder when working full time	Describing Trade-Off (putting more in for same, time)…speaks of an acceptance but also a sense of resentment ('when I am already working')	Trade-Off Resentment (Adaptation) [at need to adapt and compromise]
During my FY2 year I decided to try to get part 1. Knowing that I need to spend more time than the	Failing exam was massive knock to confidence	Significance of this CIT (given prevalence within entire	Confidence [daily 'little' reminders vs. large event

average student revising I started revising hard 6 months before the exam. Even after that massive effort I failed, which was gutting and a massive knock to my confidence. (11)		narrative) is high…impact on confidence is pervasive	e.g. exam failure] (this feels like it fits within Self)
So now I find myself on the dreaded PACES. In the last couple of weeks I have really started to settle down to some revision. I had a day off about two days ago and thought I would focus on trying to learn all about interstitial lung disease. I got out my oxford PACES book and started reading it. I read the section on ILD again, and again, and again, and each time I genuinely could not recall what I had just read. I spent 2 – 3 hours on just two pages without still being able to list the common causes at the end of it (18)	Couldn't recall information that she had re-re-read	Reminiscent of Doesn't Quite Add Up, suggesting that this may be related to her dyslexia.	Doesn't Quite Add Up
In post-graduate literature the authors seem to forget about colours and pictures, and that different doctors not only have different learning styles but also some, like me, have learning difficulties. Perhaps this is due to a common misconception that a dyslexic person would never be able to graduate as a doctor (21)	Doctors forget about different learning styles, and perhaps think dyslexics wouldn't graduate	Sense of it being unfair that needs (and diversity as a wider issue) aren't catered for in the mainstream 'dyslexic person never able to graduate' is reminiscent of the persecutory tones ("dyslexics can't be doctors")	Unfair Persecution (within Belonging) [appears to link with Conditional Visibility]
I then suddenly had a bit of a reality check where I said to myself 'why am I trying to act as if I am not dyslexic?!' The only time my dyslexia really holds me back is when I pretend I don't have it. I rummaged around in my cupboard and right at	'why trying to act as if not dyslexic?' → drew on her mindmapping techniques which brought subject to life	A sense of having deviated from the 'path' of The Dyslexic Way, and failing into difficult times… and needing to return…	Dyslexic Way [1 right way, other ways lead to greater struggle]

the bottom was brightly coloured paper, felt tip pens and colouring pencils. I then spent the next two hours mindmapping all I needed to know about ILD. Suddenly the disease came to life and I was able to make connections that I just couldn't have done reading from a paper (26)			
It sounds very simple but they're the sort of connections I just can't make if I am reading the information. Not only did it all suddenly become a lot easier to understand but it also becomes a lot more interesting and enjoyable (29)	Became easier to understand and enjoy	'just can't make' connections unless *conditions* (of Dyslexic Way) satisfied	Dyslexic Way Conditionality [of memory]
The only problem is it took me 2-3 hours to draw these mindmaps for one case. There are 159 cases in the text book, all of which I need to learn. All in all Im looking at the best part of 500 hours just to get to the point where I have my own 'textbook' to revise from. Basically just to get to the point that other doctors are at when they purchase the textbook (33)	Could take her ~500hrs to get to the same point where other doctors are	Speaks of Trade-Off (time) but also of the sense of unfairness of it ('just to get to the point that other doctors are at when they' start)	Trade-Off Resentment (within Adaptation)
In the past the thought of spending all that time re-writing with the exam fast approaching has panicked me, and that's when I've just tried to learn straight from the text book, but Im not capable of doing that so it's wasted time anyway. As always I just need to resign myself to putting in the extra time. (36)	Thought of this time scares her into 'just reading' which is wasted time, so needs to resign self to putting in extra time	Fear can lead to deviating from the Dyslexic Way which is unproductive	Fear [as a driver of deviation from Dyslexic Way]

Critical Incident Technique Reflections: 2

Transcript Text (line numbers)	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
By the end of your SHO years you get extremely good at taking blood. I have never really had an issue with the skill of taking blood; in fact I quite enjoy it and welcome the 5 min break it offers. The one thing I do not enjoy however is trying to remember what colour bottle to send the blood in for the various investigations. (43)	Good at taking blood, enjoys respite it offers, can't recall which sample bottles different tests go in.	Task (blood test) has many different skills involved, she is good at some (enjoys) but not others (doesn't enjoy)	Skill Mix
One could assume that by the end of four years of sending a test like troponin or haematinics i.e. fairly common tests, it would be engrained in my memory. However I have never been good at list learning, something I associated with being dyslexic, and learning the list of investigations that go into the various bottles is very much 'list learning'. It is infuriating as it is so time consuming to phone up the lab every single time a blood test slightly out of the ordinary needs	Assumption is that should remember, but not good at learning that way. Infuriating to waste time repeatedly calling lab to ask.	Assumption = good doctor can remember, she doesn't, therefore not seen (by self) as 'good'… the strategies she employs for this require a trade-off (time) which frustrates her (?because it is not seen as a worthwhile investment)	Good Doctor (would include Skill Mix (above) and Recall) [notion that she feels not-good-enough] Trade-Off [notion of worthwhile-ness of investment]…*linking to* → Frustration

doing, especially when you have done it one hundred times before. (49)			
being a fairly conscientious doctor, I will never just have a guess as it is important to me that patients do not suffer from a painful needle jab twice and that the investigations needed are done in a timely manner. Moving from hospital to hospital every year further compounds this problem as there can be slight variations which further confuses me (52)	Conscientious so would prefer to check rather than guess. Moving hospitals adds to confusion.	'fairly conscientious' = introducing uncertainty and the notion of resisting self-praise sense of disruption (moving hospital) contributing to difficulties → speaks of environmental component of stress / coping	Uncertainty (within Tentative Attribution, which is linked to Self) [this is relating to +ve / praise] Environment (within Conditionality of Coping, within Struggle and Adaptation)
more costly than the time and the frustration is the near daily reminder it proves to be that I have a condition that I feel at times holds me back in my everyday work compared to my peers, and the damage this has on my confidence. (55)	Daily reminder that struggles which damages confidence.	Daily reminders of little damages → evoking imagery of chipping away at her confidence	Confidence [Daily Little Damages]

Interim Interview

Transcription Text	**Descriptive Coding** (notes)	**Interpretative Coding** (notes)	**Emerging Themes** (organising into clusters / core themes) [double hermeneutic]
I: have you had anything recently where you've thought oh blow there goes my dyslexia again?	Can't pinpoint times of difficulty that may relate to dyslexia.	Dyslexia difficult to pinpoint – not a discrete thing, but	Pervasive (Dyslexia)

R: I don't think so, I feel quite bad because I haven't really sent you any reflections for a while and I find it really difficult to pinpoint (17)…[line breaks up]…I was saying that I'm finding really difficult to pinpoint times when I feel that my dyslexia is having a big effect. I think the overall experience of sitting the paces exam and I think my take on it is that dyslexia does have a negative impact on the revising for exams like that, not just when I'm revising but also afterwards I feel very much like I've lost the knowledge really quite quickly (25)	Revising for exams is harder, and then thinks loses knowledge quicker	sometimes more noticeable than others Decay of knowledge being a recognisable difficulty…but 'I think' brings in uncertainty again	Tentative Attribution [because it is so pervasive]
. But I don't know if I'm sure anybody would say that whether they've got dyslexia or not, I just feel that it's more safe for me. So I think there's not kind of ever one incident but it's just constantly like people asking, like consultants or registrars, testing me and quizzing me and asking me questions that I know that I've learned over and over and over again and I still can forget (29)	Constant reminders that forgets info she has studied lots	Constant reminder → Daily Little Damages… but in this case, uncertain re: attribution to dyslexia ('I don't know')	Daily Little Damages Tentative Attribution
I definitely do feel that a lot of it is the dyslexia, like I do blame the dyslexia for a lot of it, and I get really frustrated and it really messes with my confidence as well. When you know that you should know something and you've learnt it several times before, and somebody asks you a question and you still can't remember it it just knocks your confidence a little bit. (44)	Thinks there is a pattern. Blames dyslexia a lot. Knocks confidence.	'it' messes with my confidence → disembodying dyslexia, giving it the power to damage her confidence	Conflict (within Embodied Dyslexia) [contextuality of embodiment – disembodies to give *it* power to damage confidence]
just like when you're asked a question and you	Knocks build up over time to	'constantly forgetting stuff' →	Frustration [hyperbole as

know the answer that gives you a confidence boost, so when you're constantly forgetting stuff, especially when you're put under pressure to remember a ward round or whatever, then kind of over time that builds up to be quite damaging for your confidence. (47)	damage confidence	hyperbole (cf. passing exams and judgement from nursing colleagues) which drives her frustration	an element that contributes]
the things that I really struggle with are the things that you can't work through in your head. So for example like knowing what antibiotics work for what type of bug or knowing the antibody for an autoimmune disease, they're things you can't work out you just have to know and they're the things that I'm really really bad at remembering unless I'm able to draw a picture in my head of that particular antibody. And it's very time consuming trying to associate a picture with every single drug that you come across or every single antibody that you come across (55)	Recall strategies too time consuming to work	Trade-Off (time) to use recall strategies→ element of environmental constraints, limiting ability to compromise	Trade-Off [limited by environmental factors]
again it would just make life a lot easier if you didn't have to go and look something up every time you have a patient that you want to test for various things. I suppose in clinical practice you can do that, you can go and look something up, but it's just the more stuff you look up the more time consuming it is. (65)	Can look stuff up in real life, but very time consuming	'Clinical Practice' construed as "real life" here…a different position from being in the *Trainee Spotlight* (teaching) or exam situation. This relates to the contextuality of coping	Conditionality of Coping [context – "real" vs. "contrived" life]
I think it's constantly there at the back of your mind. I do think ever since… like when I was at school I was very much in the top of the class and the same really at college and then when I went	Top of the class before uni. At uni and afterwards, dyslexia 'kicked in'	Speaks of the environmental contribution to difficulties out-pacing ability to cope, and her sense of 'visibility' of her	Contextual Visibility (within Difference) [when difficulties outpace coping → becomes visible…at

to university I was with people who were very much of my ability and then when I graduated even more so. And I think when you're trying to learn the amount of knowledge and the complexity of the knowledge that you are trying to learn at medical school and at post grad level, that's when your dyslexia really does start to kick in. (82)		difficulties 'It's constantly there' → pervasiveness of her dyslexia	least to her] Pervasive
Like I feel like my dyslexia only really started holding me back at the post grad level. So during medical school the syllabus was still narrow enough for me to spend the time making pretty revision notes and so forth (85)	Dyslexia only really kicked in at post-grad as had time to do pretty notes in med school	Reminiscent of the environmental contribution to difficulties out-pacing ability to cope, and her sense of 'visibility' of her difficulties	Contextual Visibility (within Difference) [when difficulties outpace coping → becomes visible…at least to her]
So when I was an under grad I felt like I could compensate for it quite well and then when I became a post grad that's when I really felt that the dyslexia really kicked in and really started to hold me back and I feel like I feel that negative impact of dyslexia every day because every day I feel that little bit less confident and that little bit unsure of my own knowledge and a little bit mistrustful of my own knowledge. (98)	Negative impact of dyslexia felt every day, daily reminders making her mistrust her knowledge	'every day I feel a little bit unsure of my own knowledge' = Daily Little Damages	Daily Little Damages (relating to Confidence) [relating to decay in knowledge and altered sense of self that affects attribution and confidence]
So it's just like every day there'll be something where I think to myself I should have known that or I should have been able to remember that without being reminded. And every time that happens that's a knock to the confidence. (101)	Daily knocks to confidence	Invoking metaphor of physically being knocked (boxing) a violence (self-violence)→ Daily Little Damages	Daily Little Damages [holds violent connotation]
I think it probably has, because I think the more	Downward spiral, trusts self less,	Interconnected nature of	Daily Little Damages

used you are to just having to look up and double check your knowledge the more you rely on doing that and the less you… it's kind of like a downward spiral, you trust yourself less and less and so I think it becomes almost like quite often as a team you brainstorm what's wrong with a patient, and nobody quite knows the answer and you're just a lot less likely to offer up an opinion or even in your own head to even think out what you're opinion is, you just wait for other people to say what they think and then you just kind of go along with it (115)	checks more, voices thoughts less (to self and in groups)	perception of knowledge, confidence, and Daily Little Damages…but also there is an 'even in your own head' → a sense of this process being embodied, but dissociated (seen from 3rd person perspective)	Conflicting [sense of embodiment]
and I think in medicine there are so many kind of, I wouldn't say alpha males because you get alpha males and alpha females, but you get so many people with really strong, overt, competitive personalities and I think they're very quick to talk over somebody who's less confident (120)	Alpha personalities talk over people who are less confident	Social comparison in a highly competitive environment (environmentality) which affects frustration and sense of self, and confidence…	Relationship of ***Environmentality*** with Self
And so you could get a team where you get somebody who's less confident and then somebody who's more confident you almost reinforce those roles as time goes on. (123)	Pattern reinforces roles	Environment is self-reinforcing	Relationship of ***Environmentality*** with Self […the environment is self-reinforcing, and reinforcing of self]
I've worked on to try and improve and to try and improve my trust in myself. And I've tried to use the fact that I've passed PACES as almost evidence that I am good enough to be at the stage where I'm at because I've passed PACES and the MRCP in general is a set of exams that's	Trying to convince self is good enough to be where she is	Trying to convince self = good enough → implies that she doesn't think she is…	Confidence [doesn't think she is 'good enough' and not trusting her abilities] (in Self)

designed to establish whether somebody should be a registrar or not. (146)			
that's what I'm trying to do so I feel like I've almost halted the downward spiral but I'm not sure if I've managed to get it to the point where it's going up again, I think I'm just kind of static (148)	Halted the downward spiral, but not up yet	Sense of hope and recovery…recovery from damage (?Daily Little Damages)	Confidence → Recovery [potential to undo DLDs by correcting thinking]
So I think that's just something that I have to work on and I think it's just, or hopefully it's just going to come with time and when I'm a registrar and as my knowledge continues to grow I'll just have to work on that. (152)	Will have to continue to work on self-trust as continues to work as registrar.	Acknowledging on-going / work-in-progress nature of correcting confidence	Recovery [on-going process]
. I'm definitely, without a doubt I am definitely somebody who learns through clinical practice, I am not somebody who learns from text books, it just does not work at all. So I think becoming a registrar is just going to benefit my learning style so much and it's just going to be purely through experience that I'll get my knowledge up. (156)	Learns better from experience	Text books → doesn't work at all…reminiscent of The Dyslexic Way, but also introduces a sense of obstruction (doesn't = won't)	Dyslexic Way
so I'm really interested in medical education and my plan is to somehow go into education, so I'm doing the PG cert this year, hopefully the diploma next year and hopefully after that I'll convert it to a masters and I want to get really heavily involved in education and maybe even one day work for the deanery (167)	Interested in Med Ed	Is this interest driven by her experience of difficulties (paying back to community), also reflects family support (teaching background)	Community [paying back]
and you mentioned that one of the I guess difficulties you've had is actually teasing out specific discreet events because actually you've	Cant remember regularly – little 'insults' build up	Daily Little Damage	Daily Little Damage

felt that the way dyslexia affects you is more sort of pervasive or it's there just all the time in the background and difficult to pick out, and - R: - and they're so small as well, like it would just be like literally it'll be a snapshot on a ward round where the consultant would be like, "What's the test that we do for this disease?" or whatever, and I just can't remember it and then he reminds me and in my head I'm like well that was my dyslexia and then it's just gone and it's just kind of seconds of my day but little insults like that build up. (199)			
. I think it's just the two kind of overwhelming feelings that I associate with my dyslexia are frustration and lack of confidence. And it is very much a new thing to me because my dyslexia's never held me back, it's never held me back, it's never been a problem. (225)	Overwhelming feelings of frustration and low confidence with dyslexia.	Frustration (at self) linked to confidence (which, in turn, makes her frustrated) → feels cyclical.	Frustration & Confidence
I was like rubbish at spelling at school but my parents were very proactive in getting private tuition for me and I've always really used my dyslexia to actually learn vast quantities of information at GCSE and A Levels because when you know how to do it with dyslexia it can really be an asset (228)	Dyslexia was an asset	'used my dyslexia' → owning it (not quite a sense of embodiment here) = bringing it within the influence of her agency for adaptation	Ownership & Agency
But then just since I've graduated basically since I've started doing the MRCP this is when I've really… it's just been overwhelming and I've just	Couldn't cope with vast knowledge required for MRCP	Environment outpacing ability to cope & threshold (since graduating)	Conditionality of Coping [environment]

not been able to cope like I could because the amount of knowledge that you have to know is just so vast. (231)			[NB: threshold of (not)coping corresponds with threshold of disclosure!]
I think that's why the last time we met I was kind of more emotional about it then because that's when I'd just started first noticing that I was really really struggling to overcome it. (233)	Had been really emotional due to realising struggle	Struggle as a sense of suffering (revealed through catharsis)	Suffering (within Struggle)
I wouldn't say that since we last me I've been able to overcome it anymore, but somehow I managed to get through my exams and at the end of the day the main way that I've managed to overcome the dyslexia is just working really really hard and like to a certain extent I felt like I've worked a lot harder than many of my peers and that's what I'll just carry on doing for the rest of my career, (239)	Not overcome it yet, but 'got through'	'got through' is somewhat reminiscent of 'scraping'…so her coping is *just* getting her through…but not exactly thriving / excelling (this is the exam she 'just' passed)	Scraped Through [inferring inferior passing & belonging…but also invoking sense of struggle and suffering]
I've got the MRCP text books and even though I've completed the MRCP I'll carry on reading them on a regular basis, I'll carry on doing more online questions and I'll carry on learning to the best of my ability because I know that I need that to keep myself up to the standards of my colleagues. (243)	Will carry on working hard to keep up with colleagues	Social comparison with peer group…driving 'I'll carry on'…a sense of being obliged in order to 'tow the line'	Coping and Adapting [an on-going, dynamic, process….driven, in part, by social comparison]
This is the decision that I made when I decided to go into medicine so I knew that, when I made that choice I knew I had dyslexia and I realised I was going to have to work very hard. And I realised that I would have to work very hard for	Made decision to go into medicine knowing would mean extra hard work for rest of life	Knew it would be hard – so 'that's the way it is' – sense of deserving of struggle	Deserving appears in several other themes [guilt re: resource allocation, minimising difficulty to avoid

the rest of my life. So that's just the way it is I guess. (253)			compassion greed…and *now* in terms of deserving to struggle]
I don't regret my choice to do medicine, I do still kind of wish that I retained information slightly better than I do because it's becoming really tiring and frustrating but I guess, I don't know, I wouldn't not do medicine, (259)	No regrets	No regrets….but a sense of sadness and longing for it to be easier …evoking a sense of suffering behind the struggle, wishing it wasn't so	Acceptance & Longing (within Struggle)
I love doing medicine and I strongly believe that my dyslexia shouldn't hold me back in that and so if that means that I have to work that little bit harder then I'll do it. (261)	Strongly believes dyslexia shouldn't hold her back	'my' dyslexia → ownership, shouldn't hold her back (when Owned, 'shouldn't' but when disembodied, can/does?)	Conflicting Embodiment (Dyslexia)

Appendix: Coding notes for Sarah

Transcript Text (line numbers)	Descriptive Coding (notes)	Interpretative Coding (notes)	Emerging Theme
so I obviously didn't fit in to normal education. I failed my O levels, I failed my A levels. My dad paid for me to go to a crammer to retake my A levels and I just got enough then to go to university. And that is really the first time that I was taught how to learn was when I was at that crammer for three months. (17)	First time taught to learn	Needed teaching how to learn → learning construed as something *not* innate, as some secret skill that requires induction 'just got enough' = a sense of 'scraping' in	Ways to Learn Scraping By
At university where I studied pharmacy I think I really was interested in the subject and I was actually...I can't remember struggling particularly academically, I was always around a 2:2/2:1, and actually I had a viva and I talked my way into a 2:1 so I was actually on the 2:2/2:1 border and I talked my way into a 2:1. (20)	Talked her way into a 2.1	Sense of bargaining for her success, as if implying she wouldn't have secured it otherwise...conveying a sense of 'not (authentically) good enough'	Bargain Not good enough (within Self)
And I had always been really conscious I think throughout my education that I could talk much better than I could ever write. I just thought I was...I am Jewish, I just thought I was a gobby Jew really, you know? And I still do, I still find that is what I do. I am much better verbally than I am in writing. (23)	Difference between ability to speak and write – always put this down to being a 'gobby Jew'	Disparity between different abilities → frustration, misunderstanding, and expectations. 'gobby Jew' feels derogatory, as if self-deprecating	Disparity (within Qualities) Gobby / Gobby Jew (within Self) [there is a sense of this being a 'show' that masks difficulties]

When I went to do my PhD I just assumed I could do it, you know? And I did. It was really hard work and looking back now that I know I am dyslexic I can actually see my supervisor used to...I have got a box of drafts of individual chapters which are just green inked everywhere. And actually it was the English that he was correcting, it was never the content, it was always the English and at the time I used to just think it was Peter being really pedantic. (28)	Did a PhD, problem was with English, not content – put down to pedantry	Recognising historical features of dyslexia Also, something here about evidencing that (content) she *has* got knowledge and capability...despite later narrative contradicting this.	Historical Recognition (within Dyslexia / Power of Label) [later a stronger sense of re-writing /re-attributing is conveyed] Contradiction (within Self / Knowledge)
And it is only looking back now that I can see that I couldn't write academically. Writing and typing was such a struggle that whilst I had the brainpower to get the concepts and do the research actually writing it up was just a nightmare for me, but I enjoyed it and I enjoyed my undergraduate. (31)	Looking back, realised couldn't write, but enjoyed it	Constructing academic writing as a different language / skillset, requiring different / additional 'brainpower'...this metaphor also creates a sense of the biological in her conception of knowledge – it is embodied	Knowledge (within Self)
And I had always just thought that I had to work really hard, I have always assumed I don't have natural intelligence but I can make the grade if I put in the hours work. (33)	Always had to work had – not natural intelligence	Implication that there are two types of ability / intelligence: natural (effortless) and contrived (requiring effort)	Knowledge (within Self)
When I went to do the MPH, so that is the latest thing that I have done, I can remember saying to people, because I was obviously the oldest person on the masters programme by quite some way, and I can remember all these modules came at me with a whole different	Struggling with new knowledge as 'brain is full'	Knowledge construed as something physical (brain is full, no room) ...introducing the notion of learning being time-bound, with an age limit to capacity...	Knowledge Misattribution (within

language and a whole different...each time it was a whole new language that you had to learn before you could even start understanding the topic. And I can remember saying, "My brain is full. I am 49, it is full of stuff and I have got no room for anymore knowledge." And actually thinking that that is why I was struggling. (39)		Misattributes difficulties for other causes (full / age)	Attribution)
yet when we had class discussions I would be the only person who would be involved in those discussions, everybody else just didn't engage. And a lot of the lecturers used to sort of say 'oh it is so good because you grasp things really quickly' and I was going, "But I don't, I don't, it is the language, I can't do it." (43)	Lecturers felt she was good, but she didn't	View of self conflicts with evaluation by others → sense of conflict (different from contradiction)	Conflict (within Self)
Having now been diagnosed as dyslexia I think that all of my language issues are all tied up with being dyslexic. (44)	Now thinks it is because of dyslexia	Since Dx, re-attributing things to dyslexia, a sense of re-writing her history to accommodate her new Dx	Reattribution (within Attribution)
I can understand concepts really quickly but I don't understand the finite detail of them and the language of them. And in fact I have always described myself as an 80% person. So I do everything up to the 80% level. (46)	Describes herself as an 80% person	Struggles with finer detail. 'always' described self as '80% person'...only partially a person, less than 100% in value, due to less than 100% in performance / output...this speaks of discrepancy between expectation, input and output...as well as disparity between what she probably	80% (within Self) [relates to Expectations]

		expects of herself, cf. what others expect	
I quite often get my words muddled but the ideas are there and I have always just thought that that is me. (47)	Gets words muddled - just thought that was 'her'	'just thought it was me' → difficulties as her (personality) vs. the dyslexia...conveying a sense of internalised fault and guilt Also conveys a sense of splitting of self: a 'just her' part vs. a dyslexic part...relating to attribution	'Just Me' (within Self) [relating to Attribution]
And I think in educational terms that is why I have always struggled to get above a particular level. So I got Cs and Bs in my five GCSEs and I got B, C, D, in my A levels. And I only got a 2:1 because I talked my way into it, you know? And I think that is because the detail, I find grasping hold of the detail and regurgitating it very difficult (5)	Struggled to get highest grades	'talked her way into it' → bargaining ...but this conveys a sense of that achievement being undermined, as if it is somehow less legitimate	Bargain [related to Attribution, through attributing achievement to bargaining]
that I noticed for the first time when I was doing the MPH was how slow I read compared to everybody else. I had never noticed that. But in class where we would get...we would be given research papers to read and then critique for example, people would start the discussion about the critique and I would still be on page two out of six. (54)	Slow at reading cf. rest of class	Social comparison → slower cf. peers. 'had never noticed' before MPH classes: speaks of environmental context to manifestation / visibility of difficulties	Visibility (within Difficulties) [includes: environmental context, social comparison]

in the end I just developed a habit of just...I tried to develop a habit of skim reading everything because I just couldn't keep up. And again I just kind of assumed that I was just a slow reader. (56)	Skim-read to keep up	'just' → downplaying her adaptive abilities. Adopted 'skim reading' to 'keep up' conveys a sense of passing, but this is prior to knowledge of Dx, and more referenced to her as 'just a slow reader'	Adaptation Self [deprecation and minimisation (just) and misattribution]
So actually for me when I did get diagnosed with dyslexia through the Deanery it kind of made me feel okay about myself because I wasn't thick actually who just had to work hard. And my general knowledge is very poor but actually there is a real reason for that. (59)	Dx made her feel ok about self	Dx made her feel better about self→ challenged self-belief of being 'thick' → reframing / reattribution Notion of 'general knowledge' being 'poor' when her narrative contains examples of this being challenged by objective views and evidence.	Power of Label [relationship between reframing and retrospective reattribution] Self [doubt in capabilities]
in fact now I find that I blame virtually everything on dyslexia which my family joke about really because they have all been diagnosed. (61)	Blames virtually everything on dyslexia	Blame implies fault, and couches this in negative terms...which feels linked to the function of an excuse (to avoid negativity) vs. explanation (to share understanding) Family joke → funny / ridicule / discomfort at this use...does it breech some sort of code	Excuse (within Power of Label)

		within the community?	
my husband was diagnosed when he was at school but in those days you didn't do anything about it. And the girls have both been diagnosed sort of since five and six because it is very, very obvious. So now I just keep...everything is because I am dyslexic. (63)	Husband + daughters are dyslexia Everything is due to dyslexia	'in those days didn't do anything about it' → temporal nature of diagnosis and support... 'very obvious' refers to visibility..cf. her? Hers wasn't visible until later. 'Everything'→ extremifying language, to illustrate pervasive nature of difficulties	Visibility Pervasive (within Difficulties / Diagnosis)
I can see so many...when I am working now I can see so many dyslexic traits in what I do. I took a telephone number down today and I transposed the numbers the wrong way round. And I do that all the time and I just never, ever realised it. (66)	Can now see lots of difficulties due to dyslexia	Visibility of traits dependent on knowledge of diagnostic status / awareness of label.	Visibility
I am really good with people. I am a really good...I have always been an agony aunt to everybody. And I am very empathetic and I get people and that is the skill I have. I don't think I have any other skills as such. I am not particularly analytical, I am not particularly mathematical but I am incredibly good with people, and that is what I do. (74)	Good with people	'I *get* people and that is the skill I have' → a sense of pride, but also a sense of seeking attributes to counterbalance her difficulties, to bargain for a sense of ability and ? worth	Bargain [relating to Self]
when I was working as a pharmacist it was all about people, people interactions, you know? And I have done a lot of training in education through my work and people, again working out	Skills are good at interactions and teaching		

who has got it, who hasn't, how to get them to where they need to get to, how to present things in different ways. That is the skills that I have definitely (77)			
I can remember when we did the mocks she sort of said, "From the mock I know already who is going to pass and who is going to fail." And I was very conscious that again during the training, the three months, I had been quite gobby and I had been quite happy to enter in discussion and debate and give my view and this kind of thing. And we had the mock which I passed actually and she said then, "Oh I knew." And she put sort of three of us as definites and then she had a couple of people as maybes and then she had a couple of people, "I think you will pass one paper (94)	Told by experienced mentor was definitely going to pass	Element of externally seen as very competent (contradicts self-view) but also notion of visibility of her difficulties – which are masked by her being 'gobby'	Gobby [mask of difficulties, but also self-deprecating] -Links to→ Visibility
when I got the results back from sitting it last January I had passed paper two but failed paper one and Jane was really surprised. So when I went to her for a debrief she was gobsmacked and she said, "I really didn't expect that from you. Everything had pointed to the fact that you would definitely be able to pass." (98)	Everything pointed towards her being able to pass	Surprise at failure → dissonance as trigger, but also implies expectation. Visibility of signs- construed as tangible - (everything pointed to a pass): ? we see what we want to see vs. sense of hierarchy of visibility in certain contexts.	Dissonance [performance vs. achievement] Visibility [of signs]

And we started talking and within that conversation I was talking about my children being dyslexic and my husband being dyslexic and I also mentioned at that point that my brother's children and my sister's children were dyslexic. And she said...and the way I actually explained to her what had happened during the exam was by the end...because the way it works in public health you have a morning exam and afternoon exam on day one and then a morning exam and an afternoon exam on day two. By the time I did...and the first day you do ten essays across that day. So you get a three and a half hour paper in the morning and you do six of them and then you get a two and a half hour paper in the afternoon with an hour gap to do the other four. And I totally mucked up the last question because I didn't read the question properly. And I got into my head that it said something and I wrote three quarters of my essay about this thing and then I realised that I had got the totally wrong end of the stick from the question. But by that point I had got ten minutes left and I hadn't got time to rewrite the answer so I just had to continue on this vein (109)	Answered the wrong question in the exam	Sense of a constellation of signs becoming visible when they were looked for: visibility *requiring trigger* 'mucked up' → metaphor invoking images of crap, waste → feeling crap / as if waste of space due to performance. 'Got into my head' → question as tangible / physical object to be absorbed / transmitted. Reinforced by 'wrong end of the stick' A sense of pursuing what she thought she read, vs. what was actually asked... this discrepancy created the space for her error	Visibility Deprecation (within Self) Knowledge (physicality) Discrepancy (within Difficulties / Dyslexia)
so when I was talking to [her] about it I said, "I answered that question and I know that wasn't the question they asked and I only realised that	Mentor thought she was dyslexic	Realisation but 'brain was puddled' – invoking a sense of her brain being waterlogged	Knowledge (as waterlogging – interfering with

ten minutes before the end because by that point reading that last question my brain was so puddled I just couldn't get it in there." And she was the one who said, "Well that tells me a lot plus the fact that you have told me all about this history of dyslexia in your family. I think you might be dyslexic." (115)		by information, a sense of drowning Sense of others knowing (that tells me a lot) about her, without her being fully aware – creates a sense of 'them vs. us' in the learning relationship	realisation and processing) Relationship (learning)
And I just kind of laughed and said, "Don't be stupid, of course I am not. I am the fast reader in the family, I am the one who does the spellings." And she organised for me through [Head of School] to go and have the 45 minute computer test through the Deanery and the results of that were analysed by [Dyslexia Specialist]. And she phoned me up that evening and said, "Actually it does show that there is definitely a tendency towards dyslexia." She said, "We can't tell any more than that at this stage but I think it would be worthwhile you coming to have the full half day experience to see whether you are or not." (121)	Screening suggested had dyslexic tendencies	Disbelief at being dyslexic – weighting evidence, created through coping, to deny it 'actually' implies surprise and a sense of initial distrust – reinforcing the notion of denial	Denial (within diagnosis)
I have to say I was really gobsmacked because I was absolutely convinced that I was the normal one in this family. (123)	Surprised as thought she was the 'normal one' of the family	'Gobsmacked' = surprised, reinforcing notion of denial above. 'normal one' = construing dyslexia as something that makes abnormal in a more	Denial Normality (within Self)

		generalised sense	
I went to [Dyslexia Specialist] and it was just such an illuminating five hours because to me it just kind of explained everything that has gone on in my past. The fact that I can remember sitting in those history and geography lessons and just going I don't understand a word that you are talking about and all the letters are jumbling and all the words are jumbling and languages I can't do languages and all the things that I had struggled with. (127)	Illuminating experience with dyslexia specialist. Remembered lessons from school, where things were jumbled and challenging	Historical recognition Dx as illuminating: being kept in dark, unaware, others knew…Dx as sharing this secret knowledge of self	Historical Recognition (within Diagnosis) Awareness (within Self)
And then when I went for the five hour sort of trawl through 1001 dyslexic tests that she does it became really obvious that I had developed a whole host of coping mechanisms that I had no idea that is what I had done. (132)	Doing the test made her realise she had developed coping mechanisms	Tests made visible the coping mechanisms she had developed → contextuality and invisibility of them	Visibility Coping [contextuality & invisibility]
So the things like the writing and actually the fact that I typed quicker than I could write was amazing to me. And my memory…if it is a subject that I am interested in and know about I can remember minute details but one of the exercises we did was about…oh gosh it was to do with some archaeological thing and I didn't understand any of the words, they were all too long for me. And I couldn't remember anything about it because I couldn't latch on to anything which I found quite fascinating. (137)	Amazed at being able to type faster than can read, and noticed memory cannot handle long words	Discrepancy between different skills. Familiarity aiding retention of detail. 'latch on' implies a physicality to knowledge: to be able to hold it	Discrepancy Knowledge (physicality)
I couldn't see patterns and things where apparently I should have been able to and that	Couldn't see patterns or read unrecognisable	Visibility of patterns, and familiarity aiding recognition	Difficulty (contextuality – familiarity and visibility

really surprised me. And words...as long as I can recognise the word I can read it really instantly. Very simple words that I don't recognise I couldn't do at all. (139)	words	and reading.	ameliorate difficulties)
I had always just considered that I was just a bit thick and that is why I sometimes couldn't read words. (142)	Always thought was just thick	'just' repeated → minimising / normalising the self-deprecation	'Just Thick' (feels like it would be within Gobby – which is within Self)
I can remember reading stories, I actually quite like reading now, but reading stories, and when there is a word that I don't know, particularly a name of something, I always used to just shorten it to the bit of the word that I would remember or could read. So if it was a big long word but the first three letters were Sid then I would call that person Sid. So if it was Sidaka or something like that and I couldn't get the end of it I would just abbreviate it. And every time I saw that word in my head I would just use the first words and the same with technical stuff. The words I didn't understand I would just abbreviate so that I would try and remember (148)	Would abbreviate names and words to bits she could manage to try to remember	'actually' – surprise, didn't use to like reading... describing coping strategy: abbreviation of words (active) in order to carry on...keep up, a sense of making do and minimising difference (? To go unnoticed, and avoid judgement)	Coping [there is a sense of active evasion of judgement here...reminiscent of passing]
I have always been one for really remembering rhymes and associations. So...I can't think of an example at the moment, but you know when you are trying to remember a whole list of notifiable diseases, I would make myself up little rhymes as to which ones were notifiable and which ones weren't. And I didn't know that	Always made up rhymes to remember things. This is something dyslexics do.	'always' normalises and routinizes the (coping) activity.... 'that was something dyslexics do' → a sense of a community	Coping [routinized, normalised...visibility – in background, only became 'visible' through label]

that was something that dyslexics do. Bizarrely it is always what I have taught my children to do. (153)	Taught children to do it	of practices	Community (within Diagnosis)[community of practices]
So whenever I have taught them how to learn their spellings and things I have always tried to think of rhythms or patterns or word associations that will help. So...what is because? It is big elephant. I can't remember what because is now. But we had little rhymes for all those standard words. So I did it with them because they were dyslexic but I never reflected that that is why I do it. (157)	Did it with children to help, as they were dyslexic, but didn't realise she drew on that because she was dyslexic too		
going and having my assessment with [the Dyslexia Specialist] was startling to me. And it was actually really lovely because she sat there and said, "You are incredibly clever. I can tell you are incredibly clever. You are incredibly articulate, you have learnt throughout your life to disguise your dyslexia."	Assessment was startling. Lovely to be told was clever, just disguised dyslexia	Assessment = 'startling' with loveliness - ? expected it to be horrible, and laden with judgement. Startled at the statements of attributes that contradict her self-belief	Diagnosis (expectations of judgement) Deprecation (Self) and Conflict (Self)
I have got published papers, I have done a PhD, all of these things. And she said, "You have just coped with it and you have never...because you didn't know it you have never used it as an excuse." And it was really lovely having somebody tell me. I don't know [her] from Adam but she told me I was clever. And I came out going, "I am dyslexic and I am not thick, I am clever, [the Dyslexia Specialist] says it." (164)	Lovely to be told by stranger that is clever, has lots of achievements, isn't thick	'just' coped → minimizing and normalising coping, became background / invisible. 'excuse' → sense of not using it to 'let off the hook' A sense of requiring external affirmation that is 'not thick'	Coping [minimised / normalised / invisible] Excuse Affirmation (within Diagnosis)

stupidly aged 49 it made a huge difference and it does now. I feel justified in doing what I am doing whereas when I got into the training I actually thought it was a fluke that I had got in. But now I actually think do you know what I got in because I am a bright person and I have got the ability like everybody else (167)	Thought was a fluke that she got into training, but knowing she had dyslexia, now feels is because she has ability	'stupidly aged 49' → a sense of being 'grown up' and so an expectation of not needing affirmations, or help… 'fluke' → thought due to luck, as if membership is less legitimate, as if will be discovered and expelled → *impostorship*	Diagnosis [Affirmation and *help* – linking to Expectations: should be independent when 'grown up'] Impostorship
So that label has been very powerful to me which I would never have been able to anticipate. And actually I think I am quite glad I wasn't labelled with it younger in life because I think I might have used it a bit too much. (170)	Label is powerful now, but glad wasn't labelled earlier in life	Label as powerful…giving power, significance and agency (ability to change things) to label…not anticipated: took her by surprise, unable to control: cannot *choose* to not assign significance	Power of Label
I think part of it goes back to my upbringing. So I am number three and I am a girl and in Jewish world being the youngest and being a girl means that really you cook and you clean and you don't really have a proper career. (177)	In her culture, expectation to cook and clean, not to have a career	Overhang from cultural heritage and family conditioning: youngest, subjugated to expected norms	Overhang Expectations
I have always been belittled a little bit in terms of my ability. So when I got my PhD for example my brother who is a lawyer, and I love him dearly, but he told everybody that I had a non academic PhD, which is…I just accepted because I am the youngest. And I can't be very clever really because I am just [Sarah] and I am	Achievements always been belittled because is the youngest of siblings	Significant achievements belittled. 'love him dearly' → resisting criticism of him, reflecting her subjugated position within family	Overhang (within Self) [strong sense of her having internalised the idea that 'can't be clever because is the younges']

the youngest. (181)			
so I think having the diagnosis of dyslexia explained to me so much and just gave me the confidence which maybe partly because of my upbringing and also because I did struggle with education. Up until I got my degree I was a thicko. I failed my O levels, I think I took ten of them and I got five. I failed by A levels first time around and I had to retake them and then I still ended up with a B, a C and a D. So I never really thought that I was clever. (186)	Was a thicko until did degree	Degree challenging the 'thicko' image of self...giving agency to external marker of achievement, no internal / inherent ability to challenge → conveying a sense of helplessness	Helplessness (in Overhang, in Self)
But having been labelled with dyslexia and having achieved what I have achieved just made me feel, yes clever, and justified in being where I am and I haven't got here by fluke. (188)	Having label *with* achievements makes her realise in professional role = not a fluke	Notion of needing label and achievements to challenge sense of 'fluke' → reinforces *impostorship* Agency given to external tokens (label + degree certificates) empowering them to change her sense of self, again reinforcing sense of helplesness	Impostorship Helplesness
And it is really funny because talking to friends who have known me all my life, people who know me now, I have got a friend who is very, very articulate and she is a journalist actually, and she proofread a lot of my...particularly for my MPH, she proofread a lot of my assignments for me. And when I phoned her up to tell her I was dyslexic she went, "Yes." I said, "What do	Friends knew she was dyslexic, but she didn't	Sense of others knowing (that tells me a lot) about her, without her being fully aware – speaks of visibility and perspective	Visibility [perspective is important: external vs. internal / self]

you mean?" She goes, "Well it is blatantly obvious you are dyslexic, why are you so surprised?" And I have had that reaction from loads of people which really shocked me because I didn't know I was dyslexic so how come they knew? (194)			
It is amazing what poor insight...or maybe not what poor insight, I think a lot of it is upbringing actually. I think my expectations of myself actually have always been quite low (196)	Low expectations of self	Self deprecating: 'poor insight' Attributing to upbringing: overhang Low self-expectations...because doesn't believe can achieve (as has internalised family conditioning)	linking Expectations with Self Overhang [internalised familial conditioning]
[Husband] has always, always been really supportive of me and always said I am the bright one of the family whereas I have always accepted that he is the...because he just gets things really quickly he is like a walking filofax he knows everything about everything. (199)	Always saw husband as the clever one of the family	External recognition of abilities...but because he is close (cf. dyslexia specialist – a stranger) his opinion isn't given as much weighting...possibly due to sense of 'rose tinted glasses' or wanting to please her with ?complements...intimate social comparison	Social Comparison (Self) Weighting [of opinion] (within Judgement)
He can teach the kids physics, chemistry, history, geography. He is severely dyslexic, much worse than I am, but he is incredibly intelligent so I have always just looked up to	Husband's dyslexia is worse than hers, can't accept that she has 'brains' as was told as a	'much worse than I am' → social comparison. 'got the brains' → knowledge	Social comparison (self)

him. But he has always said, "But no you are the clever one, you are the one who has got the brains in the family not me." And I have always fought against that because it was drummed into me as a young Jewish girl that I wasn't very clever. (203)	girl not very clever	construed as physical object to obtain and possess Active denial based on overhang from familial conditioning	Knowledge Overhang
having the label of dyslexia to me has just...it has given me a lot more confidence, not that I was ever short of confidence, but academic confidence it has given me a lot, and a label (205)	Label has given her academic confidence	Different types of confidence: academic confidence being one variant	Power of Label
I do say to people, "I am really sorry but I can't keep up with this reading because I am dyslexic I need a bit longer now." And I have actually done that several times and I have been at work and somebody said, "Just skim read this and then just give me the answer please, write me a statement." And I will actually say, "Well I can't do it within five minutes because it will take me longer to read because I am dyslexic. I am sorry I will do it as quickly as I can but I can't do it." Whereas before I would have struggled and I would have gone, "Okay, okay." And then I would have really got myself into a panic because I wouldn't be able to do it very well. (212)	Explains that cannot read quickly when expected to rapid-turnaround tasks at work	'sorry' – apologetic at difference, difficulty: guilt at not meeting expectations Diagnosis empowered her to challenge / correct expectations (cf. 'before') 'Panic'→ fear of not meeting expectations, of making a mistake, of pressure	Guilt (relating to Expectations) [and sense of fear] Power of Label
now I am much more open and just say, "I am really sorry but I am dyslexic, it will take me a few more minutes longer." So it has been really	Now more open, dyslexia label has been empowering.	'empowering' → emboldened to speak out about difficulties 'if I had have got it earlier in	Power of Label

empowering. God knows what I would have been like if I had have got it earlier in life, probably unbearable (215)	If had used earlier in life, would have been unbearable	like, probably unbearable' →sense of discomfort at challenging expectations, feels as if shouldn't be doing it, or doing it as much as she does, as if there is some sort of code relating to use of label	Codified Use (within Power of Label) [speaking of discomfort at over-use]
because most public health is just like I guess most medical training is actually on the job training, I think that people when I go to a new placement, they have...because I am gobby and I do sound like I know what I am talking about, I think that they have a greater expectation or a great expectation of what I am able to deliver than I can actually deliver. (222)	Because is 'gobby' people develop higher expectations of her	Gobby → feels like is projecting an over-inflated image (relating to impostorship) and this leads to over-estimated expectations	Gobby linking to Impostorship
now when I go to my placements I will make sure that everybody knows very early on that I am dyslexic and I will actually say, "What you hear come out of my mouth may not match the speed at which I will write reports or do a press release or whatever it happens to be. I am capable of doing those things but you have to accept that I am dyslexic." And I actually go in with that now to almost lower people's expectations. (227)	In new situations uses dyslexia to lower people's expectations	Impostorship actively managed through undermining the projected self, so expectations can be 'lowered' → a negative way of describing alignment...this conveys a sense of disappointment, as if she is letting them down...this action has agency, but the consequential *disappointment* is outwith her control.	Managed (within Impostorship)
I have got a PhD and I have done my MPH and I have worked at a high level in sort of strategic	Has a good CV, but tries to manage people's	A sense of her achievements *falsely* elevating expectations	Achievement [how success is defined and

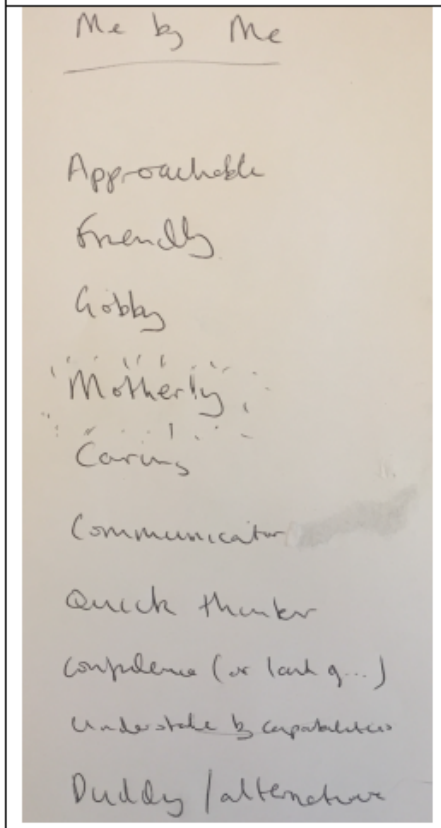
NHS work and education and training, I have got quite an impressive CV, I think people's expectations from me I try to manage them more now (229)	expectations	above her 'abilities'…misconceiving achievement with notions of working 'the same' …construing success as 1-dminesional	conceptualised, leads to interpretation of achievements in a way that affects Expectations]
Because for me the world of public health is very new and although I have got a lot of life experience I am not a public health consultant. I don't look at the world through public health eyes yet, I am learning to do that and so I need the opportunity to train just like everybody else. And I sometimes think that my trainers, certainly in my first placement, his expectation of me was way out with what I was capable of doing both because I am dyslexic but also because I am new to public health. (234)	Other's can have unrealistic expectations because of her dyslexia AND being new to world of public health	New world – explorer, brave, exciting and frightening. Looking through 'PH eyes' → evolution and development of physical attributes of consultant Expectations higher than her perceived capabilities, related to her projection of experience (via ? gobby-ness)	Knowledge (new, physical) Gobby (projection of experience, leading to →) Expectations
although I was 47 when I started with a big bit of knowledge behind me in life, public health is still new to me. (236)	Public health is new to her	'big bit' → knowledge as physical PH = new knowledge, sense of no foundations to this construction	Knowledge
I think I probably manage it better now and I try to reduce people's expectations of me. And I am quite strong in the workplace of not going out of my depth. And if I am beginning to feel overloaded with work then I will definitely say, "I can't take any more on right now, I need to	Better at managing expectations and pressures at work	'better now' → temporality 'try to' & 'quite' → uncertainty waits to be overloaded: reactive, trial to see if can	Coping

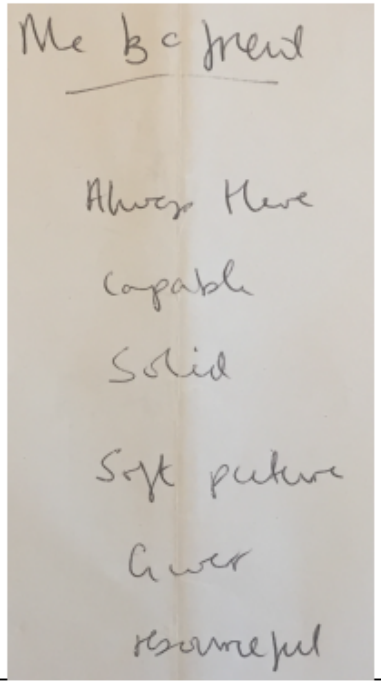
do these things properly." (239)		cope, can meet expectations	
I know that I have a tendency to do everything to the 80% level and that is not appropriate anymore in life, in public health I need to do everything to the 100% level. So to try and manage my natural way of working I try very hard to manage my workload. And how that will pan out as I become a consultant I don't actually know, that does scare me a little bit (242)	Needs to be working at 100% in public health, rather than her usual 80%. Worried about consultant future	A sense of conventions operating, a rule that she dare not break in this new 'world' Sense of impending crash – unable to cope, strategies won't work as a consultant…because of different expectations again	Conventions (within Expectations…bridges Coping)
I am very aware that I can make dyslexic like mistakes. I think I was always aware that I made a lot of typing errors for example but I probably wasn't aware that when I read things I read them through my dyslexic eyes. So now I am very…when I proof, I actually do proofread things and I try to hear the voice in my head say each word rather than just read each word that I think is there which is what I used to do. (257)	Aware reads with dyslexic eyes	'dyslexic eyes' → embodied dyslexia, but partitioned into specific organ Coping strategy → proofreading with voice in head, implies mistrust in default style	Dyslexia [partitioning] Trust (within Coping) [trusting of her strategy, mistrust in self → engagement of coping / developing new strategies]
So I think probably the quality of what other people see is improved now because I take more time at the detail of it. I think the other thing is…and I suppose this is a frustration for me, is that I quite often think that because I am quite quick at grasping hold of things. So for example today I was having to scope out a letter that the school could send to parents.	Words come from head to paper in a muddled way, only picked up on slow proof-reading	Knowledge construed as physical currency: words …getting muddled, lowering value, in her head. Frustration appears borne out of disparity, between speed of comprehension, and speed of (coherent) written output…her	Knowledge Frustration [includes sense of disappointment and shame]

So it was all in my head and I typed it all up and it was all done and I was really pleased, it took me a few moments and it said exactly what I wanted it to say and I was absolutely sure of that. And then when I proofread it really slowly I realised that I had got all my words muddled. Because it is all in my head and it comes down on paper but not the way I think it does. (265)		example also conveys a sense of disappointment (*was* really pleased)	
so for a moment today I was going, "I hate being bloody dyslexic, why do I have to be dyslexic?" Because otherwise in my head it would be what I thought in my head would then be on paper whereas I had missed out I's and they's and their's and I had got one sentence totally back to front and I had to go back and I had to back and I had to click on words and move them. And I was just like oh come on [Sarah] because I also knew that I was working to a 3:30pm deadline for the school so they could get the letter out. And that frustrated me. (271)	Frustrated working towards deadline, as had to spend time correcting slips. Hates being dyslexic	Intense frustration, hatred at her difficulties → discrepancy between what is in her head, and what materialises 'outside'	Frustration [hatred of dyslexia] (links with Diagnosis and Attribution – as can only direct hate towards it via the awareness and attribution)[this also links with coping as it is directing negative affect at something else rather than internally at herself]
Now in my pre diagnosis days I would have been really angry with myself and saying, "Oh for God's sake [Sarah], less haste more speed. Come on you know this, you are an 80% woman, you have got to slow down and do it properly you can't get away with it anymore." (274)	Pre-diagnosis would have got angry at herself	Resonates with sense that her *hatred at dyslexia* is a means of coping with the frustration borne out of difficulties attributed to dyslexia …here is an example of the '80% person' being deprecating (= you know you're not good	Frustration [Hatred at Dyslexia] (within Coping)

		enough)	
And that is what I would have been saying in my head whereas today I was angry because I was doing it like this because I was dyslexic. So it is a slight change of blame. It is not...I now blame the disease rather than blaming me (276)	Now has diagnosis, aims anger at dyslexia rather than blaming herself	Anger (similar to hatred) at dyslexia, 'a slight blame' = still *slightly* falls on her sense of self (as it is *herself* who is dyslexic) but it is attenuated, as it is mainly placed on this partitioned, yet embodied, disease	Frustration
actually my fourteen year old last night came home from school and she had had a really bad dyslexic day and she said, "Even in maths all the numbers were getting muddled up." And she was really angry with the disease. (2779)	Anger at dyslexia	Shared anger, a common enemy, a binding experience Different ways of being dyslexic: comparison of 1 daughter (just got on with it) with another (finds it very frustrating)	Frustration Different Ways of Being Dyslexic (within Coping)
And I had not really thought about it before actually because my other daughter she just seemed to accept that she was dyslexic and just kind of got on with it whereas [Maya] finds it very frustrating. And today when I was doing this letter I had that same build up of tension against the disease that [Maya] had identified last night. (282)	Her daughter finds it frustrating, and she had same build up of tension against 'disease' of dyslexia		
. Sometimes being dyslexic is really crap because it stops you performing. So it is a reason why you don't do things first time as well as you think you are and you can't change it (285)	Being dyslexic is crap	'crap' speaks of frustration constructing dyslexia as a physical hurdle – getting in way of doing 'things'...'can't change it' → surrendering	Frustration Agency (within Power of Label) [label gives something to surrender agency to]

		agency to it	
I keep thinking...because actually having been diagnosed with dyslexia and having got my extra time in the exam I kind of...I haven't chased up getting any other support because I kind of feel that I have got this far in life and I probably will just continue. (294)	Comparing her support to that which her daughter receives at uni (ClaroRead etc). Feels has got this far in life	'have got this far' → sense of 'too old' to change, missed opportunities to integrate newer approaches within coping strategies: a context and time-bound process.	Coping [context and time-bound → age & opportunities]
But sometimes I wonder like today when I was doing this letter, I was wondering whether I would be better dictating everything and getting somebody else to type it up which is actually what [Maya] my fourteen year old, she now has a scribe for everything. So she is learning very quickly and is actually flourishing with it at dictating physics answers, stories, everything she dictates. (298)	Daughter has found dictating really helpful, and she wonders if it would help her	A within-community social comparison, differential access to resources in different contexts. A sense of missed opportunities...	within Coping
because I have never done anything like that I kind of think oh I don't want to change I will just poodle through. I don't know, maybe I do need to take time to learn how to deal with it rather than just cope with it. I don't know. (302)	Doesn't want to change, but maybe needs to take time to learn to deal	'will poodle on through' → sense of 'too old' to change, missed opportunities to integrate newer approaches within coping strategies, but uncertain ('I don't know') and ? open to explore	Coping [context and time-bound → age & opportunities]

Transcript Text (line numbers)	Descriptive Coding (notes)	Interpretative Coding (notes)	Emerging Theme
	'I can't draw' (312) writes and discusses a list of qualities: Approachable Friendly Gobby Motherly Caring Communication Quick Thinker Confidence (or lack of) Understates my capabilities Duddy / alternative	Motherly highlighted → reflecting the significance this role has to her in her life 'duddy / alternative' → still casting self as *other*, but in deprecating terms…and Gobby comes up again	Gobby Self Confidence
So I think approachable. Friendly, gobby motherly, caring, communicator, quick thinker. I think that one probably really highlights me, very motherly. I think everybody always says that and I think it is really true. (354)	Describing qualities she sees in herself, very motherly.	Reflects above	Self (motherly, caring)

Transcript Text (line numbers)	Descriptive Coding (notes)	Interpretative Coding (notes)	Emerging Theme
	Always there, Capable, Solid, Soft Picture, Giver, Resourceful	Notice that friend's perspective doesn't contain anything negative (cf. personal view of self)	Confidence Self
I think always there, capable, very capable. Relatively solid, too keen to solution things. Not thorough enough, good with people. Almost too likeable. A bit off the wall and actually a bit of a threat. I don't really get that but I know one of my trainers has said it (347)	Describing qualities she thinks friends see in her – always there, capable, too likeable, a threat.		

As I say I don't understand it at all but he was very...yes. So I think this is quite a soft picture if you like. I am definitely...and people will always say I am definitely a giver but very resourceful. (350)	Soft picture, not sure why seen as a threat	Soft picture → gentle, harmless, comforting	Self

Transcript Text (line numbers)	Descriptive Coding (notes)	Interpretative Coding (notes)	Emerging Theme
	To keen to solution things Not through enough Good with people 'to likeable' Off the wall 'threat' Messy		
I have put not thorough enough because I think that probably is something that people consider me as. (351)	Not thorough enough	Fits in with her self-view of '80% person' → self judgement of 'not good enough'	Self
Well I think as a pharmacist I moulded a career for myself which probably allowed me to work very independently. I did a few years work in a community pharmacy but then I went into sort of training and education for pharmacists and then I did my PhD and then I worked in sort of strategic health authority management. But I always worked on contracts so I remained independent (357)	Engineered career to work independently	Found her way of coping → creating work environment where didn't have to be in an office and potentially get judged	Coping (historical coping)
And I always persuaded people to employ me to do the job not to employ me for an amount of time and I did it so that I could raise the girls from home and everything and be a mum. But actually I kind of wonder whether looking back now part of that was I didn't want to be part of a team where I could be	Persuaded people to employ her ? didn't want to be part of a team	Persuaded → bargaining, undermining legitimacy 'exposed for my oddities' → conveys sense of self-deprecation,	Bargain

exposed for my oddities. (361)		embarrassment and fear (of exposure)	Fear
I could work as many hours as I needed to do a report or to plan a presentation whereas if I went into an office people would see how I worked and I think that is part of my resourcefulness really. (363)	If worked at home, could do as much work as needed without being seen	A sense of covertness to her ways of working → hiding her coping strategies, and difficulties, to appear as if coping [this doesn't feel the same as passing, this just feels like hiding]	Covert (within Coping and links to Fear)
when I put myself into this position the one thing that scared me most about going onto the training scheme was the fact that I would have to work in an office full time and be seen every day by the people who could judge me. And that did…that scared me a bit definitely. (366)	Scared of working in an office, full-time, and being seen by people who could judge her	Fear of *exposure*: 'people could judge me' (for being 'duddy/alternative' or an '80% person') [a sense of fear of having her own negative self-image confirmed externally]	Fear
I have actually thoroughly enjoyed not working from home and working in a multidisciplinary kind of environment and I always get on famously with everybody within any department except for a really hard power crazed manager and you find one of those wherever you are don't you? And I always feel very threatened and very insignificant and very incapable in front of those people. (371)	Enjoyed working in a team, gets on well with everyone except power-crazed manager types	Doesn't get on with 'hard power crazed' types…cf. her 'soft image' from friend's perspective: clash, she is <u>vulnerable</u> (soft is easily wounded by hard) …this sense of vulnerability is enhanced by her perceived inability to perform capably	Vulnerable (within Self)
Everybody else in the departments wherever I have been, and I have been to four different placements so far, have always been 'you could run the place [Sarah], you can do this, you can do that'. But I am always afraid that one person will see through me and it is always the top guy, I am always sure that they will. (374)	Colleagues have told her she could run the departments she has worked in Afraid boss will see through her	Externally perceived very positively and as competent – contradicts self-view	Contradiction (within Self/Knowledge)

I still feel that everywhere I go. (374)	Still feels afraid (that she will be seen through by boss)	Links back to her fear and vulnerability - pervasive	Vulnerability
So this work that I have done today I have done it for the lead consultant within our department and I felt so pleased today because every time he said, "And don't forget to do this" I could go, "Oh I have done that." And, "Yes here is that letter" (377)	Able to show the consultant she is capable	A win→ sense of proving herself, which implies that she doesn't think she is 'good enough' ('80% person', alternative/duddy, going to be exposed)	Not Good Enough / 80% Person (Self)
actually I came away from work today with an absolute buzz because it is the first time I have worked with him on anything and it has gone swimmingly - touch wood - today and I kept totally on top of everything that he needed me to do and that has been a real boost (380)	Felt buzz from good day at work 'Touch wood'	'touch wood' → idiom introducing uncertainty, doubt and fear about her abilities and performance, and the potential to be exposed...this fear speaks of her pervasive sense of self – not being 'good enough'	Not Good Enough / 80% Person (Self)
Whereas when I was working in the local authority whenever the head man used to come down and sort of say, "Will you do this, will you do that" I would be like, "I can't do it, I can't do it. He is going to see, he is going to tell." So I think...I don't know it is kind of...I suppose really I think confidence is one word or lack of, and sort of understate my capabilities. (384)	Lack of confidence. Thinks boss will see, and be able to tell she isn't capable	'he is going to see' → fear of exposure borne out of her belief about not being good enough	Not Good Enough / 80% Person (Self)
although I appear very confident inside, especially in front of really big people, I am a quivering wreck and think I know nothing (385)	Quivering wreck inside, as thinks knows nothing.	'quivering' → fear, as above 'think' I know nothing→ potential for implication of doubt in that self-judgement	Not Good Enough / 80% Person (Self)
whether that is because I know that my dyslexia will show up at some point, at some point I will be found out that actually I am just a gobby person who is not really great at writing things, I don't know. And that has definitely...me by my trainer, I am always very	Knows dyslexia will 'show up' and she will be seen as being 'just a gobby person' rather than clever	This explicates her fears alluded to above – but the prevalence throughout her narrative indicates a pervasiveness and significance	Not Good Enough / 80% Person (Self)

wary. (388)		3 kinds of knowledge: 'gobby' and ? natural (referred to earlier)	
And I try really hard to get my trainers on my side very early on. And that has worked really well with most of them. One of them it didn't because of the threat actually with that particular person. I think he particularly felt that I came to him with all this knowledge and all this life experience and I was older than he was so I think that was our problem really whereas my other trainers I have deliberately gone in and sort of said...and been very open actually about who I am and what I know and what I don't know and tried to get them on my side before I then produce work for them which they are then going to go, "It is not great is it?" (394)	Tries to get trainers on-side and be open about dyslexia, before they say her work isn't as good as they'd expect	'get trainers on my side' → as if preparing a sports team to win a game, or army regiment to win a battle... getting the odds in her favour, bargaining...for chances of ?success / being perceived as successful Pre-empting her self-believed inevitable failure...again, speaks of her sense of self and lack of self-belief	Bargain Not Good Enough / 80% Person (Self)
It is funny isn't it because I know that if you asked my friends about me they would just say "[Sarah] can do anything. You ask her she will do it, she will make it happen." (396)	Friends would say she can do anything	'funny' speaks of the realisation of absurdity that she holds these fears/beliefs...external evidence of capability	Not Good Enough / 80% Person (Self) Fear
generally in the workplace people don't because I hide it until the big people it definitely comes out with, it comes out at. It is interesting isn't it, people? (399)	Lack of confidence 'comes out' in front of 'big people'	Vulnerability (soft person) manifests in front of big (hard) people...contextuality to her vulnerability	Vulnerability (contextuality)
I think they also think I am a bit messy whereas I like to think that I am quite duddy and a bit alternative (400)	Mess vs. alternative	Thinks is perceived as messy, and contrasts with another negative self-evaluation	Self [negative self-view]
I have been described as an old student by one of my trainers. I dress like an old student apparently which to me is quite a compliment really but he didn't mean it as a compliment,	Expected to dress the part, but is comfortable looking like an 'old student'	A strong sense of self and non-conformity... not equivalent to not-belonging, but belonging in a	Conformity (within Self)

Transcript Text (line numbers)	Descriptive Coding (notes)	Interpretative Coding (notes)	Emerging Theme
I ahve another example of hassle cos of being dyslexic.... I was doing the Ebola airport screening the other day and had to screen a gentleman who had been screened before but he had travelled again with his 21 day incubation time and therefore needed re-screening. he was very grumnpy about held up in his journey home and I tried to get through the screening process with him as quickly as possible. I needed his email address and I was writing it down on the form and he said it very quickly and I couldn't work out how to spell it! I asked him to spell it out but he did so so quickly I couldn't get it down, I asked him to repeat iot and he was getting more confrontational and yelling at me, I still couldn't get it down so i asked him to write it himeself. He tutted a lot but did do it (but he wrote it so badly we couldn't decifer it when he left!!) (12)	Struggled with man's email address and he got annoyed	Visibility of her difficulty interacting with man's attitude (implying expectation of desire for faster, more accurate working)	Expectation Visibility (of difficulty)
I really felt stupid and embrassed as I just couldn't sort out the letters in my head quick enough to get them down on the paper. I did try to make a joke about being dyslexic but he just gave me a look which said 'you are just thick'. It was, a horrible encounter and I am not sure if I dealt with it well or not, but it was certainly	Felt stupid and embarrased	Embarrassment speaks of shame about visibility of her difficulty, at not meeting expectations (to be quick and accurate → implied by man's attitude)	Shame

he wanted me to go and put a suit on and put some high pointy shoes on which was just never going to happen (403)		non-conformist manner	
I do find it really interesting talking about dyslexia in my world because each time you talk about it you kind of unpick a little bit more of you that you didn't really realise. (417)	Each time you talk about dyslexia, you unpick more of it	Dyslexia as a tangle, temporality and contextuality (talking) to understanding	Dyslexia (linking with Knowledge)
actually talking about my relationship with my trainers it makes me think actually I have…my coping strategy to hide the fact is to be very friendly and very open and actually I quite often will belittle myself and sort of say, "Look I am new, I am the oldest trainee." Things that people are getting really sick of me saying, "I am the oldest trainee in town." And it is like me making excuses before anyone finds out (421)	Making excuses before anyone finds out	Coping = to *hide*…her efforts are not so covert, as the intention to *be* covert	Covert (within Coping and links to Fear)
again I think part of that is my upbringing as a Jewish youngest female of the family but the other part of it is I know that when I produce anything written people will work it out. And that is always at the back of your mind, always (423)	Always at back of her mind about being found out	Fear lurking (at back of mind)…pervasive, in background…	Fear (pervasive quality)

an example of dyslexia being very much a part of not being able to perform well (17)			
yesterday i went to see a dyspexic support person to help me prepare for my Part B membership exams. I am doing the exam on 20/2/15 and have being panicking a bit aboiut the amount of reading and knowledge assimulation that is needed to perform the OSPHEs. [She] was able to instantlky see my issues and helped me develop a really clear framework which if I stick to should help. Her ability to see my issues and then help develop coping stratgies was just great, all I could do was see the problem which I was very able to articulate but i couldn't have developed the framework without guidance. (27)	Preparing for exams, dyslexia specialist able to see how to work around problems	'all I could do was see the problem' – speaks of perspective and visibility...of solutions (ways of coping) over problems	Visibility

Appendix 10: Coding notes for Helen

Helen – Initial Interview

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
I enjoyed school. I wanted to always do well. I didn't enjoy my last years of school, I felt that the upper school wasn't geared to help people that wanted to achieve highly, so I found that very difficult because they were more interested in people that had Ds and they needed Cs than the people that wanted to get straight As, so I felt I was unsupported during that and I had a lot of outside tuition because lots of my teachers kind of weren't bothered or I felt they weren't good enough and I wanted to do really well. (36)	School wasn't set up to help high achievers	Tension between enjoying (then not enjoying) school, and an implied sense of needing support (that was absent) Conditionality of support on externally apparent (visible) struggle	Visibility (conditionality of Support)
I didn't get into medicine the first year I applied. I felt that was because ... even though I'd got straight As I felt it was because I had made some bad choices about where I applied. I think I applied to too prestigious places and I think that was because I had bad advice because my	Bad a-level choices led to not getting into medical school 1st time	Directing blame to *choices* as if they were a convergence of external factors (support, advice, prestigiousness)	Blame (directionality)

school didn't advise me at all practically (46)			
I struggled a lot with English. I found it very hard to write kind of stories or essays ... I found essays really hard. I'm much better at factual things, so like chemistry and maths, they're very factual, and it's kind of if I think about medicine now I'm much better at like presenting a case which is ... you know, you're giving factual information than writing reflections. (58)	Struggled with English and writing.	Types of knowledge, learning and working (factual vs. narrative based). Struggle linked to narrative nature of writing in English lessons	Types of Knowledge
so if I speak to somebody I think I can really draw on the experiences of how I feel and what I could have done differently etcetera, but I find that really hard to put that from my mind and speaking into actually typing it and writing it, but I'm ... but having said that I'm not very good at just speaking, do you know what I mean? (62)	Finds it hard to put narrative from mind to paper	Thoughts as something tangible to be transferred Disconnect between being / thinking in a narrative and reflective way, and being able to communicate it freely	→ may relate to types of knowledge Cognitive Conveyance (disconnect)
My sister had just gone to university and for some reason – I don't know exactly why – but she was tested for dyslexia and they found out she was severely dyslexic and I think everyone – even my family – thought she was just not very clever (83)	Sister tested for dyslexia	Sense of 'thought she was just not very clever' being a phenotype for dyslexia in her sister…this seems negative,	Phenotype of Dyslexia (sense of this being different from her- so *difference* within phenotype)

around the same time I'd done my year nine SATs and I hadn't improved my English grade, so from year six ... so three years previous ... so in year six I got level five, five, five across English, maths and science which is considered good and then in year nine I got seven, six, five, so seven for science, six for maths and five for English, so my English grade hadn't improved at all, so then that was a bit of a shock because that isn't what they were expecting me to get (88)	Discrepancy in performance in English led to diagnosis	Sense of expectations being set uniformly high, which weren't met.	Expectations (within Visibility)
me and my brother as well went for dyslexia testing and they both said we had kind of a form of dyslexia. Not as severe as my sister, but ... and then like you said before did I get any support after that? Now I think back I don't ... we didn't really, (92)	She and brother had testing together. Both had a 'kind' of dyslexia	Different kinds of dyslexia – linking to ? phenotype (how it manifest and appears)	(spectrum – within) Phenotype
It's completely different. I don't know if that's because people are more aware of the fact and there's more things they can suggest and programmes and stuff they can put on your computer, but when I was at school nothing was provided for me in terms of, you know, like coloured paper (96)	More known and done about dyslexia now	Support conditional on social acceptance and awareness of condition	Acceptance & Awareness (within Conditionality of Support)

you know, all the things, apart from I was allocated extra time for my exams, but I didn't take any extra time in any of my exams, I think mostly because I was ... it's different when you're at university because you're in a completely separate room, whereas at school you're in the same room and everyone would leave and you'd still be there and I don't know, I think it was just hard to come to terms with ... I didn't want that to kind of be a weakness, I didn't want other people to think that that was ... that (102)	Extra time at university = separate room, but at school = same room	Conditionality of using support offered (extra time in exams) based on environmental context	Uptake (under Conditionality of Support)
You mentioned there that you didn't want it to be a weakness. R: More so from other people's perspective. I don't know. I didn't want people to think that I was getting better grades or whatever because I had extra time – if that makes sense? And ... yeah, I don't know what I was thinking then. It's different because I took all my extra time when I was at university. (109)	Didn't want people to see her as being weak and that better grades due to extra help	Premise that receipt of accommodation implies weakness.	Weakness (within Struggle & Attribution)
... I always dreaded English. I don't read for pleasure, I find it very hard. I never read for pleasure even now, mainly because I don't enjoy it because actually it's a struggle to read – if that makes	Dreaded English, reading a chore	Chore *but not struggle* implies unpleasant but not extra effort… explains that takes longer → more time	Work (discuss un/pleasant vs. struggle and effort)

sense? Like a chore, not so much a struggle, it's more a chore and it takes me a long time and I suppose more in school ... like I said before I struggled to write, I struggled to do the essays (124)			
so whilst I may be able to talk to someone if they were talking to me I couldn't ... I don't know. I suppose in some ways I'm a bit perfectionist, so I'd like keep going over my head ... oh like, "How should I start it?" And then I'd think of something, I'd be like, "No, that's not quite right," and then that would be going over and over instead of actually writing anything and then obviously your time's going and then, you know, by the time you actually start you haven't done anything (130)	Perfectionism would stop her from translating thought into writing	Perfectionist disruption of cognitive conveyance	Cognitive Conveyance
My brother ... we went to the same testing – if that makes sense? So it wasn't as daunting and ... I don't know, I just kind of went along with it because I wasn't against it, I just ... it was kind of one of those things. I didn't think about it too much I think (142)	Tested with brother, so not as daunting	Daunting assessment process → fear involved …doesn't think about it too much → ? creating sense of distance	Fear
I don't tell people, but I don't feel the need to. So I wouldn't like say it. I don't know. I never really say it. (148)	Doesn't disclose	Doesn't feel need→ to be open, or to share (because it doesn't manifest, or because she doesn't	Disclosure

		attribute)	
I think because I know that I've got it I know sometimes if I'm struggling with something I think it's because of that, but I try not to let myself struggle with anything, but then I suppose I just shy away things I can't do, so like I don't read really, apart from if I have to ... you know, (151)	Sometimes if struggles thinks may be due to dyslexia, but tries not to let herself struggle.	Interesting notion: permission to struggle (or the lack of) Soft attribution: 'sometimes' and 'I think' and lack of use of actual label	Permission (within Struggle & Attribution)
reads out loud for you and some other programmes to do with ... like spider diagrams and a Dictaphone to record lectures, although you weren't allowed to do that ... it becomes difficult in something like medical school to record things and extra time ... I think that was the biggest thing that I needed was extra time (170)	Difficult to record things in medical school	Environmental influence (conditionality) over utility of coping/support strategies.	Conditionality of Support [conditions of utility]
I think I found lectures very hard because ... I think they were the hardest thing because a lot of the other things I could do in my own time, so even if it took me three hours it didn't matter because it was actually my own time and I did do a lot of work outside of my time in medical school, but lectures I suppose were the hardest because I was kind of ... they	Things easier if could do in own time → taking longer didn't matter Fixated on specific way lecturers said things	Confidence in self-direction to learning: prizing and prioritising the *specific* way things were said / phrased by lecturers Coping strategy → over-working…easier in own time, as it 'didn't matter'…a sense of not	Visibility (of coping strategies / ways of working) Confidence (in self, in relation to learning)

would say something and I would think, "God, that's really good the way they've said it," and then I'd be fixating like ... thinking, "Right, I need to write down exactly what they've said like word for word," I find it really hard to like listen to what they've said and then kind of put it into shorthand or my own words. I want to write what they've said and then when you're doing that like they're obviously moving on and then you kind of miss the plot a little bit or you're trying to concentrate on the next bit and then, you know, you can't write as quick because obviously they're speaking quicker than you can write (190)		mattering because it was hidden, not visible, didn't impact on other things , like keeping up with class / peers in a lecture theatre	
Obviously I did my intercalation which was super-duper hard, mainly because obviously you had to write a lot and read a lot, so that took up a lot of brainpower, but in some respects it's nicer because it is very factual, you know, you're condensing other people's research, but there is quite a lot of review articles you can read and it's much more scientific writing. I find scientific writing a lot easier than reflective writing, even though I am a very reflective person (200)	Writing and reading took up lots of brain power Factual = nicer	Tension between being 'a very reflective person' and struggling with that form of writing/knowledge → much prefers 'factual' knowledge and writing	Work (discuss easy vs. struggle and effort)

yeah, what was the question? Oh difficulties. I don't think so. I suppose I ... what I was worried about was while I could have extra time in my written papers I could never have extra time in the OSCE, but part of the OSCE was reading, so you have to read what's on the door in a very short amount of time and I used to worry about if I was going to be able to read the scenario on the door quick enough before you go in because even though apparently they're supposed to have the scenario inside you're actually supposed to read it on the door and then go into the station and complete the station without then thinking, "Right, can I refer back to the scenario?" But actually it was OK. But I used to always worry about that (210)	Didn't think had difficulties. Was worried about not having extra time in OSCEs	Initial denial of difficulties …but then revisits struggle with reading and concerns about un-accommodated assessments. This hints at an internal conflict that may represent a resistance to acknowledging extent of struggles. Differential accommodation practices provoke anxiety in anticipation	Conflict (within Struggle & Attribution) Anxiety (within Conditionality of Support) [anxiety *at* the variable accommodation practices which are conditional on certain formats of assessment]
the hardest thing in terms of that is writing because of spellings, so when you're ... a lot of medical words, stuff like drugs and stuff, I have to look up ... or I've learnt what they're supposed to be, but when you're under a lot of pressure and ward round's going very quickly sometimes my words are not as great (218)	Struggles with spelling drugs on quick ward rounds	Environmental factors (speed) influencing struggle. Speed undermining / preventing use of coping strategies (looking things up)	Environment (within Struggle & Attribution) Coping (links with struggle and attribution *through* 'undermined')

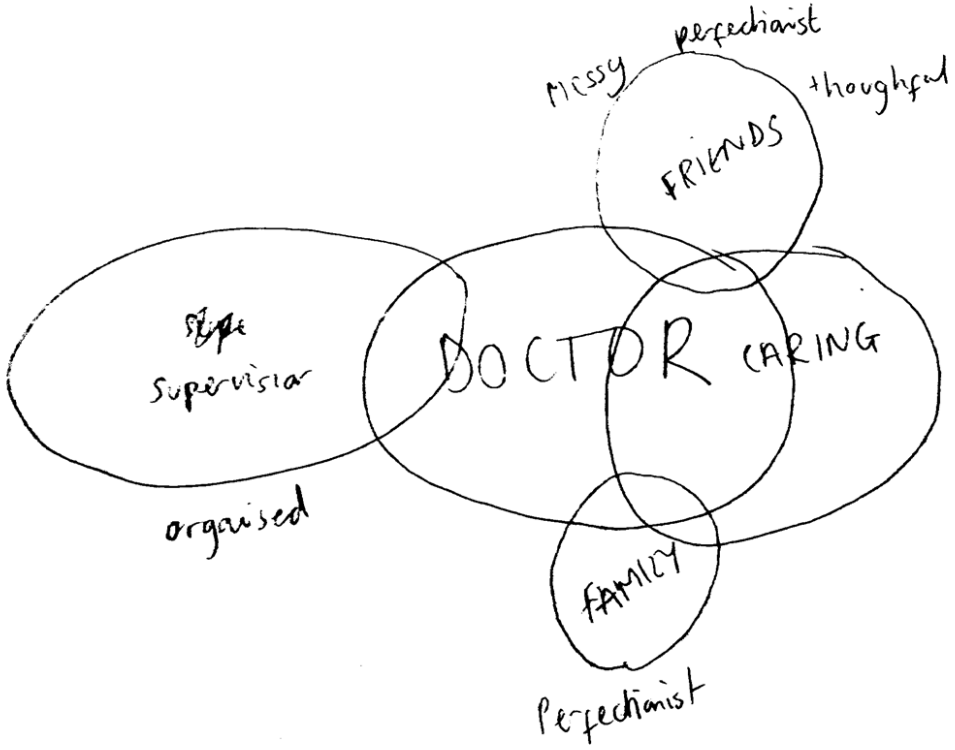
I can present the case very well, I know what's happened with the patient, I can talk about the bloods, everything, but then it's after that to then write in the notes a summary of what's happened – I find that really hard and I have to think really hard about what I'm writing and am I writing enough and in enough sense, you know, to encompass exactly what's been decided. **I: And how does that make you feel?** R: Stressed. I don't know. I know it's because of that and I do feel stressed about it and I think, you know ... I suppose frustration because you want ... I want to be good (229)	Recalling conversations for clinical notes is hard and stressful	Stress borne out of frustration → sense of not being good enough at specific task, of failing somehow and being found out.	Good Enough (linking to Struggle & Attribution *through* Stress and / or Frustration)
I don't think it's affected my professionalism – if that's what you're asking. But I don't think I've allowed it to (246)	Not allowed it to affect professionalism	Implication of fear that difficulties could affect professionalism [NB: wasn't the question] …but doesn't *allow* it to → exerting agency over impact of difficulties	Permission (within Struggle & Attribution)
I think I'm quite determined, I want to be as good as I possibly can, I think it's very hard to be as good as you can in the circumstances, not necessarily because of dyslexia, but the current job I have is so	determined	I want to be as good as I possibly can → conveys a sense of wanting to prove herself, and therefore insinuating that she doesn't feel quite good enough.	Good Enough (linking to Struggle & Attribution – but introducing a new element: Environmental Contextuality)

busy, you cannot be as good as you want to be which is horrible when you've always ... like sometimes you go away or you go away from a situation and you think, "I didn't ... I wasn't as good as I could have been, I didn't ..." not that I didn't do my best, because I did my best for that situation, but because of what's happening and the constraints and the busy-ness, you couldn't have done what you would have been able to do had you had time and no pressures (259)		…'it's very hard to be as good as you can' reinforces this → but this is attributed to the **<u>environment</u>** rather than her dyslexia…a sense of internalising environmental shortcomings	

Helen – Self Characterisation Sketch

1) how you see yourself

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]

		Being a doctor is **central** to her identity (centrality in graphic representation) …other things are peripheral (supervisor, friends, caring and family) but still an integral part. Other things are peripheral traits (messy, perfectionist, thoughtful, organised) but not integral	Professional Identity
so this is me and I'm a doctor which takes up most of my life, so I feel that's probably what represents me the most and especially now because you basically have no life, apart from being a doctor, but then I think I'm caring and I think that other people would see that as me whether it was a critical other or a sympathetic friend. (298)	**Bein**g a doctor represents her most – takes up most of her life	Doctor takes up most of her life = most significant part of identity	Professional Identity

This is my family and obviously they cross over because they ... the same as friends. Because you're a doctor and although they're supposed to see you first and foremost as a friend they never do and you've always got this title as a doctor and you'll always end up giving some kind of advice or caring for the ill people in your life and even outside of medicine which is why caring crosses over (303)	Friends and family never see you the same when you're a doctor – professional title changes that	Identity formation influenced by other's perception of her professional role / title	Professional Identity
for me my ... like my friends never cross over with my family and I suppose I have quite a difficult relationship with my family, so they're separate and also there's ... they don't cross over lots with my doctor job because they don't really understand what medicine's about it or what being a doctor is; like they think they do, but they don't and I suppose that goes the same for my friends outside of medicine, but not the same as another medic friend because they do understand (308)	Friends don't 'cross over' as much as family as they don't understand doctor job	Identity formation influenced by other's perception of her professional role / title	Professional Identity

2) how a sympathetic friend would see you?

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
I think my friend would say I was messy, but also I think they would also say ... but alongside my family would say I'm a perfectionist, is that how you spell it (310)	Messy but perfectionist	There is a sense that her perfectionism is an apology for not being good enough (e.g. by being 'messy')	Good Enough [Perfectionism linking to concept of not being good enough]
I think my friends would say I was thoughtful, I don't know if my family would say that. (315)	thoughtful	Doubt about positive attribute → alluding to a negative sense of self as perceived through, or projected on her family	Good Enough [negative sense of self manifest through doubt in positive attributes]
so I suppose for the family in some ways we probably are all dyslexic, even though my mum and dad haven't been diagnosed. Mum could never help us with our homework. She does read for pleasure, but it's hard (332)	Whole family are probably dyslexic	Sense of belonging not being contingent on a label, but more on an internalised sense of 'knowing'	Phenotype of Dyslexia (something conveyed sense of 'knowing' without diagnostic label)
I think she probably is dyslexic, like she can't spell, her writing is atrocious, but then it's hard because I haven't like done specific things to work that out and dad's probably the same, but I suppose it doesn't really come into that because	You're never exposing your dyslexia – so cannot tell if they are or not	A sense of dyslexia only being discovered if 'exposed' by certain factors → made visible through conditions	Visibility (exposure within this)

you're never exposed ... you're never exposing your dyslexia – if that makes sense (336)			
Or maybe you are, but we just don't know because we've always done what we've done, it's not out of the ordinary, you're not being challenged by your family, does that make sense? (338)	Just don't know if are exposing dyslexia or not in context of family	Doubt, and potentially fear, about exposing	
you're never put in a situation ... well I feel that when I'm with my family I'm never put in a situation that makes me think, "I'm struggling with this because I'm dyslexic." Does that make sense? Whereas that probably would happen in other circumstances because when you're with your family you're just watching TV or going shopping. (350)	Doesn't feel dyslexic when with family	Conditionality of *feeling* dyslexic: environmental + social comparison	Within **phenotype** is a sense of 'feeling' which complements the 'knowing'
What are those other circumstances? R: So if I was at work, say for example as I've said before like trying to summarise notes, writing a ward round (355)	Feels dyslexic at work	*Feels* dyslexic… Environmental conditionality of dyslexia and its (?)tangibility [not the right word]	Feeling - within phenotype
when I'm with my family I don't feel that dyslexia becomes a part of it because you're never being challenged ... well you're never ... not challenged so much, just it's never been brought to light that you've got it because there isn't anything	Feels dyslexic when feels struggle → not with family	Sense of feeling dyslexic being associated with struggle and failure	

to make you think, "Oh, I'm struggling with that." (363)		Social comparison (family) → conditionality of *feeling* dyslexic	
sometimes I think maybe ... like I was saying before I find it hard to kind of ... if I have ... if I want to say something or do something it's taking it from my mind and either writing it down ... so if you're like trying to communicate something with your friend, like if you have a feeling or something, that ... I find that hard and I think ... and I'm sure that's because of dyslexia (375)	Finds it hard to get stuff from mind to paper or communicate to friend	Difficulty, barrier or even disconnect between thinking something, and communicating it verbally or in writing → essence of her dyslexia	Cognitive Conveyance

3) How a critical other would see you?

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
They'd have to be connected to supervising me and I think they would say I was organised which I think's probably the ... well, I've decided that's definitely what you need to be as an FY1. (322)	Supervisor is critical other, but would see her as organised	Tension between feeling criticised, but being seen as organised (a positive attribute) → is this orgnaisation driven by fear of criticism	Professional Identity

Appendix 11: Coding notes for Gemma

Gemma – Initial Interview

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
I remember writing one of my GCSE assignments and being really proud of it because I had written it all by myself without anyone proofreading it or checking it or whatever and then getting it back and being really deflated because it was just covered in red pen, that was a little but gutting. (24)	Wrote coursework and was proud, but gutted to find covered in red pen when marked	Deflated and gutted → very physical responses to negative feedback, or perceived failure. Pain derived from mismatch between effort + expectation and resultant feedback	Perceived Failure
And I think they probably knew I was dyslexic really, we used to just kind of laugh about it and joke about it. And I never really pushed to get tested because I was doing fine at school and there was always that niggly feeling of what if I am not and I am just rubbish at English or writing or spelling or whatever it is and it is just because I am crap	Knew she was dyslexic → laughed about it.	Knew → some secret, tacit knowledge. Joke → her difficulties were source of amusement and / or ridicule. Niggly feeling – 'what if I am *just*	}- Dyslexia [encompassing difficulties, recognition, and ridicule]

rather than because there is a reason. **(28)**		rubbish → what if she isn't good enough, some kind of un-excused personal flaw…tangibility of self-doubt and self-disappointment	Doubt (within Self) Not Good enough (within Self)
I remember my physics teacher when I did my A levels, he was amazing, his name was Mr [Smith], and he was a big guy and you didn't want to cross him because he had a temper. But when you got to sixth form he just suddenly switched. So he was one of these ones that really kind of muddled through the lower years but he really enjoyed teaching the sixth form and he used to teach his third years on a Wednesday afternoon. And when I did my course work he used to come and get me to help him set up his third year classroom and get them going on an experiment. And then he would sit and he would be like, "Right what on earth were you trying to say here?" And he would go through it line by line literally and rewrite what I said and adjust it so that when we actually wrote it and sent it off I actually got the marks he said I deserved. **(38)**	Amazing physics teacher helped her	Significance of a 'big guy' who people 'didn't want to cross' (intimidating) was so open to helping her → sense of guardian, looking out for her, going the extra mile. 'marks he said I deserved' → he believed in her, which is why this was so significance	Ally (within Support) Belief (within Support)

I think he had a son who was dyslexic and he was like, "Yes you know." He never mentioned dyslexia, he never mentioned why but he just said, "Well you know if you need a hand writing it then come along and help out and we will fix it together" essentially which was lovely. And I sent him an...I e-mailed him after I got my actual diagnosis and he e-mailed back 'yes, yes I am not surprised. I am just glad you got to where you want to be'. **(43)**	Amazing teacher had son who was dyslexic	Insider knowledge of dyslexia → somehow tacit again (although different from above) + made her dyslexia visible to him …visibility of her difficulties (and therefore his ability to help) was contingent on this insider knowledge	Insider Knowledge → Visibility (within Dyslexia)
I had had a place to do medicine which was a deferred entry which I ducked halfway through. And then came back and said okay nursing is shorter, more paediatric focus which I knew I wanted to do, potentially academically not as difficult. (52)	Ducked out of medicine at first, and did nursing – thought was easier	Low self-belief in abilities: anxiety about abilities triggered a change in mindset about medicine, so studied a course that was perceived to be easier and more aligned to her strengths.	Self-Belief(links / within Good Enough)
So got accepted, got almost through to the end of Christmas term and I was on the phone to my mum and there were some assignments that were due in and mum said, "What have you managed to get some good books out of the library?" And I think I probably made a comment like, "I am not quite sure where the	Didn't know where library was, mum took as a sign of dyslexia	Visibility of signs of difficulty (organisation, avoidance of literacy-based resources / activities) → to others (mum)	Visibility (within Difference)

library is." Or, "I don't think I have made it into the library yet" that sort of thing, and there was just silence on the other end of the phone. And she was like, "Hannah will you please get yourself tested for dyslexia and please get some support." And I was like, "Yes, yes, yes I will be fine, I will be fine." (59)			
then I was like, "Actually the uni offered to pay for it because I completely flunked one of my assignments." And they were like, "This isn't like you, you work hard, we don't really understand what is going on." So they paid for it and I went and had it done. (62)	Failed assessment triggered university	Visibility of sign (failure of exam) → to others (university) Discrepancy between expectation and outcome	Visibility (within Difference…links to Dyslexia) Expectations (both feel like they relate to Dyslexia)
I just remember being terrified the whole way through that she was going to turn round and go 'don't be ridiculous you are not dyslexic you are absolutely fine'. And I don't remember finding any of it particularly difficult, I made a good attempt at everything she asked me to do. And then I got to the end and she looked at me and she went, "So how do you think that went?" "I don't really know, it wasn't that hard, it wasn't that difficult." And she turned round and she	Terrified of assessment Terrified of being told was just an idiot	Sense of: Fear + Relief + Forgiveness 'legitimately' → permission to	Power of Label (encompassing so much – all of those feelings as well as the action of legitimization)

said, "Hannah, I haven't looked at...they haven't formally assessed each component yet but I think it is pretty much 100% guaranteed that you are definitely dyslexic." And I was like, "Oh okay." And I walked out and I got back to my room at uni and I just burst into tears and cried for about half an hour because I was just so relieved that that was what it was, that it wasn't because I was an idiot, and that I could actually legitimately be like yes this is difficult for me and that is okay. (73)		struggle Cried → intensity of emotional response in private contradicts the calm exterior presented in public: deeply moving experience for her, but one that she wished to keep private and ? secret	
. It doesn't make it any easier really, it doesn't change how difficult it is to write assignments and all of that, but it just makes you feel a little bit less stupid. (75)	Makes her feel less stupid	The label appears to confer a sense of permission – allowing someone to struggle *legitimately* and NOT have it attributed to stupidity, but to this label, this diagnosis instead	Attribution → Power of Label
Difficult things were things like if I answered the phone at home and took a message I would remember that I had answered the phone, I would be like, "Oh mum someone phoned for you. I can't remember who it was and I can't remember why but there was definitely a phone call." Or I would completely forget about it until someone would say, "Oh such and such phoned." And I would be like, "Oh yes they phoned	Recalling messages was difficult	Information there, just needs external trigger → sense of justifying, conveying a sense of fear or shame about her struggle → shame Memory patchy and slippery→ expression of type of difficulty	Shame Difficulty (within Dyslexia, perhaps

earlier they wanted to talk to you about..." It is almost like the information is there but the recall of it isn't always from me. It kind of needs something else to trigger it. (93)			linking to Attribution)
strength wise I don't know, I am not very good at talking about good things about me. (94) I was always quite practical. So you could give me...I used to build a lot of Lego for my little brothers and sisters. And I could build...they would be like, "I want that" and there would be a picture on the front of the box but not necessarily the instructions, but I could build it anyway, that kind of thing. So my 3D kind of spatial awareness stuff was always quite good. (99)	Not good at talking about good thins about herself Used to build lots of Lego well	Modesty, sense of embarrassment (and shame) in talking about self in positive manner (self)Doubt: 'I don't know'	Good Enough
yes I guess I was always fairly...and I don't know that it is necessarily a dyslexia trait or if it is just a me trait, but I find the sort of empathy/compassion	Good at empathy and compassion	(self)doubt creeping in again: 'I guess' Neutralising the positivity in self-	Good Enough

side of things I can talk to people, I can sit with people, it doesn't bother me sitting in silence with people. (102)		judgement: 'fairly'	
do you think that having that diagnosis in...because that was whilst you were still in nursing, did that affect your decision to go on to medical school or having the diagnosis or the dyslexia affect your journey through medical school? R: Yes. I think it probably did because I...so I only did a year of nursing because I got partway through and realised I hated it...not hated it, it wasn't what I wanted to do, it wasn't the career I was after. And I realised that I was probably fairly influenced by me being really unsure of how I would cope with the academics of med school. And I think having the dyslexia diagnosis made it easier to then go forward and say actually I probably need to give it a go because it is probably what I want to do with life (119)	Didn't find nursing was for her. Diagnosis made it easier to go forward into medicine.	Diagnosis making easier to change career trajectory: permission to struggle 'look this is where I struggle' = feels slightly defensive, having to bargain… Support-seeking	Permission (within Power of Label)
I can go to them and say, "Look this is where I struggle, is there anything there that you can offer or support when it comes to exams or what is the set up	Can use label to help seek support	Differentiates from bargaining → there is a sense that the label, in this case, helps define *as well as*	Mitigating (within Power of Label)

when it comes to OSCEs that would help me get through. And it probably felt like I had been...not a bargaining, but kind of something to go with, so it would explain why I might struggle, whereas before it would have been oh well I think it might be quite difficult because I am not very good at spelling and I am not very good at reading and I don't remember things easily and I have to work quite hard at stuff. (126)		justifying the need. Mitigation …sense of pre-emptive apology	
But if I could go forward and say actually yes I struggle with all those things because then it probably was in some ways less daunting. (128)	Having diagnosis made medicine less daunting	The possession of a mitigating token made prospect of medicine less daunting → conferred a type of confidence to be able to try…galvanised her	Galvanised (within Power of Label)
The first couple of years were really difficult because they were quite intense in terms of workload like written, writing, reading workload. And I probably always felt like I had to work harder than everybody else partly because I felt like I owed it to myself to work hard enough to actually get through and partly because I kind of felt like I had to prove to the medical school	Initially difficult due to intensity	Intensity → felt like had to work harder than 'everybody else' = Social Comparison 'because I felt like I owed it to myself…and…had to prove to the medical school…was still good enough'	Good Enough (includes Prove Self) Social Comparison (linking to perception of Difficulty or Difference)

that even though I had dyslexia I was still good enough to stay in med school (136)			
in my year there was quite a core group of us there was about six or seven of us who were dyslexic and you always got your own little separate exam room which was...it tended to be quite nice because it was a lot quieter than the usual exam halls so I had no problems with that whatsoever. But it meant we kind of got to know each other which was kind of nice. (141)	Separate exam room quite nice	Sense of community and belonging	Community (within Dyslexia / Power of Label)
And med school weren't very accommodating the first 18 months to two years that we were there. So they kind of...before we all started we had all got this learning agreement that they basically said, "This is what we will offer you. If this doesn't seem enough for you then don't come" kind of thing. And then they kind of didn't do quite a bit of what they said (146)	Medical school not accommodating	Were made to sign up to unilateral agreement, that then wasn't delivered on… sense of monopoly and injustice. Conditionality of acceptance based on diagnosis…	Conditionality (Support…linking with Acceptance)
we kept going back to them and saying, "Look you said you would do this, you said you would do a print off of handouts from the lecturers who don't normally	Worked with welfare staff to try to improve support offered	Injustice again Sense of attempting to drive	Conditionality (Support…linking with Acceptance)

do handouts. You said in advance that we can scribble all over them so we can actually engage with the lecturer rather than trying to write everything down. And having it afterwards is no good because any notes that we have made we can't put together with the slides afterwards, it just becomes too tricky." So we did quite a lot of work with a couple of the senior welfare people in the medical school. (152)		change through collaboration	
talking to some of the guys in the younger years I know things have improved from that point of view in that the medical school offer less as part of their learning agreements and therefore stick to them rather than offering them more and not sticking to them. And I think they have...they did at one point have someone that they employed who was specifically targeted for them (159)	School now offers less	A sense of equality (not fairness) through lowering of standards…lowering expectations Also a sense of tokenism in the seemingly flippant response…	Conditionality [including sense of injustice, equality (not fairness), and tokenism]
I know it came out in quite a lot of discussions that myself and one of the other students in my year had with senior management teams at various points. And I think they were trying to stop gap because there was at one point I know one of the parents was threatening legal action that they	Legal action due to not upholding deal of support	Implies duty – contractual. We do something (disclose and agree to conditions) in return for acceptance and support…the conditions of this were not met	Conditionality [including sense of obligation and contract…which also ties into a sense of coerced disclosure]

weren't upholding their side of the contracts and that kind of thing. (167)			
I remember having one meeting with... I can't remember who it was, a male part of the senior team, who when I was speaking to him I was putting forward the general concerns of the group and I remember him turning around and saying, "Look if you think this is such a problem and it is so difficult then maybe you should reconsider medicine as an option." (176)	Told to reconsider medicine if so difficult	'If you can't stand the heat, get out of the kitchen' is brought to mind… creation of barrier, creating medicine as exclusive and *too* difficult…inferring that dyslexia precludes success… A sense of rejection and defeat and yet defiance at being told this	Good Enough (reinforced: basically told is NOT good enough in this instance) Injustice (links good enough with Difference)
So I remember one of our exams that they set up they extended the amount of time for it because the previous year it was an in course assessment. The previous year everyone had struggled to finish it in the time that they had been given so they made it longer. But they didn't give us any longer because they said they had made it longer for everyone so they had increased the time so we didn't need the extra time. And we were a bit like that doesn't make sense, if everybody else needs more time we need even more time. And that got sorted out right at the last minute. So there was a lot of less than organised	Was told didn't get extra time because EVERYONE got more time. Sorted last minute	Sense of injustice Downside to the 'dyslexia-friendly is everyone-friendly' argument: sense of wanting to be treated differently	Injustice (within Difference) → born out of not being treated differently

chaos around exams and things. (190)			
But it was just one of those things we kind of just got on with mostly and knowing who the other guys with dyslexia were made it easier because we could just have a bit of a whinge and a moan if things weren't going well. Otherwise it wasn't...it was just the way it was really we just got on with it. (193)	Just got on with it	Community Sense of acceptance of conditions	Community Link between Conditionality and Acceptance
Being on call on a busy weekend and having like 101 things to do and prioritising them. And it is hard to know whether that was just the fact that I was an FY1 and it is difficult at the beginning for them to prioritise and how much has dyslexia impacted? (199)	Hard to know if difficulty was due to dyslexia vs. busyness of on-call	Teasing out dyslexia-specific influence from environmental factors is difficult / impossible.	Difficulty [includes: Environment, and Complexity]
I think sometimes I find it difficult to ask for help because I am not sure whether it is something I should be able to do. Yes it is hard to know whether...it is kind of like am I finding this difficult because...and I should be asking for help because I am a junior doctor or do they just expect me just to be getting on with it? So I still find that difficult sometimes. (204)	Difficult to ask for help	Barrier to seeking help: 'feeling like an idiot' and not knowing if should 'just get on with it' This speaks of perceived expectations, linked to professional status. There is a sense of shame being a motivating factors operating here….	Barriers (within Support) Expectations (links Barriers with Social Comparison and Shame)

That is really interesting. Do you wonder if finding it difficult to seek help has anything to do with some of the things that you have mentioned around -? - Feeling like an idiot? **Well yes things around that and around the feeling that you have got to work harder to earn your place and stuff?** Yes. (210)		Feeling like an idiot reinforces the notion of 'not good enough' and undermines sense of self	Not Good Enough
It is easy to feel inadequate. So I was on call this last weekend with a registrar who is relatively new to the unit, has come from a big unit where he had lots of juniors previously, and on the weekend at Hereford you have an SHO, a reg and a consultant. And you kind of get torn in a hundred different directions (218)	Easy to feel inadequate	Easy to feel inadequate → not good enough. This incorporates a sense of environment undermining self, resulting in unfavourable social comparison (professional group is the reference point)	Not Good Enough
But for some reason the registrar who was on at the weekend isn't so keen on doing that and he thinks the SHO should be doing all of the clerking and split yourself into 101 pieces. So on the Saturday we got asked to go and see a	Colleague thinks she should split into 101 pieces to get jobs done	Sense of expectation & need to 'split' herself: be in several places at once, be several different things to different people simultaneously… a sense of the	Expectations

baby in the community postnatal clinic. It had a slightly skanky belly button and a patch under their arm that they thought might be a bit infected and was a bit grim. And he had said, "Oh yes, yes I will go and see it, I will go and see it." Fine. So I kind of just put that one out of my head because I was like I know I don't need to deal with that one, that is fine. And then on Sunday I ran into the midwife who had been in the clinic the day before who I know quite well because obviously we are over on that side quite a lot and we get to know the midwives. And she said to me, "Oh your reg isn't your biggest fan is he?" And I went, "Oh really why is that?" And apparently he had apologised to her for taking so long to go and see this baby because he was working with an SHO who doesn't do any work and it is always the same when he is on with that particular SHO and he has to pick up all the slack. At which point I was livid. Because (a) it is not true but (b) I just thought how unprofessional is that to say to somebody you don't know about a colleague? (240)		inevitably impossible. Notions of environmental chaos which factors in difficulties Sense of disappointment / let down *by* her – enforced through gossip	Plurality (Self) Environment Shame

But then me being me it was like well maybe I am crap, maybe I just think I am okay. Maybe I don't work hard, maybe I am just really slow. Maybe because of my dyslexia it takes me too long to do everything and actually I am dumping work on all of my colleagues all of the time. And I promptly got myself into a bit of a stress and I got quite upset. (245)	Thought she was crap because of feedback	Self-doubt: some of which is borne out of her relationship with her dyslexia …massive sense of guilt ('dumping work on all my colleagues')	Guilt (from Difficulty – linking to Attribution) Self Doubt → Not Good Enough
I didn't really feel like I could speak to the consultant who was on at the weekend but spoke to the consultant who was on this week who I was on with who assured me that it was nonsense as have many of the nurses. But there is still a bit of me that thinks well maybe there is an element of truth in it even though that is really silly (249)	Was told –ve feedback was nonsense, but still doubts	Self-doubt in face of credible evidence to the contrary: a 'bit of' her that thinks there is an element of truth: plurality in self	Plurality (self) Self Doubt → Not Good Enough
you know junior doctors are supposed to take longer than registrars because we don't know as much. But yes so there is a bit of me that wonders whether actually maybe I am a little bit shit and I think that probably reflects back to the feeling like I need to prove myself and not wanting anyone to think badly of me because then maybe they won't accept that sometimes I am slower because of	Part of her wonders if she is a little bit shit	Need to Prove Self driven by *part* of her that thinks she is a 'little bit shit'	Plurality of Self → 'little bit shit' → Not Good Enough → drive to Prove Self

my dyslexia. (255)			

Gemma – Self Characterisation Sketch

4) how you see yourself

Transcript (line number)	Descriptive Coding	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
		Me (purple): longer to document - Hard to recall minute detail Friendly (green): Loyal Team player Takes time but thorough Critical (red): Lazy Doesn't know patients well	

So the green stuff would be stuff that they would say 'oh yes well yes it does take her time to do stuff but she is thorough and committed' and whatever else whereas other people might perceive that as being lazy and just being a bit work shy. (289)	Friend would see thorough and committed, but others would think probably lazy and shy.	Contrast in friendly review between hypothesised friend's review, and a critique of that which feels like it originates from her self-doubt	Good Enough
Whereas I know that because of the dyslexia it just takes me longer to read and write and then document what I want. So even though I have done the clinical bit takes a reasonable amount of time but then the writing and documenting of it takes longer (292)	Dyslexia makes it take her longer to read and write.	Attributing specific difficulty to dyslexia	Attribution (within Power of Label)
Or after a clerking a lot of people will write whilst they are clerking but I will have a conversation with a patient and their family and then I will come away and write it so it kind of makes some kind of coherent sense rather than being oh I thought about this, oh I thought about this. Even though my questioning might be relatively coherent, if the history isn't then I come away and write it more coherently. (298)	Others write as they go, but she writes up afterwards	Social comparison here – suggesting she isn't like her colleagues (because of the way her dyslexia makes her work) that somehow conveys not being *as good as them* (not good enough) – conferred through the follow-up justification ('more coherently')	Social Comparison Good Enough

the purply stuff is kind of me saying yes okay I take time but I am thorough. But sometimes because it takes me a while to document sometimes someone who is being critical might see that as being lazy or I don't know my patients very well because I find it harder to recall stuff, like the small details. (302)	Self: thorough, but takes longer Critical: lazy	Self- deprecating, but justifying by linking to views of others' perspectives…including the view that this could be perceived as laziness: this conveys a sense of fear (shame at how long she takes – this is referencing an implicit social norm / convention / expectation)	Shame (links to / includes Expectations) Good Enough
Whereas people who know me well go 'yes we know she knows it well because we know she has taken her time we know she has been thorough, she just hasn't said it back to us, but we know she asked it' kind of thing. So I guess that is kind of the thought behind it. (305)	Knowing well = just taking time	A sense of knowing her conferring the ability to see underneath the performance façade to the underlying motive and effort → to a hidden 'truth'	Self (secret self / hidden truth)
So I went to see some friends last night and we were talking about FOP applications which opened about four weeks ago and close on Thursday that I haven't started yet even though I know that that is what I want to do... (314)	Leaving exam application to the last minute	Sense of inevitability: knows she wants to apply, recognises her pattern of behaviour (putting it off) but ? lack of agency in choosing alternative…	Agency (lack) (within Self)

I will probably get it written on Wednesday evening in all honesty and I will be really stressed about it on Wednesday evening because I won't have done it and I know that. I know that I should start it now but I still won't do it until Wednesday. I can't explain that and they look at me and go 'this is ridiculous, it takes time'. And I go, "I know, I know I need to do it." But I won't which shoots me in the foot. (318)	Will write application the night before the deadline and will get stressed	Recognises above, and that it will stress her: repeats 'I know' …but cannot explain why does it (and knows it is 'ridiculous') …reinforces sense of inevitability and self-sabotage (shoots me in the foot)	Agency Insight
my portfolio doesn't reflect well on me because I registered for my exams and the deadline was 4.30 yesterday. (321)	Portfolio doesn't reflect well on her	Concern about how she may be misrepresented by these tokens of conformity	Something about conformity and fear… **Shame** (which includes / links to expectations)
it had been open for two weeks but I did it at 3:30. And I had a minor panic attack because I didn't have the log-in for my RCPCH account. And when I phoned them they were saying, "Oh no you can't register for your exams unless you upload a copy of your GMC certificate" which was at home and I was at work which actually turned out not to be true. I just needed to put my GMC number on and it went 'yes you are automatically registered it is fine'. But then I had half an hour of panic being like oh my gosh	Panic over near miss of exam application deadline. Ridiculous pattern of behaviour. Set alarms etc.	Recognises above, and that it will stress her: repeats 'I know' …but cannot explain why does it (and knows it is 'ridiculous') …reinforces sense of inevitability and self-sabotage (shoots me in the foot)	Agency Insight …this somehow relates to Dyslexia, as she is attributing this style to her SpLD

what am I going to do? Because I don't have my GMC certificate because it is at home, this is ridiculous, so I am going to miss the deadline. And if I had thought about this two weeks ago when it opened for registration I would have been fine. And I did think about it, I had even set an alarm on my phone to say 'registration for your exams has opened' and I went oh good yes I will get around to that. And then oh crap it is nearly two weeks later it closes at 4:30 today and I still haven't done it and I am at work. (337)			
I get so frustrated with myself because I know I should have done it two weeks ago or a week ago or even three days ago and I would have known but it gets to the last day and I go, "Oh crap now I need to pull my socks up and do it now." And it doesn't matter how many times that happens I still...and that is why I ended up in [LOCATION] because my portfolio...I didn't leave myself enough time to make my portfolio good enough score to go to where I wanted to be. And I love [LOCATION], I am really enjoying it, but it is really far away from where I wanted to be for lots of personal reasons. (344)	Frustrated at herself because of pattern of leaving things to last minute. Recognises that this has had an impact on her career etc.	Frustration with self intermingles with her sense of inevitability / lack of control	Agency Good Enough (frustration is self-directed anger / self deprecating in nature)

Appendix 12: Coding notes for Paul

Paul – Initial Interview

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
I think something that became reasonably apparent relatively early that I think I was a reasonably bright child but after a little bit of a hiccup I think when starting I was very, very good at reading and clearly quite articulate, something that apparently hasn't changed much since and but I had a real difficulty with writing and spelling and written tasks but I think that projected all the way through (29)	Discrepancy between articulate ability and written ability detected early on	Reasonably + apparently (softening / doubtful / modest language) Metaphor: hiccup → minor, trivial...when things don't go as *expected* Discrepancy between one ability and another hinted at difficulties early on...feels unanticipated /unexpected	Self-doubt (linguistic) Hiccup (including: expectation / the unexpected)
my parents were more worried that … that I would probably because I was clever enough to hide most of it, I wouldn't get as much extra support and probably	Parents worried would cope, but not do well	Worry → concern at support not being offered because of appearance of coping...ability / coping as *negative*	Coping (negative) Self-doubt (from parental worry

wouldn't do as well as I could do (34)		Doubt → probably wouldn't do as well...held back from reaching potential	about reaching potential)
I think it was at secondary school I got identified as dyslexic which I think was very, very helpful because it gave me an explanation as to why I struggled with some things (36)	Identified with dyslexia was helpful	'I think' = doubting 'identified' (rather than diagnosed) – conveys sense of recognition, part of identity, integral Diagnosis was 'very, very helpful' because of support (& later we see clarity /explanation)	Identity (dyslexia is part of his) Power of Label ('very, very helpful' → affords access to support)
it wasn't that I was thick because I could clearly do lots of things but I found it very frustrating to get that onto the paper (39)	Wasn't thick as could do lots of things	Implication being the default assumption operating here is that he *was* thick, but that the diagnosis challenged that Frustration borne out of getting thoughts out onto paper	Power of Label (challenge assumptions) but also links to Self or Identity (as 'thick' is an apparent component) Frustration (speaks of something akin to cognitive conveyance [NB: this is notion from another's data])
and I remember being told by someone relatively early on I started getting some	Someone helped him by saying not to worry	Quite = modifying language	Doubt

specialist support, "Stop worrying about whether you can spell it, just write it and see what happens" and that was, that helped me quite a lot (42)	about spelling	Coping → one way of coping, or support, was to minimise anxiety around performance	Coping
and I think through that I then gained a lot more confidence and I started to find the things that I was really very good at which was more science side and I always knew that, you know, I was keen, very keen to go to university from there. (45)	Gained confidence, and was good at science	Found strengths, and confidence from support inspired his ambition for university	Ambition (fuelled by confidence gained from support)
I had some issues in my second year particularly my mum wasn't very well and I spent probably more time commuting between Leicester and Stafford than I did actually doing work at the time and I had some issues, failed my second year and had to re-do it and I think at that point I, one of the things that I said was, "Actually I'm not sure whether I am working …" I think with the dyslexia I wasn't sure if I was working as efficiently and effectively as I could be (56)	Struggled in 2nd year as mum was ill, but wondered if (because of dyslexia) wasn't working well	'Some issues' sounds euphemistic (like hiccup) ...life crises overwhelmed his ability to cope Failure (hiccup) prompted his reflection on learning and coping strategies in light of his dyslexia	Hiccup: as contributing to overwhelm of strategies (negative), and as prompt for reflection (positive)
although I'd had strategies that had clearly got me through secondary school the level of work and the information I was being required to retain and process was now a lot higher (58)	Had strategies that were outstripped by university work	Sense of established coping strategies being outpaced by what medicine demanded	Coping (outpaced)

		Required to retain- implies a sense of feeling like he *had* to do something, rather than wanting / needing to → a sense of lacking agency, of being a passenger on this element of the learning journey	Agency
and I had quite a bit of intensive support for probably about a year from the dyslexia people at the university which again I think changed a bit how I worked and you looked at some strategies and since then I've found things have, you know, things progressed very well (61)	Help from the dyslexia people	'Dyslexia people' → community (in this case, allies) something external changed how *he* worked...invoking images of mechanics	Community (linking Identity with Power of Label) Coping (re -/- calibrate)
I think I just needed a bit of reconfiguring to a much more advanced learning environment and since that I've, you know, done pretty well, came out of med school very, very well in the end (66)	Needed reconfiguring	Needed reconfiguring – again invoking imagery of mechanical processes, calibrating to new learning environment and expectations	Calibrating to pace, nature and expectations of environment
I've found that actually looking at education, how and why people learn and how we can help them to learn and to maximise their performance is something that really interests me but I suppose actually part of that is because I had some difficulties in that area myself and that makes it interesting to me and makes me want to do things with others. (71)	Difficulties in education have sparked an interest	Difficulties have sparked an interest. Difficulties have made the process of learning and drawing on support interesting. Wants to help others – sense of paying forward the support he had. This is imbued with a sense of positivity, agency and capability	Coping: *paying it forward*

I suppose from the sort of primary and early secondary school it was a very clear distinction. One of the bits I remember quite, quite a lot was that when I was in year five or six at primary school during, you know we sometimes we often had some reading time built into the day and, you know, we'd bring a book in that we were reading and I was ploughing my way through a copy of Lord of the Rings at a fair rate but our weekly spelling tests I could never achieve more two out of ten (83)	Discrepancy between reading and spelling ability	Spelling abilities didn't meet expectations determined by advanced reading skills	Expectations (within Hiccup)
since I've come to university and beyond that it's been more I think things like the organisational issues have come out more. I mean I still think and people joke it's a miracle that I actually manage to turn up on time to work every day with the level of organisation to have remembered my stethoscope, my ID badge, my pen and my stamp and I don't need a lot more than that and actually making it in with all those things is sometimes a little bit of a rarity. (98)	Now finds organisation difficult and people joke if he gets it right	Organisational issues have 'come out' more – become manifest, visible, emerged (is if from the woodwork) Joke: turns up on time Ridicule, minimises difficulty and trivialises the implication	Emergence (of difficulties) [more than mere visibility] – due to factors that outpace coping (related to Coping) Positivity (he interprets things in a positive light, and this could be seen as ridicule – but it isn't, it is a joke that he takes part in, contributing to positive reframe)
I mean I know that my spelling is still relatively disastrous but people can understand what I mean and I just for	Somehow able to spell medical terms, but most people know what he	'relatively' → implied comparison (relative to peers? To expectation?)	Expectations (within Hiccup) [construction of difficulties *through* comparison / benchmarking against

some reason have the ability to spell most medical terms correctly even if they've got 20 syllables (103)	means	sense of mystery ('for some reason') created around abilities → distances from self, not 'him'	socialised norms and expectations] In contrast: abilities are contextualised by a sense of mystery (inexplicable)
but I think I've just started ignoring that; I can't do synonyms and things like that. I will spell bear as in bear in mind. I will always spell it B-E-A-R and that's just regardless but I think that's become less of an issue and so much stuff is now computerised that the spelling and grammar bit kind of isn't so much of a problem. (107)	Spelling isn't much of a problem now	Now = implies it was → temporality, what has changed isn't ability, but due to ? acceptance or environment (technology)	Hiccup (mitigating the impact – environment & acceptance) → relates to **Coping**
It's sometimes more of the organisation side that has been an issue but I have tried to come up with strategies to cope. My phone reminds me every evening of what things I need to pack in my bag for tomorrow morning and I know that if I listen to my phone's reminder I will remember to do it and I try and set routines and things in place and I think I cope with that a lot better than I previously would have done because I've just had to learn how to get the strategy that lets me deal with it (113)	Has reminders from phone to try to cope	Organisation side → 'side' to personality / self (that struggles) with 'side' to performance goal 'I know if' → conditionality to coping strategy 'just had' → lacking in agency, forced by external factors	Coping: has a 'side', conditional, and sense of surrendering agency to external forces in order to develop strategies

I think being dyslexic gives me an advantage in a lot of areas. I have always found thinking my way through problems to be something that I'm really quite good at and I found that a lot in medicine. I just seem to feel like I can see the answer some of the times and talking to some of my colleagues and friends who are dyslexic sometimes things just seem to make slightly more sense because I'm not sure I follow an entirely lateral (122)	Thinks dyslexia can help him see solutions easier	The dyslexic advantage Sense of ownership & reframing dyslexia positively	Coping: reframing and owning
There was a lady who I saw in resus the other day and I looked at it and everything just seemed to slot into place and I knew exactly what I was dealing with and I couldn't entirely explain why I was absolutely convinced that this was the diagnosis and I was correct in the end but it just seemed to make sense (127)	Everything slotted into place	Evoking imagery of knowledge tessellating, or like Tetris: all fitting together, to complete the picture. Note the 'everything just seemed' → external control (it happened *to* him) and sense of mystery and the inexplicable	Agency (is surrendered to a mystical external force)
thing I used to really enjoy at school was chemistry. I always found I could almost … the way I could work my mind was just sort of almost physically watch my mind join the molecules together and things and that's how it all made sense to me.	Could see the molecules joining together – chemistry made sense	The way *he* could work *his* mind – actor as observer, exerting agency in this attribute	Agency (exerting it)

(130)		Observing Mind	Observing Mind
I used to just watch, make myself watch it unfold and talking to other people, friends who are dyslexic, they kind of almost use a similar technique and I just think that you don't always think necessarily laterally, sorry, you know in a linear path. Sometimes you have that slightly wider lateral view and it helps me to pick things up, it helps me to see problems in different ways and work out ways to deal with them and I think that's a real strength (136)	Dyslexia helps him think differently	Observing mind (actor as observer – of thoughts) **It** *helps* → conferring sense of power and agency to the condition (away from him)...	Observing Mind – a form of Coping
at secondary school. It was clear that things like my reading was at a fairly advanced stage as I said, you know year five, six I was polishing away through Lord of the Rings, do you know isn't completely exceptional but I could handle that level but I think at some point they did a, one of these assessment tests on you when I got to secondary school and my reading level was classed as adult and my spelling age was that of a six year old and that discrepancy, there was clearly something not right there that I could you know my verbal and my reading skills are so much	Discrepancy between verbal and written skills triggered diagnosis	'It was clear' – implies a certainty and visibility to this discrepancy. Implication that reading skills set up an expectation that he didn't meet. 'not right' – sense of deviancy	Visibility of difficulties – within Hiccup

higher than my written skills (149)			
I can remember the building it was in and I can remember going into it and I can remember going through some of the stuff and I can remember the discussion afterwards. (156)	Remembers being assessed for dyslexia	A strong sense of significance conveyed through the repeated 'I can remember'	Diagnosis (significance of experience)
it was, for me very, very positive because at the time I wouldn't have really understood what dyslexia was or anything like that but suddenly there was an explanation for why no matter how hard I tried I just still couldn't spell stuff and why my writing was, you know, constantly marked down if you set me a maths problem or a reading problem I could cope with it very well. I think it just kind of provided a reason why things were as they were (166)	Diagnosis was positive – provided a reason	'suddenly there was an explanation' – a realisation, a moment of illumination...unexpected	Diagnosis (positive experience)
it wasn't something that was wrong with me, I wasn't stupid, there was a reason for it and with some support we could work round that. (168)	Difficulties weren't because he was 'stupid'	Reason shifted locus of problem from him to outside of him...became something that could be worked around...changing the very nature of the difficulties: from stupid to struggling	Diagnosis = reason – shifted locus of problem
I think I've viewed it as such a positive thing. One of the things my mum did in	Because dyslexic role models could do it, he	Sense of community of capability demonstrating the possibilities	Community (within Diagnosis – bridging with Coping)

her dyslexia centre was she had a wall with you know the thing of famous dyslexics and I know if you...I don't know how many of them actually are true but you sort of get a list of, you know, all these NASA scientists and you know there's so many very successful people who are dyslexic and I suppose, you know, there's the thought if, if they actually some of them got where they were because they're, because of their dyslexia and not just … also in spite of it but also because of it then I've got that capability too (181)	felt he had the capability too	'even' with the dyslexia...	
There is I think certainly at one point there has been a lot of stigma surrounding it and I think some people would see it as a lazy excuse for kids who can't write or something like that but I've always mentally steered away from that (185)	Aware of stigma ('lazy') but has steered away from that	Agency – choice in being able to avoid stigma...implying there are 2 components to it: giver and receiver	Agency
I think there are a lot of positive aspects to it but also I've always felt if I see it as a negative problem it's going to be a negative problem. If I can look at it positively and think what I can do with this and what benefits this brings to me I'm more likely to get a positive outcome out of it. (189)	If thinks negatively, will be a problem, if positively will be an asset	The way he looks at it changes the nature of the problems – reframing, but also a very strong sense of agency being exerted here	Agency Reframing

I suppose there is still a little bit of an element of stigma to some of it. I've never had it but I can think of people who've been asked, well you know, "How can you be a doctor if you're dyslexic? What if you misspell a drug?" or you know, "What if your … how can you do this, your writing will be unreadable?" Well that's what everyone says anyway (200)	Still element of stigma	'still' – implies resistant to imposed agency / reframing...recognising an element of stigma doesn't disappear with positive attitudes... knows others who've had it: so change in attitude doesn't mean it doesn't exist, but has very much altered his perception and experience of it...	Stigma (resistant to change, modified by positive attitude / changing the way it is perceived)
I think that dyslexia's a strength. I think it's a part of what makes you the person that you are and you know you have experiences and things that I think help you relate to people but also I think by the time from my year I can remember there was sort of a discussion about for some of those with dyslexia about when we joined you know what sort of services and support was available and where to get to it and me and friend was just, there's loads of people there, there's loads of people with the same thing as you and they're, they're great people so it doesn't kind of, you know they're just as good if not better than you so it's not a problem (208)	Dyslexia doesn't have to be a problem	'I think' repeated, creating a sense of active construction of the reality of his dyslexia through agency over thought Social comparison as a positive thing → comparison within dyslexic community, not competitive, but 'all great people' → just as good if not better = doesn't matter ...the skill and ability of the community negate the perceived issues with dyslexia	Agency Social Comparison (Community) → *positive*

I find the organisational aspect quite difficult. It's not something that fortunately I think I'd ever really got to do again but managing a medical ward and a medical ward round has been very tough because you've got if I think back to my last job in care of the elderly I'm seeing sometimes on my own, sometimes with an F1, sometimes with a senior person 16, 17 patients on a ward round a day and I've got to remember them and I've got to remember about them for when I'm ordering things or doing things or speaking to people and I've got to keep a list of what I've got to do and I've got to try and prioritise that (225)	Found medical ward rounds very difficult	'organisational aspect' → facets of work, describes tasks with a sense of chaos and difficulty, and a sense of fear 'I've got to' → conveying a sense of obligation, duty and even fear (or else consequences etc.) A sense that the number of people under his care being a stretch (16 or 17) → implying a risk factor for chaos	Facets of Work → Hiccup
Sometimes there are things that you forget to do or it's been busy and someone's interrupted you before you'd written it on your list and it hasn't migrated it onto my jobs list and if it's not on the job list it isn't going to happen and actually managing that I found really, really difficult. (233)	If missed off his list, a job won't get done	Interruptions as risk factor Information migration → a physical, tangible task that can disrupt *his* internal cognitive processes The 'you' here implies others, but also implies externality to the locus	Risk Factor → Hiccup Describing components of **Hiccup** and in doing so, alludes to an external attribution or loss of agency to someone/thing else

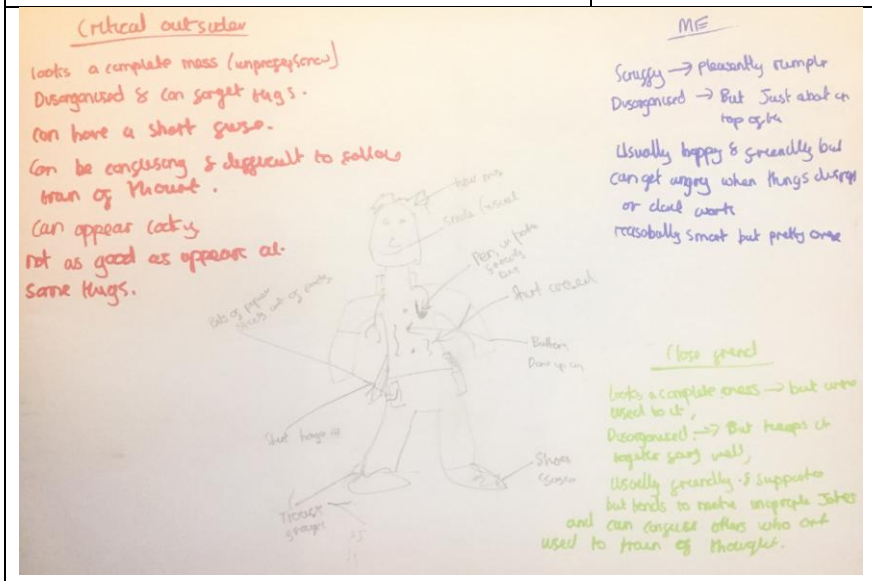
I've got my strategy, I do all my list, I like my list in a certain way. I have a know-how, how I initial jobs and I try and give a priority to order to some of them or a time when they need to be done with just, I've got my own little shorthand notation for it all but, you know, the points where this frequently happens I misplaced that list round the ward I'm stuffed because I can't handle that and if it hasn't but actually just remembering you know when it gets onto the second page it's not all in front of you in one group what job needs to be done next is really, really difficult (240)	Has strategy, but these can go wrong (e.g. losing list) and finds difficult	'I misplaced that list round the ward I'm stuffed because I can't handle' → a sense of precariousness and impending catastrophe A sense of recognising the difficulty of the task, and in doing so- excusing finding it difficult (irrespective of underlying SpLD)	Hiccup (precarious balance)
but for home I've got, you know, an electronic jobs list which goes in my phone, my computer and my tablet and when I need to add something I just remember to put it in and it's across everything so I can always see it but at work I can't do that, I'm not allowed an electronic list. I can't have things with patient details on and I find that really challenging at times (245)	At home has electronic lists, but prevented from using this strategy at work	Coping strategies being environmentally contextually specific / operational 'not allowed' → a sense of injustice at having his coping strategy barred from use in work....as if he is being set up for a fall somehow	Coping (contextuality)
It's not so much in A&E because I've rarely got more than three or possibly four patients that are physically mine in the department so I'm only having to	A&E is easier because fewer people on his 'list' but distraction and complexity of tasks is	Environmental contextuality to difficulties → manifest in wards, but not in A&E because of nature of	Hiccup

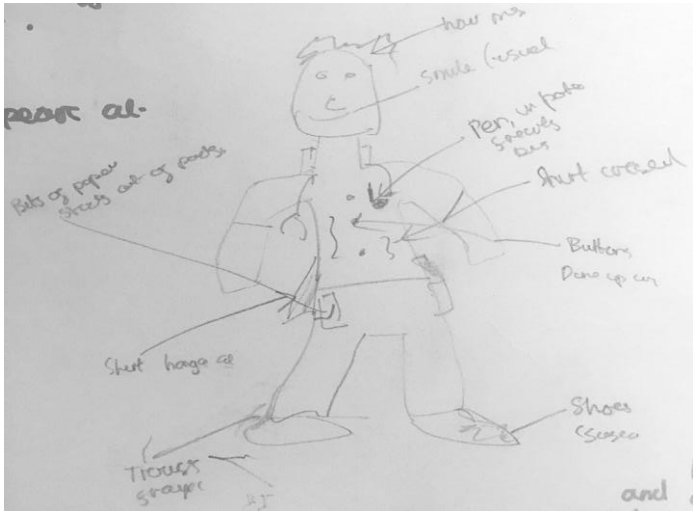
remember one or two things but even then because I'm not actually using a written list in front of me all the time remembering that I've got to balance doing that and that and that has to be done within this time limit so I need to get, chase that CT and make sure that the ward referral is in place and at the same time someone's distracting me about and I find that organisation very, very difficult (253)	challenging	tasks and task-patterns	
I've had the label at least of dyslexia for so long I think it's an integral part of who I am. I'm good at the thing I think at least that I'm good at the things I'm good at because I'm dyslexic and I'm bad at some of the things that I'm bad at because I'm dyslexic but that's just a part of me (266)	Dyslexia responsible for good and bad parts of him, but there is more to him than that	Temporality of integration of label. Sense of seeing dyslexia as responsible for positives somehow mitigating against the difficulties it causes too Parts of self	Diagnosis / Power of Label
sometimes because you've had a problem in one way or another it's easier to identify with other people who you see who have a problem. It doesn't matter what that type of problem but you see,	Dyslexia has changed how his life works so affords extra empathetic dimension	Positive attributes afforded from experience of adversity → attributing a self-identified trait (empathic) to his experience of difficulties, which he in turn is	Power of Label / Coping → attribution of positive outcome to label help him cope with or somehow justify the negativity

you know the Crohn's patients is just an example off the top of my head who have something that changes how their life works. Well I don't have Crohn's, I'm not equating the two but actually I've grown up with something that changes how my life works so I think that gives me an added empathetic dimension (274)		attributing to dyslexia	
actually I suppose at times it can work the other way and you think, "Well come on" you know, "I can manage this, sort yourself out" (275)	Experience can work the other way – 'if I can do it, so can you'	The double-edged sword of social comparison: can imbue a sense of capability, and also qualify a sense of judgement	Within-Community Social Comparison
I think you have a little bit of an understanding into how that works but I think the way I've grown up with the personality traits that I have I'm, I feel at least and I seem to get the feedback that I'm good at talking to people and relating to people and I think part of that comes from the dyslexia but it shapes your personality to an extent with some of those traits and you know you get good at the things that you're good at (281)	Understanding Good at the things you're good at	Positive attributes afforded 'in part' from dyslexia → attributing a self-identified trait (good communication) that has been reinforced by others' observations, to his dyslexia ...does this mean he is attributing positive outcomes to something he has (admittedly) integrated but talks of in terms of being a separate 'part'	Power of Label / Coping → attribution of positive outcome to label help him cope with or somehow justify the negativity

Paul – Self Characterisation Sketch

5) how you see yourself

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
			'Me': scruffy → pleasantly disorganised → but just about on top of (?) Usually happy & friendly but can get angry when things disrupt or don't work Reasonably smart but pretty coarse(?) 'Close friend': looks a complete mess → but we're used to it, Disorganised → but keeps it together fairly well, Usually friendly & supportive but tends to make inappropriate jokes and can confuse others who are used to train of thought.

<table>
<tr><td colspan="3"> 
</td><td>‘Critical outsider’:

looks a complete mess (unprofessional)

Disorganised& can forget things.

Can have a short fuse.

Can be confusing & difficult to follow train of thought.

Can appear cocky

Not as good as appears at some things.</td></tr>
<tr><td>all joking aside that’s frequently a little bit how I look on an average day at work so I’ve usually got my hair in a complete mess, there’s probably a pen burst in my pocket, my shirt is probably creased and hanging out at the back, bits of paper everywhere sticking out of my pockets. (388)</td><td>Joking aside – scruffy appearance</td><td>Recognises some element of humour in his appearance...does this humour come from identification with a stereotype, or with an external representation of chaos

...there is a sense of embarrassment or shame here</td><td>Chaos → Hiccup (some sense of internalisation and embarrassment)</td></tr>
</table>

my list's very important but I try to remember to dispose of my lists every day from one day back so I've always got … but I sometimes end up with lists in my pockets and forgetting which one's which and five copies of one and not having of the other (391)	Lists are important, sometimes forgets some or has old ones	His coping strategy (lists) is prone to failure in chaos – manifest here as spilling out of his pockets 'I try to remember to dispose' → implies a sense of justifying or excusing, seeking forgiveness, emphasising his effort	Chaos (? Within Image / Self) Hiccup (a sense of fear or shame or wrongdoing)

Paul – Self Characterisation Sketch

2. How a sympathetic friend would see you

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
I would jokingly consider myself pleasantly rumpled; it's the sort of, you know the friendly, family GP who doesn't iron his shirts type look and I think a lot of my friends would be quite used to me just looking a little bit generally scruffy and disorganised but I think I usually just about keep on top of it and I think my friends would agree (397)	Joke: pleasantly rumpled	Considers himself a joke, a sense of diffusing tension around embarrassment and shame at his chaotic appearance / persona... 'just about keep on top of it' → sub-visible struggles (relating to Hiccup)	Shame / Chaos (? Within Image / Self) Hiccup

but I suppose some might see me turning up, you know with bits of papers and wear a shirt that's a complete mess, shoes fairly dreadful, trousers frayed as usual round the bottom as looking quite scruffy, messy and unprofessional. (400)	Some might see him as unprofessional	Shame is alluded to here- a professional shame...an incompatibility	Shame
I think I just about keep a lid on it and I think my friends would agree that I can be disorganised and I can forget things and if there isn't a mechanism in place to stop me forgetting something I am going to forget it and that can be a worry (403)	Just about keeps a lid on it	'just about keep a lid on it' → reinforces notion of sub-visible struggles ...enabled by coping strategies (where there *is* a 'mechanism') but manifest / made visible where there isn't one available	Hiccup (visibility)
I suppose if I look at, I don't think I've been, well touch wood at least, not involved in any sort of serious clinical incidents but I can think of things when they have gone wrong or you know when I've misread something under pressure which anyone can do or just forgotten something that somehow didn't make it onto what I was trying to do and there have been problems around that. I don't think it's more than anyone else ever has but that can be an issue (410)	Not involved in serious incidents, but recalls times where has misread or forgotten something	Forgetting = near-miss: normalised (no 'more than anyone else ever has')... a sense that this normalisation is offered by means of an excuse or apology.	Hiccup → normalised
I usually think I'm relatively happy, friendly and I think most of my friends would agree with that. I tend to go for the usual variety of thoroughly inappropriate	Relatively happy, tells inappropriate jokes, and can have a short fuse	Usually – implies sometimes (significantly) isn't... Counterbalance to positivity = short	Positivity within Coping (counterbalanced / contrasted with Short Fuse)

jokes and all this kind of thing but I think it's relatively typical of, well, certainly a lot of my friends but I can have quite a short fuse and I think people from outside could see that and I suppose I can get very frustrated when things aren't going how I would like them to and you know another day where I'm going to be at work until 8:00 even though I finished at 5:00 and I'm really tired and then something throws up (418)		fuse... Frustrated when things aren't going his way → tipping point beyond extra effort...	Relates to Hiccup
the IT infrastructure at my place is appalling and the computer won't turn on again and this is delaying me and I've got five things that need to be done and that job has to be done in the next ten minutes and this bloody computer wouldn't turn on again and there have been incidents where things have gone flying around the ward because I've just got so angry about it, you know the red mist descends and the caution cleaning sign disappears up the hall and that, that has happened. (424)	Frustrated at equipment not working resulting in kicking signs around	Here, his coping (emotionally) is overwhelmed: demanding task + environmental limitation → frustration + emotional outburst	Short Fuse → Coping & Hiccup
You know I might joke about it but that doesn't really look very good if you walk onto the ward and see the junior doctor booting the cleaning signs around, it doesn't look great and I think some people could, you know find that actually to look	Venting frustration can appear unprofessional	Concerned with compromise of professional appearance by overwhelmed coping. Insinuated negativity ('doesn't look good') adding to sense of Shame	Image (professional) → relates to Chaos

quite unprofessional (427)			Shame
Sometimes I tend to know what I'm thinking but because my train of thought moves at a pace sometimes I find it become disorganised and what I'm actually saying doesn't come across very well and I think I'm quite good at communicating. It's very easy to get lost and you know my friends are used to it. I think, you know, they've all known me long enough that they will just tell me I've descended into utter garbage but actually, you know, if I'm talking to somebody else and something breaks my train of thought and it, it can go to pieces (435)	Train of thought can sometimes become disorganised	Metaphor: Train of Thought → breaks into pieces and 'descends' into 'garbage' ...*despite* being a good communicator (implied: generally / otherwise)...his façade shattering	Coping (his abilities/strategies overwhelmed, and derailing his thoughts, progress and professionalism)
I suppose I've always thought of myself as actually reasonably smart but probably about average. I certainly hope I would be average for the sort of thing that I do. I think others sometimes find that some of the extra things I've done make me appear very smart but I suppose some might see that as being quite cocky and although I don't intend to be that I think I very much could give that impression and you know there's lots of things that I've done (442)	Thinks he is reasonably smart but average, but thinks others may see him as cocky	'smart but average' → contrasting social comparisons: one with ? dyslexic-peers / general public (smart), the other with medical peers (average)	Social Comparison (within a plurality of communities)

I could appear as not as good at things as I might have given the impression of; that's probably because I've given the wrong impression as to what I actually do and can do (446)	Could appear not as good as impression he has given	Sense of self-doubt and fear of fraudulence (or of being found out)	Self-Doubt → Image
it just depends, you know, I think a relatively rumpled appearance but I just about hold it together professionally and I've got the coping mechanisms that will let me get away with most of it but actually when that breaks down it can break down quite spectacularly and it will usually result in me being very confusing and getting very frustrated and getting very angry at the things and that's quite hard to overcome and I think part of that is the dyslexia (453)	Just about holds it together professionally, but when coping mechanisms break down can become confusing and frustrated	Sense of desperation and being overwhelmed... 'professionally' implies different facet to 'holding it together' → plurality of projections: professional (sense of being clinically competent and organised) versus some form of personal / superficial (appearance etc) → this speaks of self doubt	**Coping** (his abilities/strategies overwhelmed, and derailing his thoughts, progress and professionalism) **Image** **Self Doubt**
sometimes I can't understand why I can't retain this thought or this plan or even though I know perfectly well why I can't but I've forgotten something and something's distracting me and it's breaking my coping mechanism and it's gone to pot (456)	Can't understand why he can't retain information. Distraction breaks coping mechanism	Environmental factors influencing integrity of coping strategies → described in terms of physical mechanisms that are vulnerable to breaking	Distraction → Coping & Hiccup
I'm very keen on playing cricket; I'm actually bad at it but I find it resulted in me tending to umpire in school in the last couple of years so I did some more of that	Keen on cricket – has a routine that, if broken, becomes easy to lose way with the game.	Drawing on analogy of finding niche (umpire instead of player) and coping (routine) from one field (cricket) to	Coping

as well but we were, I was at a training session for some of our local area the other day and we were talking about your routine of doing things on pitch and actually if somebody breaks that routine it becomes very easy to lose your concentration and have a problem and I suppose that's true. If something disrupts how I want to do my ward round or how I am approaching this, something interferes with me (465)	Same applies to clinical work.	another (medicine)	Distraction → Coping & Hiccup
and there's a paper, what was it in, the BMJ Quality and Safety or something like that was suggesting that in an average clinical environment you are interrupted four times an hour. In A&E it's up to six times an hour and that interruption is really difficult for me to deal with and I suppose that leads to some of the frustration and some of the other things that come out of it and I think that may affect how other people, particularly critical outsiders see me (471)	More distractions in A&E and finds really difficult, leading to frustration, which may affect how other see him	Describing environmental factors that can overwhelm his coping and compromise his professional self / image... there is a sense of this being academicalised in order to defend or justify it	Distraction + Short Fuse → Coping & Hiccup (again referring to abilities/strategies being overwhelmed, and compromising his professional image)
I think my friends are all used to the general air of chaos and mess that will surround me but I usually manage to come out of it reasonably okay. I think from an outsider that would start, that's	Friends used to air of chaos about him	Sense of 'usually managing' being reinforced by those who *know* him getting desensitised to the 'chaos' and therefore accepting it / him	Chaos (desensitised friends)

an aspect of breakdown. (475)			
some of the difficulties and some of the frustrations that I probably wouldn't have talked about as much as you know when that, that moment where you've got everything ready but you've, and you've put a lot of effort into, you know, I know that I've got to pack my bag and it needs to include my gym stuff and this and that and I've got the list and then I've got up in the morning and I'm on time and I've managed to drag myself out of bed in time to get to work and then I can't find where I've put my glasses or my car keys or something like that and it just start … that's the point where it all breaks down and actually although I'm keeping going it doesn't take a lot to tip it over the edge. (494)	Getting stuff ready, knows he needs certain things, but then forgets something else – start of where it all breaks down	Frustration borne out of effort being put into getting it right, and then sense of self-sabbotage / letting self down at the final hurdle	Frustration Cycle → self originating and perpetuating
Sometimes particularly in a clinical environment where you can't predict what's going to happen stuff does constantly disrupt you and you can't always have that routine and those mechanisms that you rely on. Very easy to go to pot very quickly (497)	Can't rely on routine in the clinical environment	Environmental factors that limit capacity of coping strategies → chaos of environment combined with chaos of self negates effect of routine	Chaos (environment & self)

Appendix 12: Coding notes for John

John – Initial Interview

Transcript (line number)	**Descriptive Coding**	**Interpretive Coding** (notes)	**Emergent Themes** (notes) [double hermeneutic]
in a Comprehensive in [Wales]. That's where, looking back, was the start of the sort of dyslexia, and I think if it was as accepted now as it was back then there's a few things that probably would've gone slightly differently. (48)	Looking back, dyslexia started at school	A sense of temporality to dyslexia ('starting') but also contextuality – only existed (emerged / manifested) at school	Dyslexia (contextuality)
Mainly started off with not getting my A-Level grades. (52)	Failing A-levels is how it all started	Mainly = most significance ascribed to exam failure	Failure
You know, the rest of my logbook's okay but it's my exam I'm having trouble with (98)	Skills are okay	Sense of compensating / excusing / apologising with demonstrable adequacy elsewhere (surgical skills log book)…shame implied through apology	Shame → failure
I never had a problem with school, this was always the case throughout, you know, junior school, primary school, you know, even going into 15, 16 different	Never much of a problem at school	Sense of trying to prove self / demonstrating adequacy elsewhere again (never had a problem in school) …a sense of desperation	Desperation (to not be a)Failure

subjects, I never really had much of a problem with exams and things like that. (112)		about how …there is remorse here too.	
looking back on it, there was quite a few instances where I really… the exam from a, you know, knowledge perspective, it was just a time issue and I was always told just write quicker. Because my handwriting was always really messy (115)	Messy handwriting Just write quicker	'just write quicker' → sense of being fobbed off by being told to do something that was impossible 'just a time issue' → minimises the significance of this (time = less important than knowledge) but this 'just' also serves to excuse him	Impossible + }- forgiveness Excuse
then the more you rely on sort of dictation and the more I relied on trying to scribble things down quickly, you know, I found a way of trying to write legibly enough for me to understand but had to rewrite a lot of stuff for my teachers (118)	Found a way that worked for him, but had to re-do	His way worked for him, but not for his teachers (had to re-do it) unacceptability of others/system to him…not conforming to the conventions and expectations operating	Conformity (construing → Failure)
my English, though, is really, really rubbish and I'd never had a C in anything else other than English. And, again, I just found sort of strategies, ways around it, to kind of muddle my way and it was the only thing I had a C in in GCSE. (122)	English was 'rubbish' and had to 'muddle' way through	Muddling way through → sense of being alone, without a guide, and precariously developing own strategies…implies risk of failure / rejection	Muddling (Coping)
funnily enough, it was at GCSE level where my Maths teacher picked up on the situation; all my homework was	Maths teacher picked it up – and informally	Informal / subvert accommodation and support from teacher…conveys a sense of understanding and	Acceptance (conformity is conditional to expectations – which

absolutely… you know, always As, A*s, never any issue, and when it came to an exam, you know, she'd try and give me an extra sort of five minutes at the end of the lesson and I still wasn't finishing it, and although I was still getting sort of really quite good grades, I really wasn't meeting the standards in the rest of my work. (128)	adjusted for him	acceptance	can be modified)
she, you know, mentioned the dyslexia thing, about me going into the special needs class, and of course I mentioned this to my dad and my mum and said, "Oh well" and they said, "Why do you need to do that, you're getting As anyway, you just have to work harder." (132)	Teacher mentioned the dyslexia thing	'the dyslexia thing' → disembodied 'special needs class' → stigma, special as negative Parental response reflecting expectation that excellence in 1 domain precludes need for help…hints at non-conformity (breaking rules) to expectations and disappointment	Conformity (Failure)
she was the only teacher – and I didn't like her very much – who took enough interest to just pick up on those little cues and, you know, if I could've got that sorted earlier on my life would've panned out differently. (136)	Only teacher who took interest and picked up on cues	A need for an ally → pre-requisite for visibility is interest	Visibility (conditionality) of little failures
It goes on to just about scraping my C in English, knowing full well that I only finished about half of the paper; there was an entire section on poetry at the very end	Scraped a C in English as ran out of time	'scraping' a grade implies struggle, near-miss, dissatisfaction but also a sense of desperation (couldn't have	Failure (significance, scraping as a near-failure)

of the exam - I can see the poem now - and I literally wrote three lines and that was the end. (140)		done better). Significance → 'can see the poem now' (some ? 15 years later). Ran out of time – unable to keep up with expected pace (non-conformity)	Conformity (pace of work)
I was doing Chemistry, Maths, Biology and IT. IT wasn't too much of a problem and I was trying to like decipher code and things like that and, you know, that seemed okay, but it was the finishing of my exams because as you progressed with the Chemistry and Biology obviously the length of the questions go from a few lines to, you know, a paragraph and, again, you know, I only finished about sort of 75%, 80% of the paper but what I did write was – in classes anyway – was enough to give me the good mark straight As (151)	As progressed in subjects, questions got longer which made harder to complete	Running out of time – unable to keep pace with expectations There is a strong sense of this being **<u>unfair</u>** Demonstrated excellence in what was able to complete, but a sense of being held back by expectations of time-frame/-pressure	Expectations & Conformity
I did my AS-Levels they weren't quite up to the standard that I wanted. So I ended up taking sort of 23 exams, I think, in just over three weeks. **I: Oh goodness me!** R: So I think the extra pressure of having sort of like four or five exams in a day sort of… it was that extra pressure that, you know, there wasn't really… you	Due to re-sitting exams, had 23 exams to do in 3 weeks Time pressure remained an issue	A sense here of being expected to do the impossible…an inhumane expectation, accompanied by a sense of trying to prove himself by still doing it Felt like couldn't cry for help as nobody had spotted any issues	Expectations Not Good Enough

know, I couldn't say, "Oh well I haven't finished that, I'm really struggling to finish," because they looked back on my grades and they looked back at my teachers they'd never really raised an issue apart from that once, you know, and it was rather informal (165)	Teachers never really raised an issue.	before – invisibility of difficulties ….a sense that these needs could only be made visible through recognition by a teacher – needs legitimacy of authority	Invisibility (difficulties and needs)
And then come out in my A-Levels I had three Bs and a C in Maths and I didn't get into [Medical School X] for Medicine. I was actually two marks away from my A that I needed but it wasn't enough. So I had a hard decision whether to do, you know, an undergraduate degree and then go on postgraduate or spend a year doing my A-Levels again, and I went for the latter because I didn't want to go into uni for something I didn't want to do. (172)	Just missed getting into medical school, but decided didn't want to do a different degree	'actually two marks away' from what would have gained him entry to his choice of medical school → a sense of near-miss, of the unfair, of a cross-roads, of a robbed opportunity	Failure Crossroads
Absolutely horrible year but I got through it and it was just a case that I know I needed to finish 80% in them and if I did that I'd get an A. So it wasn't a case that I didn't know what I was doing, it was more the case that I was desperate to finish the exam. (175)	Just needed the chance to answer 80% of the questions in order to demonstrate he had the knowledge	Reflecting the notion that he was being tested on time (ability to complete enough questions in timeframe) rather than knowledge (which was adequate) …this creates a sense that failure, or near-failure is constructed by the system	Failure
And I go to [Medical School Y]; they were the only one who really gave me a chance.	Different medical school gave him a chance	'they were the only one who gave me a chance' → a sense of being an outcast, non-conforming to	Crossroads

(176)		conventions that would allow him entry to 'most' or 'normal' medical schools…needed a 'chance' (second chance) to prove himself	Not Good Enough
I go to [Medical School Y] and go through okay as far as, you know, the interim assessments go, my OSCE sort of stuff, the practical side of it, never a problem, but then it came to an exam and then I thought, "The exams only 50%, that's alright, I can get 50," and I was coming back with like 40%. I was like, "Well how is this possible, what on earth am I doing wrong?" (182)	Still didn't pass exams and couldn't understand why	A sense of the goalposts changing so he is still not conforming to expectations …'what on earth am I doing wrong' creates a sense of disbelief, the unfair and being kept in the dark / blinded to how his abilities and difficulties	Failure (again a sense of this being crated by the system rather than by him…or at least an interaction of the two, shifting attribution slightly)
then I looked first, "How much did you actually finish of that exam?" and I was missing massive chunks of this exam out and doing things so quickly that a lot of the time it was the illegibility of my writing because I was trying to write so quickly. (185)	Missed chunks out and wrote illegibly	Failure construed from pace-driven omission and illegibility… a sense of blame being apportioned to the system and conventions of the assessment, rather than the content	Failure
my sort of pattern recognition and, you know, looking at pictures and… you know, a lot of my revision sort of style is, you know, very picture-based, you know, lots of different colour pens and that sort of thing. And, you know, we had a slide-based exam which I thought would be a	Revision style is very picture based, so thought slide-based exam would be a doddle	Belief that a slide-based exam would play to his strengths and therefore be a 'doddle' challenged by struggles and underperformance in the exam, largely driven by time pressure again.	Expectation (own expectations – 'doddle' unmet, but also system expectations unmet → this constructs the Failure)

doddle for me but I had 90 seconds to answer three questions on one slide (190)			
If it was a slide with a graph on or a slide with, you know, more than one or two lines, I just couldn't do it, I couldn't get through the questions, and I was so frustrated with myself because I thought, "Gosh, in exams and I've had no problem with OSCEs and then I'm sitting this exam, I've got reams of notes and done loads of practice questions and my results were appalling." (196)	Frustrated because results were appalling despite work	The element of 'graph' or 'more than one or two lines' in slide-based exam appears to construct an element of 'it's not fair' → interacting with over-work (reams of notes + loads of practice questions) and 'appalling' results which causes frustration… 'I just couldn't do it' evokes desperation	Frustration (in failure → borne out of way it is constructed *despite* effort)
And I just couldn't figure it out. So I failed all of my exams in my first year and I think a literature review and some other sort of neither here nor there stuff. (198)	Just couldn't figure it out and failed	'neither here nor there stuff' → implying what elements he failed were not of 'core' importance to medicine, minimalising his failure 'just couldn't figure it out' → couldn't work out how he failed, kept in the dark	Failure (minimised significance → a sense of preserving his forming identity as a doctor [it wasn't a clinical subject/skill he failed on])
I was allowed to re-sit the rest of my exams in the summer, complicated again by a family bereavement and what-have-you, but when it came to my exams again I failed them all again. And I came to my	Re-sitting exams coincided with bereavement and failed them all	'family bereavement and what-have-you' → a sense of trivialising something significant. Also a sense of chaos (life is chaotic) coinciding with failure and reassessment…not	Failure (construed from or made worse by chaos)

viva then which I wasn't really ever going to pass because I was just a bit of a mess, to be honest with you (202)		directly attributing, but his discussion of it implies a significance and relationship → 'just a bit of a mess' …mess also resonates with chaos	
I went through the Progress Committee going on and it was actually [Jane] that mentioned… When I was doing my revision with her she… We were talking about random stuff and reading the paper and it was something like top ten British comedians and one of them was a chap called Les Dawson and I said, "Des Lawson," and then just carried on, didn't even pay any attention to the fact that I'd got the letters and the words mixed up. (209)	Spoonerism flagged up difficulties to his wife	Visibility of difficulties → invisible to him (resonates with previous concepts of 'not knowing' and being 'in the dark') but were to others (with an interest – wife)	Visibility → conformity (didn't conform, as spoonerism error, which highlighted difference, and his lack of awareness alluded to difficulty)
[Jane] couldn't understand, she said, "[John], I've seen what you've done, I've seen the notes, why aren't you passing your exam?" "Well that's a good question, I don't know either." So she gets me to do this dyslexia assessment and then I go there, do the assessment and they find… I think they said grade F dyslexia. (213)	Wife couldn't understand his failures so does dyslexia screen	A sense of desperation in seeking an answer for discrepancy between (effort + abilities) and (performance + outcome) 'Grade F' → a sense of categorising it as 'severe' to add weight and legitimacy to screen	Answer → visibility (difficulties)

they give me this tutor which, to be honest with you, didn't really tell me anything that I kind of hadn't worked myself. So anyway, they gave me 15 minutes on the hour for my exams which meant that I got like 120 seconds per slide, and I re-sat all my first year and passed (217)	Tutor didn't add anything, but got extra time and passed exams	Contrast between tutor (nothing new) and extra-time (passed) implies alack of benefit from model of tutorial support offered. Additional time afforded him chance to demonstrate abilities and pass…but this is reflected in a very simplified, minimalized way… this represents another crossroads, or hurdle, at which he could have stumbled	Crossroads (simplified, but critical difference in allowance of extra time)
And then obviously the progress test is slightly different in the third year but, again, it's… you know, I knew that I could do enough to pass with the extra time, it wasn't so much just, you know, knowing that I had some extra time, it was also I had a little bit less stress knowing that I didn't have to rush as much, and I think that had a… just I was going into the exam slightly calmer. (227)	Test in 3rd year is different. Knew had extra time so less stressful, so approached exam calmer	Impact of extra time → assuaging fear: 'going into the exam slightly calmer' which, combined with allowing time to complete more questions, *allowed* him to pass …this imbues the additional time with significance and power that was responsible for his pass, and there is less of him & his abilities here	Attribution: Accommodation → Extra Time = Assuage & Allowance (shift in attribution of success to accommodation rather than his ability)
And that was it really, and then finals came along and, you know, I just put the work in, passed them, they weren't getting their grades and, you know, I couldn't understand… you know, don't get me wrong, I'm not an exemplary student but I passed and that was the May. (231)	Just worked and passed finals. Others weren't getting the grades	Couldn't understand how others weren't getting the grades + 'just put the work in' → alludes to a minimisation of the significance of the hurdle (lack of attribution to ability, more to effort and system)	Attribution

the few things I've sort of done in more sort of clinical was, again, trying to be legible while writing on a ward round. Now, I know that's a bane of the existence for everybody, you know, every junior doctor that's got a surgical, you know, ward round that lasts like half an hour (235)	Adapted work in clinical environment to meet demands of pace and writing	Aware of time pressure and writing difficulties potential to impact on clinical work → adapted …alluding to a native non-conformity …there is a sense of referring to this experience being common, but his difficulty or need to adapt being very particular	Conformity
, I mean, I was fine if I had time and, you know, on a medical ward round I would have to bullet point things because the more I wrote, the less sense it made, and it was just because I felt like I was rushed, (244)	Was fine if had more time. When felt rushed, his written work made less sense	Implied sense of apology or excusing – proving self (work was fine under right conditions) but introduces conditionality to environmental / system factors that undermined this – inherent within medicine. This apology implies a strong sense of shame driving this	Shame (from non-conformity)
So that's me but, you know, I just kind of get on with it and, you know, try and see how I go. (245)	Just gets on with it	An acknowledgement of difficulties and experience of failure, and a sense of resignation to it – 'just kind of get on' …& by implication a form of helplessness	Helplessness
my MRCS Part A exam which I am currently revising for me sixth and final attempt. Now, I've put hours and hours of revision, done thousands of past questions, I've reams of notes. I had to have another dyslexia assessment because I wasn't 21 when I had my last	Last chance Had to have another dyslexia assessment	'sixth and final' = sense of last chance, another potential crossroads. 'had to have' another assessment → to somehow prove himself & his	Crossroads

assessment, so that cost me another bloody six or seven hundred quid, but the results were exactly the same and I got my, you know, 15 minutes per hour. The shame of that is I have to go down to London because that's the only people that accommodate it so that's a bit of a pain, but, you know, for the longest time I've been trying to get this exam out the way and I'm just… I'm falling short every time; I need 70% to pass and the last three attempts collectively I've only been seven marks away, the last two being one mark away. (258)		needs, at great financial cost. 'exactly the same' confers a sense of frustration and futility at the process… a sense of jumping hoops or almost being punished because he is different	Hurdles (this links to failure → how failure or hurdles can be constructed by the system, seemingly arbitrarily so) Not Good Enough
There's no more work I can put in, I've been on courses, you know, I've done loads of stuff, but the thing I'm finding is, obviously, you know, it's all of surgery so it's going to include a lot of things that I'm not familiar which obviously I'd spend more time on, and then the orthopaedic sort of stuff comes to hand, but it's the wording of the questions. (263)	Can't do any more to help pass. Wording of questions designed to catching him out.	'there's no more'…he can do → reinforces finality, and also an element of surrendering: the resultant outcome is due to the system / luck Wording catching him out etc – implication that it is the system that construes the failure through intentionally manipulating expectations	Failure Crossroads
they say they're not there to catch you out but I'm sure, as you've done a few in your	Exams not trying to catch you out, but the	'they say' → implies doubt and deceit…constructive misdirection	Failure (borne out of constructive misdirection)

time, that you'll have a question that'll say, 'What is the least likely?' or 'What is not the case?' or, you know, 'What is…' that sort of wording of a question. And even though I know the subject well, I can read around, I've read around the question, I can tell you about all the bits and pieces, you know, I do it, do the question and I come onto the next one and then I'm shocked then when I've got it wrong, and then I realise it's because I read the question incorrectly. (271)	questions are worded in a tricky way	intended to construe a failure Recognition that it was he (*I*) who read the question incorrectly → surprise and disappointment in self	
I said, "But this doesn't make any sense, I've just got this right, I've literally not even two hours ago got this exact question right, and I've read it and I've read it again and I've read it again…," I can read it ten times and I still get it wrong. Reading the question two or three times doesn't make a difference for me; if I've read it incorrectly in the first chance it's usually the case that the next time I read it I read it exactly the same. (282)	Got a question right, but then later got it wrong	This invokes a strong sense of 'It's not fair' – despair and frustration. Re-reading doesn't make him get the question right: if he's read it wrong the first time, subsequent readings result in the same interpretation…his dyslexia blinds him to the correct reading	Frustration (Failure) Here the failure is located and constructed by self – but this is due to his unfair dyslexic difficulties
. It's become more evidence as I've… you know, this slight change in style of the exam, and often, as may be the case for a lot of other of your sort of subjects, it's the people around you that pick up on it as opposed to yourself. I think because I	It is those around him that pick up his difficulties rather than him as he is dealing with it	Dealing with it in my own way → becomes invisible to him (but not to those around him)	Visibility (variable and contextual visibility of difficulties)

spent so long just dealing with it in my own way, whether I appreciated it at the time or not, (287)			
my coping mechanisms were, you know, pretty good but when the workload increased and the importance of the exam increased then that I think is where I really came unstuck (289)	Coping mechanisms generally good but workload increased and made him unstuck	'unstuck' → overwhelmed 'mechanisms' …very tangible sense of strategies to cope: when working, invisible-ises difficulties, but these are made manifest by a change in context	Visibility (coping) Failure (construed in part by a change in context)
I mean, at the time when I crashed and burned so terribly in the first year, which, as it happens, is still the year which I did the most work, it was a real kick in the teeth because, you know, I'd gone into this excited and, you know, despite my best efforts I was doing worse than I'd ever done before, and to follow on from having to re-sit my A-Levels - that really was a dreadful year (303)	Failure: Crashed and burned when failed, kicked in teeth	Failure construed as a very painful, damaging, and traumatic experience: kicked in teeth, crashed and burned, doing worse than ever (despite best efforts)	Failure (the violence of failure)
that really was a dreadful year – because there was about half a dozen of us there re-sitting our A-Levels and the rest of them all had Es and Ds and Fs and pointless basically, couldn't even get into a college, and there's me with grades they'd rip my arms off for and I was thoroughly miserable, absolutely thoroughly,	Dreadful year, others were resitting with worse results	Acknowledgement of disparity of perceived failures (his was outranked by others') …a sense of not belonging to this group, or being an outcast Thoroughly miserable → reinforces the violence and impact of failure on	Outcast

thoroughly miserable (307)		the individual	Failure (violence and significance)
So of course it affected me and that was… you know, they were all saying, "Well why are you here, why are you here?" and I had to, you know, explain myself. I don't know, it's hard, it was hard. I just wish that, you know, if… now it's such an accepted sort of thing, you know, they'd be more knowledgeable, a bit more sensible about it. (312)	It was hard to justify why he was in the resit group	Sense of missed opportunities – crossroads (if had been spotted earlier) Hard – repeated, implying significance at justifying to immediate peers why he was in resit group → intensifies failure	Crossroads Failure (intensified)
If, you know, Miss [Smith] had turned round to me and said, "I think you may have a form of dyslexia"… well I didn't know what that meant at the time, all I knew is that I had to go to the special needs class, and my dad was like, "Well you're getting As, why are you going to the special needs class?" And I thought, "Well no, I suppose you're right, why am I going to the special needs class, I am getting As so what's the problem?" So I just ignored it and carried on and just always put it down to, you know, my	Father would have said no need for special help as was doing ok in other subjects	A sense of remorse at difficulties not having been formally identified earlier, but also of resignation to the fact that his father would have seen him as undeserving of additional help as was doing ok… An invisibility to his difficulty created by getting As in some subjects 'just crap' → shifts focus of problem	Support inVisibilty …but also a sense of helplessness

grades in English, of all things, being poor because I just thought I was crap at English and it was always my worst subject and I hated it. (321)		with subject, to with himself	here Not Good Enough Self / Attribution
It was the only class I really, really hated, the only reason I hated it was because it was the only thing I didn't get As in. I mean, my grammar and punctuation is bloody appalling now I have to get [Jane] to proofread everything I do from an email to an essay because again, you know, it can make perfect sense to me but be completely ridiculous to [Jane] (326)	Really hated English, wife has to proofread everything for him	Really hated → emphasised through repetition…dislike through relative failure (discrepant performance). Strategy: wife proofreads 'everything' for him → implying a lack of trust in self, drawing on others to help (but someone intimately close)	Failure Coping (but this strategy demonstrates lack of self-trust)
even something as simple as writing an email to check up on my rota, I'll still get her to check it because I don't want to look like an idiot if it doesn't make any sense. (329)	Still gets simple things wrong	Sense of self-belittlement ('even something simple') Self-mistrust Fear of appearing as an idiot – implication that literacy difficulties (or Failure) = idiot	Fear (belittlement+ idiot) Lack of self-trust → coping
But I'm kicking myself, you know, like I said, my life could've been extremely different if I could've had extra time, I will	Life could have been different if given extra	Crossroads → potential alternative realities **if** diagnosis made earlier…a	Crossroads

guarantee you that I would have got those two marks in my IT exam if I had even ten minutes extra time, that would've took me through to [Medical School X], that would've, you know, completely redirected my entire life (334)	time earlier on	strong sense of remorse… A sense of reduction of complex 'failures' to a matter of 'ten minutes extra' → reinforces notion of remorse, resentment and even frustration at the system (externalising)	Attribution (within Failure)
I don't regret anything now obviously, you know, you deal with the hand you're dealt, but how different things could've been. I don't tend to dwell on it but, you know, sometimes I do get… (336)	Deal with the hand you're dealt with	A strong sense of sadness and missed opportunity here → 'deal[ing] with the hand you're dealt' implies a sense of resignation and helplessness Conflict: 'I don't regret anything' BUT 'sometimes I do get…[unexpressed, but probably frustration]'	Helplessness (victim)
particularly when… I'll have a good day and a bad day and that hasn't got anything to do with when I got… It can be if I'm a little bit tired, which, you know, with a 10-month-old is a perfectly reasonable thing to be, and I'll have had a stressful day in work and, you know, my reading will… Well I'll be trying to do as much as I can in a shorter period of time because I haven't	Good days and bad days, when tired or has had stressful day, his reading will be less accurate	Good & bad days → an acknowledgement of the contextuality and dynamic nature of difficulties (which lead to failure) 'can't find that [consistency]' → a sense of something tangible that is lost or just out of reach, holding him	Difficulties (contextual & dynamic) → Failure

got home from work 'til seven o'clock and I'll go through a string of questions and get like half a dozen right and end up with like 20% out of 60, 70 questions, I get fed-up, turn it off and go to bed but I've lost two hours' revision time. Then like today I've set up ready, I've had a good sleep and I sat down and took my time, I read my questions, and I'm averaging 85%. You know, nothing's changed, my brain hasn't got better overnight, but it's… you know, there's no consistency and I can't find that consistency and I think that's what's hindering me in my exam. You know. You know, it could be stress, it could be a combination of things, but I definitely think it plays a role and it's about to play a massive role again, (352)		back	
I'm at another crossroads, you could say, because if I fail this exam in April I have no future in theatre and no future in surgical whatsoever because I can't finish my exam, and so I'm going to have to completely rethink my career again. (355)	The potential of failure makes this another crossroads	There is a finality to this crossroads – his alternative career path is opaque to him…a feeling of being lost, and again this conveys a sense of resignation rather than determination (cf. 'I've done all I can')	Crossroads Helplessness (a sense of resignation to fate)
Goodness, that's quite a profound thing to be faced with. What thoughts have you had about that? R: Well everything from completely	Considered giving up	Completely giving up → dramatic, and extreme, GP a compromise…	Crossroads

giving up medicine to accepting the fact that I'm probably going to end up being a GP, which I never ever set out to be. Having [a baby] in my life means that my priorities, you know, have adjusted somewhat and changed things (363)		'giving up' also conveys resignation and helplessness re-shuffle of priorities with baby	Helplessness
I've had a bit of a problem with the deanery in a way, my ARCP, my annual review, was actually on the date of my January exam so it was in absentia and he looked at my portfolio from November. In November it wasn't really quite up to scratch but I figured, "Well I'll get everything done ready for the actual meeting and they shouldn't have any qualms." So they absolutely destroyed me when I wasn't there to defend myself and had me meeting with one of the clinical directors. So I sits down with him and he basically tells me that if I haven't passed this January exam my career's over. If I do pass it I might get an extra six months, even though they had already told me I was going to get an extra year, and they basically said, you know, "You're	Was reviewed in absentia, unable to defend portfolio, told if he doesn't pass his career will be over	A rough and harsh finality in the statement, and unfairness in the dealing… Violence of failure: absolutely destroyed me. A sense of blindness to his effort and other skills, honing in on single aspect of failure…a sense of unfairness… 'great, thanks a bunch' reinforces resignation and helplessness → very	Failure (violence, victim)

unlikely to progress in orthopaedics, have you considered another career?" So "Great, thanks a bunch." (375)		much a victim Helplessness	
So it transpires that I failed the exam mark and he tells me then, "Oh we'll discuss your case in your ARCP next week," and I said, "Hang on a minute, what ARCP, I've already had the ARCP, that's why I've had the meeting with you." And I don't get a response for like a few days. There's nobody really above him that I can go to, end up speaking to the administrators and they arrange for me to have another meeting the following week. And it turns out that they got me mixed up with another candidate, with another trainee, and information about my future. (Laughs) So it was a bit traumatic at the time. So you could almost say that I've mourned the loss of orthopaedics already (385)	Failed and had another ARCP	A sense of additional hurdles being put in his way (additional ARCP) → victim, unfair, powerless… A sense of this crossroads being precarious: fate lying in the balance, the wrong information… 'Mourned the loss of orthopaedics' → a sense of grief, adding to the notion of failure and expulsion being traumatic and, in a sense, violent	Failure (constructed by system – barriers and victim) Crossroads
So they said all of those threatening things to you based on having read somebody else's information? R: Well they looked at my logbook and I said, "Look, you can see that I've done this, this, this and this and you're telling me I haven't," you know, "I can show it to you, I can tell you about them, they are there." So he wrote a sort of	Looked at log-book and saw he had done lots of work, which informed their compromise	Sense of his additional information (logbook) saving the day here…put educators in a position where they had to compromise. 'harsh but they gave [him] an outcome that [he] could do	Victim

response. And in my first ARCP they said, "Look, we're going to give you an extra year but we're going to do it in a manner in which if you progress with your exams you can still apply but if you don't you'll have that extra year for you to finish off your exams and get a bit more orthopaedic experience and be more competitive for registrar application," which made sense. I mean, they were harsh but they gave me an outcome that I could do something with. (400)		something with' → harshness here is reminiscent of the brutality of the process, but there is acceptance here, even forgiveness: the harshness is mitigated by the second chance → conditional acceptability → conditional resignation and helplessness	Conditional Acceptance (Helplessness)
But this time he was very matter of fact and told me all this and I was dumfounded because, you know, I was under the assumption I had a sixth attempt and that was… you know, I knew that was my last chance. But for him telling me no just blew my mind because I wasn't expecting it. And then when I managed to get this second ARCP they were really positive, really nice with me, they made sure I had my extra time, they had a quick look at my portfolio, had no complaints and said, "Look, it's very simple, you've got one more chance, if you pass we'll give you an extra year, if you fail then you will be removed from the training programme." So that's where I'm up to. (410)	Blew his mind, dumbfounded at thought that wouldn't get 6th attempt → contrasted with positivity of second ARCP	Second ARCP → although was another hurdle, was actually positive: which contrasts with previous experience. Words such as 'dumbfounded' and 'blew my mind' reinforce the notion that this was a brutal process to go through [like Brute Facts, this form of Brute Experience appears to have no reasoning, which adds to the negative perception] There is a clear enactment of social conventions here: pass by our rules,	Failure (contrived experience) Violence (of failure)

		or you're out… Conformity	
Gosh. So next few months are going to be really tough for you. R: They're going to be horrible. [Jane's] going to America with [the baby] for three weeks and so I've got two and a half weeks on my own to just spend all my time revising and hope for the best. (416) Like pictures and drawings, they're my sort of forte. I've always been interested in art, I've always been really very good at art which helped me with sort of my anatomy perspective. It's probably helped me with my sort of three dimensional appreciation of anatomy. So my operating skills and things are actually, you know, really good, I've always had sort of really positive sort of, you know, reviews and things in my logbook (430)	The next few weeks will be horrible but he hopes for the best. Always been good at art. Operating skills are good, demonstrated in logbook.	A sense of resignation to the fact that he will undergo suffering…penance to gain or maintain group membership… Family difficulties – the chaos of life (happens to all, but this makes him more vulnerable) A sense of bargaining: demonstrating he is good at surgical skills (proving himself)	Resignation → Helplesness Conformity (demands sacrifice to gain acceptance) Chaos (and precariousness to social support – the fragility of life) Proving himself
Although my options have been limited by being in a failing Trust that is Stafford what I had done I'd always had pretty good feedback from. And I think I've picked up a bit of a talent for teaching as well and mainly by, you know, sort of…	He was in a failing Trust, which limited training opportunities. Picked up a talent for	There is a shifting of the locus of Failure or fault from him to the Trust ('failing Trust'), which could suggest a means of bargaining or excusing his Failure.	Failure (bargain)

involving surgery, of course, because that's my main area of expertise, but giving them sort of hints and tips via the way I learn as opposed to, you know, just spoon feeding the information and… (437)	teaching	Teaching →drawing on his experiences and difficulties, he has developed a skill in helping others → positivity, reframing, paying it forward…	Reframing (coping)
And, again, I seem to get a pretty good rapport with the people that I've taught and I've given hints and tips to and, you know, that's been pretty good. (439)	Good at teaching and gaining rapport	Teaching →drawing on his experiences and difficulties, he has developed a skill in helping others → positivity, reframing, paying it forward…	Reframing (coping)
But definitely the pictures for anatomy, you know, I can learn more from a picture than I can from half a dozen pages of writing, easily. When I was writing more as well I tended to use sort of symbols as well as words to try and speed up the way I write and that helped a little bit as well, but mainly pictures. Like I say, if you asked me to explain to you the anatomy of the skull, kind of half waffle, if you give me a board and a pen I can tell you it from back to front. (445)	Uses pictures and symbols to help learn	Describing visual learning strategies and development of coping mechanisms that draw on that (symbols when writing)	Strategies (coping)

like I said, it was [Jane] that really picked up on it, mainly for not being able to understand why I wasn't doing as well as I should, and obviously from then on it was a case of, you know, going through Keele and through the sort of education centre side and getting assessed. And they were excellent there, I didn't quite appreciate how much was involved and how long the process took, the actual, you know, examination. (461)	Wife picked up on his difficulties	Visibility of difficulties → intimate relationship afforded someone external the insight…he didn't have insight himself	Visibiity
As the process was going on, you know, she was getting me… I think she got me to write just… She said, "Just write a paragraph," and she went of the room and came back and I'd written like three lines, and she was surprised and I didn't pay it any attention. And I pressed so hard with the biro to write legibly that I'd gone through like three sheets of paper and you could still make out what I'd written. And I was quite… You know, and reading speed. As I was reading out loud I wasn't… you know, I thought I was saying things correctly and she picked up like half a dozen mistakes and I was like, "Really? I've read like a children's book, what mistakes could I have made?" And so it was a real eye-opener, to be honest with you. (475)	Slow at writing and pressed very hard with a pen, and read very slowly	Describing the shock at realising he was unaware of his patterns of errors and difficulties → there are 2 kinds: an *experiential difficulty* (one that impacts on experience, and is 'known') and *observable difficulty* (one that is only seen by others [conditionality!!!]). 'a real eye opener' → the process made observable difficulties visible to him → illuminating and enlightening	Different Difficulties (?within conformity or failure) Visibility

then she gave me like these shapes to, you know, match the pictures up with the shapes, and literally in seconds I went through the entire set of them with really no problems whatsoever and really didn't appreciate it, and then she showed me on the scale of where it should be for my intelligence level and where actually it was and then when I saw my sort of reading and spelling and stuff it was way down and then my sort of visual spatial awareness sort of skills were way above. I just thought, "Well that kind of makes a bit of sense, actually it says a lot about what's happened" (483)	The tests for his dyslexia diagnosis made sense about his experience	The tests making visible his patterns of difficulties, and strengths to him – this was illuminating and helpful… Again, speaks to the notion of 2 kinds of difficulties: experiential vs. observed	Different Difficulties & Visibility
is it something I've completely not appreciated or have I always been pretty good at sort of shapes and pictures and things like that or have I developed that skill to try and get over the fact that some of my other skills are a little substandard?" (487)	Hadn't appreciated he was good at visual processing	Visibility – his strengths were hidden to him, as were some of his (non-experiential) difficulties	Different Difficulties & Visibility
then when she told me that I was dyslexic and at quite a degree and that I should be getting… You know, I was expecting like five or ten minutes if I was lucky, to expect like… you know, I was getting fifteen, twenty minutes extra on the exam, I just thought, "Why didn't I do this years ago, this could've saved me so much	Felt relief	Diagnosis → relief, implication of fear of being 'not good enough' …this corresponds to the narrative elsewhere where he appears to be trying to prove himself	Not Good Enough

trouble." And I felt relief because I just thought that I wasn't good enough, I thought that, you know, I'd managed to get through A-Level and GCSE… or got through GCSE, scraped through A-Level, and I just thought that, you know. (495)		Sense of missed opportunity (why didn't I do this years ago) → crossroads	Relief… Crossroads (missed opportunity)
And, you know, I'd done well in my interviews and I got my place and I just felt like I just wasn't good enough, I'd been found out, "I'm not as intelligent as I thought I was." You know, it's just come to the point it's so complicated that it's too difficult for me and I couldn't do it. And then to be told that this might be a major contributive factor to this, it's not just the fact that I'm not intelligent enough was a massive relief (501)	Thought wasn't good enough and that would be found out. Diagnosis was massive relief	Explicitly conveys the 'not good enough' notion, which is accompanied by a fear of discovery →will be found a fraud at any moment. Diagnosis = relief = somehow assuages this fear, as the *experiential difficulties* are explained to him by his diagnosis, which legitimises his experience, and validates his membership	Not Good Enough Relief
like I said, getting the extra time was great. And the other thing I found quite positive as well is, you know, obviously you do your exams separate and then bumping into familiar faces from the years that I've had this diagnosis of dyslexia, before they even came into university, telling me that they never would've passed their exams so they never would've got the grades, so I think, "How the bloody hell did I manage it?	Extra time was great, familiar (dyslexic) faces helped	Yes, extra time helped (acknowledgement), but also a sense of importance and reassurance from belonging to a community (familiar faces) The fact that these other community members struggled too galvanises his self-belief that e isn't 'as much of	Community / Belonging

Maybe I'm not as much of a dunce as I think I am." (508)		a dunce' as he thought.	Not Good Enough Coping (intra-community social comparison)
And, you know, having had to redo my A-Levels and then completely failing first year I genuinely thought my chances were out. I really wasn't interested in anything else and I was very close to just saying, "Oh bollocks to it all, I'll just be a plumber." And my dad always told me I'd be a good plumber – my old man's a plumber – and I was really resigning myself to just giving up on this uni business altogether (513)	I was very close to just saying, "Oh bollocks to it all, I'll just be a plumber."	I was very close to just saying, "Oh bollocks to it all, I'll just be a plumber." → crossroads…permission to struggle and keep trying by diagnosis Sense here of conformity to family heritage (plumming) and expectations, as well as the safety of sticking to what you know you're good at…therefore implying the risk (and unsafe nature) of learning/training in medicine	Crossroads (diagnosis was swaying factor, allowing forgiveness and permission to struggle and forgive self) Psychological Safety (training in medicine is not safe – it is risk laden for the learner) Conformity
and then just to be given this diagnosis was such a massive relief and had such a profound effect and… you know, my pre-exam psychological status, you know, obviously I was worried but not as worried as I was, knowing that I had that few minutes, even 30 seconds on a question extra time, you know, it might make all the difference, and it did (518)	Diagnosis was a massive relief → profound effect on psychological status	Diagnosis was relieving in 2 ways: impact on psychological status → relief to know isn't 'just a dunce' AND relief to know has the additional time he needs	Relief from diagnosis → influences Crossroads

as I said, it's only now when I'm doing my MRCS with the level of intelligence increased again, you know, I can't get that extra time and now… you know, I can't get any more extra time. I am just about finishing the exam, I am rather pushed towards the end but I am able to finish it. There's a lot of reading, there's like 130 odd, 135, 140 questions per paper, and so there's a lot of reading. (524)	Now MRCS exam is taking longer to compete, struggling	The level of this exam (in terms of knowledge required, and demand on reading) has increased, and is now outpacing his coping (even with additional time)	Coping (outpaced)
The one thing I haven't really picked up on that blue filter that they said would be good for me but it's not really practical so I can't wear blue tinted glasses. And, you know, a piece of acetate to move over, you know, combined about 300 questions, you know, it's just not feasible. I don't know whether it would actually help me read quicker, I don't know. It did help me at the time and I've never really used it as such. (530)	Blue filter isn't practical	Describes having scotopic sensitivity, and benefitting from colour overlay, but this strategy is not accessible to him because it isn't practical → compatibility with profession (working / exams)	Coping → conditionality of compatibility
They gave me a slightly bigger font, which was ridiculous because there was different levels of increased size of font. So they'd give me in my exam paper the first time I sat down in my first year re-sit with A3 sheets of like Times New Roman size 16 and it was just absolutely preposterous, there was like three questions per thingy, it was just dreadful.	Bigger font was ridiculous	A sense that this approach (1-size-fits-all) did not suit him, and the sense that it is ridiculous as it is less compatible with professional exam	Coping → conditionality of compatibility

(536)			
as far as sort of note-taking and stuff, it's just an adaptation of my revision techniques and my sort of clinical studies. You know, if I'm in a lecture now I very rarely take notes because I realise that it's just word vomit. Occasionally I will… if printouts are available beforehand I'll print them out first, but more often than not what I'll actually do is, if I know what the subject going to… read a little bit about it beforehand, I'll sit there and just listen for the lecture and then I'll go home and write a few things, you know, or highlight a few points which I struggled with understanding (557)	Note taking is an adaptation of other techniques	Adaptability of coping strategies to use across different settings…malleable to environment and task → condition for success and utility	Coping
I got a recorder to use in my lectures and again, to be honest with you, that really didn't help. What helped me was printed and then reading around beforehand and afterwards to sort of, you know… (562)	Recorder didn't help	Recorder didn't help – sense of '1 size fits all' not helping, not compatible for him …but his malleable techniques were	Coping
And the same sort of thing I've applied to my teaching. You know, a lot of my friends, you know, my colleagues will spend a couple of days and they'll have loads of slides and I will find the people that I see, you know, that I want to teach and try and sort something out there, and	Draws on approaches to working to help his teaching in his 'own sort of way'	A sense of greater flexibility and engagement in his chosen / developing teaching style, because of his difficulties, and drawing on the skills he has learned in addressing and mitigating these → this is positive, and he is reframing himself	Coping (reframing)

I will give them a subject to go away and read because I said, "I'm not here to spoon feed you medicine, I'm here to address problems, address questions and things you would like to ask." So I get them to go away in the first week and think about ten things that they struggle with , regardless of what the subject it, regardless of, you know, whether it's exam or clinically related, and then I'll take all that onboard and just kind of address it in my own sort of way (575)		here as the skilled expert – because of his experiences	
I've got really sort of good feedback from there and there's not anything that I went out of my way to find out that was what I should do, you know, that's what a good teacher should do, that's what I've developed during my clinical studies and my exams and things as the way that it's helped me. (580)	Really good feedback for his teaching	Reinforcing the positivity of his teaching approach and expertise through reflection on positive feedback → adds weight, evidencing his claim…implying he *needs* to prove himself	Coping → but also related to Not Good Enough (needs to prove himself)
I don't necessarily think that that's only good for a person with dyslexia, it can be good for more people. And there's a few of my friends that, you know, are dyslexic and sort of together we've spent time sort of, you know, revision and sharing one another's techniques and things. I think that probably, you know, helped somewhat, you know, that I wasn't on my tod with all this (586)	His approach to teaching is good for everyone. Not being alone helped him cope	'wasn't on my tod with all this' → sense of belonging to a community helping him cope with adversity and to continue Teaching approach is good for everyone	Coping Coping (increasing the generalizability of his teaching

			approach)
my note-taking in as far as writing and notes and things, again, I completely changed that within like the first few months of being an F1, whereas being really astute and trying to write paragraphs and, you know, try and make it sensible. It's all bullet points, it's all clear, relevant, to the point, no waffle, only information that's really required. And that's helped me, especially with sort of medical reviews and stuff like that. (600)	Note-taking in clinical setting is challenging, but adjust the way he works to different settings	Environmental Adaptability – contextuality (e.g. medical vs. surgical) requiring he adapt his 'astue[ness]' and approach to note-taking. Adaptability appears to be an underlying theme to success in developing approaches to learning and working	Coping (adaptability)
Normally I would've spent three hours reading through the exam, if you've got a poorly patient you can't, so I've developed sort of my process of picking up the bits of information that I really need to know, writing them all down in front of me and then, you know, if I'm speaking to a medical reg or something like that literally I've just got to bullet point everything I've said and, you know, they're usually pretty happy with that. (607)	Can't take extra time with patients, so developed a strategy to work	Adaptability driven by perception of not being able to have extra time with poorly patients → something here about perceived 'reality' of a contrived assessment driving fear, but also revisiting the idea of adaptability to different environments	Coping (adaptability)
Sometimes I'll just be handed a set of notes and then go and call the microbiologist and you're there sifting	Taking longer with reading and working from patient notes but	Adaptability to different clinical contexts and associated challenges → coping	Coping

through stuff and of course it clearly takes me a lot longer than some of my colleagues, you know, we can both be sitting there looking at an equally difficult like third volume of notes on this patient with past medical history, you know, a list as long as your arm, and, you know, they will definitely finish before me but this is just, you know, the way I've developed that I've, you know, increased my speed somewhat by just picking up the points. (614)	has developed an ability to pick up key points		
Even in something as simple as discharge summaries, you know, you know what it's like, you get given a discharge summary of a patient that went home over the weekend, they've been in for like six, seven weeks, you don't know anything about the patient, it takes me like an hour and a half to do it but then I don't get a complaint from the GP, whereas some of my other colleagues will have a quick flick-through, write four lines and then they get a complaint by the GP saying, "This patient's [electronic discharge summary] is six lines, I don't know what's gone on with this patient." And so that's where I think it's, you know, a little bit different. (623)	Takes longer but writes better discharge letters	Takes him longer, but is able to be more thorough → finding benefit in approach (positive reframing) but also a sense of proving self, by drawing a social comparison with peers to demonstrate 'betterness' – this implies a fear of not being good enough	Coping (positive reframing) Not Good Enough

in my first job in hepatology I really, really struggled then, never came home before sort of eight o'clock, mainly because I was still on the ward doing, you know, admin more than sick patients. I had a locum Somalian F2 and a part-time reg who I saw once in a morning and my other F1 quit. (629) **Oh gosh.** R: So to say it was a challenge was… well, to put it lightly, yes. (Laughs) (633)	First job he struggled and finished late all the time	Sense here that his experiential difficulties interacted with challenging clinical context and additional life chaos (ESL IMG doctor, and rota gaps) A sense here that his coping strategies adapted to different clinical contexts (good) but were 'forced' to…lacking agency, in fact shifting focus of that attribute onto environment	Chaos Adaptability (a positive aspect of coping – but in this context lacking in agency)
I went onto vascular surgery which again is no walk in the park, your hand is forced to write quick and your hand is forced to work quicker because the volume of patients and the turnover of those patients are, you know, obviously much more of an issue than your general medical patients. (640)			
then I went off from there and then again sort of moved on, where again it's a little bit more complicated because you've got your oncological patients as well as your medical and surgical, but by that point I'd learnt to be efficient, whereas some of my other colleagues that were on well-staffed	He had learned to be efficient as time went on	This example of adaptability has more agency cf. above → 'I learned' he owns this process here …to the point where he was 'flying through' (sense of thriving)	Coping (adaptability)

wards were struggling, I was flying through with no real issue. And, again, you're not specifically doing better than anybody else, it's just the way I'd learnt to work (649)		Here he includes modesty ('not specifically doing better than anybody else' → implying concern for appearing over-confident, or incompatibility with Not Good Enough self-talk	Not Good Enough
so like the picking up of information and the manner in which I put it on the paper, it completely changed from, you know, first day in medical F1 to, you know, month six surgical F1, it kind of stayed from there and I don't really have as much of a problem, dependent on who the surgeon is doing the ward round basically (658)	The way he works has changed, depending on the surgeon he works with	Adaptability → environmental contextuality here includes people (surgeon who is doing the ward round) This doesn't have agency though…there is a disembodied sense to this talk	Adaptability (Coping)
I think in a round about way the fact that I take slightly longer means I'm on the ward a little bit more, which the nursing staff like, you know, and for the ones that don't take the piss, you know, they think I'm great. So I've always had sort of, you know, good feedback and, you know, I've always been classed as this conscientious person, unless you want to do orthopaedics then I'm deemed to be too conscientious and I need to relieve myself from my duties (671)	The nursing staff like that he is around for longer, which is a benefit to his slower working	A sense that his longer-working demonstrates 'carrying his weight' (not taking the piss) and sense of proving he is Good Enough or at least trying hard enough…	Good Enough