In: Good Work: The Ethics of Craftmanship
Harry Kunneman (ed.)

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Good Work in an university hospital

Professional responsibility revisited

Yolande Witman

Introduction

Following Gardner and Sennett, this paper is premised on the idea that society needs professionals who value Good Work and craftsmanship (Gardner 2010, Sennett 2008). However, good work is in risk of being compromised. As Sennett argues in his book The Craftsman, social and economic conditions often stand in the way, and the craftsman often faces conflicting standards of excellence (Sennett 2008).
Also in health care there are reasons for concern. Although medical practice has always been demanding, most practitioners have found the joys of their work prevailing over the burdens. This seems to be changing. Growing numbers of physicians are leaving practice prematurely through early retirement or because of disability (Kassirer 1998). In the Netherlands there are worries about the numbers of residents who suffer from burn out or leave medical training (Prins 2009).
Medical professionals have to perform their tasks in a complex context, often with conflicting values, that might challenge good work. Dwarswaard shows in her research the dynamics of professional ethics regarding general practitioners and surgeons (Dwarswaard 2010). Through changes in mutual relations between physicians the standard has shifted from personal continuity to offering continuity in health care as a whole. After introduction of the market for instance, surgeons are required to devote more attention to financially attractive and easy to plan health care options. Prioritization is no longer solely based on medical necessity.
The managerial logic seems to dominate these days in various professional contexts (Oakes et al. 1998; Prichard and Willmott 1997; Townley 1997). This logic knows also other values and different language than the professional logic does (Witman et al. 2011). The management logic presupposes mostly a technical instrumental understanding of professionalism. Values and means that fit in this understanding are for instance: efficiency, transparency, measurability, output, protocols and checklists. These terms are not sufficient to describe the moral and process aspects of professionalism (Van den Ende 2011). Besides, quality of care is the subject of social discussion; for instance regarding the (bad) performance of medical specialists and the amount of errors or 'adverse events' in the delivery of care (World Health Organization 2004). The focus on incidents gives rise to more rules, procedures and institutions that control the quality of care. Whereas these external control grows, international research shows that motivated, engaged people perform better when their work is recognized and valued and when they are addressed on their intrinsic motivation (Gardner et al. 2010). They deliver good work from their own perspective and from that of the society.

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Concerned about these developments, the GoodWork Project has arisen, conducted by Mihaly Csikszentmihalyi, William Damon and Howard Gardner. Since 1995 these researchers have studied the meaning of good work for and with professionals. They summarize the essence of good work in the three E's: Excellence, Ethics and Engagement (Gardner et al. 2010): work of excellent quality, ethical and personal engagement. They have developed a 'toolkit' that might help professionals to reflect on their professional and personal values and gain insights into work that is meaningful and of high quality. With these insights they might be better capable of developing strategies to stimulate their professional practice in the long run and to handle opportunities and limitations, now and in the future. Herewith, good work of professionals and the organizations in which their work is enhanced.

A Dutch university hospital agreed, at the initiative of the *Professional Honor Foundation* in the Netherlands (www.beroepseer.nl), to do a try-out with the toolkit. People in the hospital believe that it is important to discuss together and to develop a vocabulary for good work, aimed at the power of professionals who take pride in their responsibility and an even better patient care.
The range of thought of the GoodWork toolkit starts from a psychological perspective and is focused on the individual, mostly young professional. Research has not yet been done in organizational settings with experienced professionals of the same discipline. Therefore we wanted to include the organizational and sociological perspective when exploring the effectiveness of the toolkit in raising the consciousness of the professional values of good work in a hospital organization.
The study aims to answer two questions: 1. What is the yield of these sessions? 2. What is the meaning of good work for these professionals? After a brief introduction to the literature regarding the medical profession as a narrative discipline and an outline of our study, I will describe our findings.

The medical profession: a narrative discipline

The medical profession can be fruitfully considered as a narrative discipline (Hunter 1999; Atkinson 1995). The case presentation functions as the fundamental medium of clinical thought and discourse (Hunter 1991). Sharing stories of patients is important, also for learning and the production of knowledge (Atkinson 1995, Witman & Smid 2009). In review meetings one might hear the phrase 'that reminds me of a patient' as a variation of 'that reminds me of a story' as a common sensemaking gambit (Witman & Smid 2009; Gabriel 2000; Weick 1995). Simpson & Griggs speak about the mnemonic effect and the vital function of anecdotes in the acquisition and organization of knowledge next to the more general social value (Simpson & Griggs 1985). Charon underlines the significance of narrative competence in medicine, that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others (Charon 2001).
Recently Prober and Heath plead in their proposal for medical education to use patient stories from the start of medical training with the argument:

> 'Messages also become stickier when they come in the form of a story that elicits emotion in readers or listeners. Patients' stories are what make the acquisition of medical knowledge compelling. They serve as the scaffolding on which facts and concepts can be organized and reinforced' (Prober & Heath 2012).

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The narrative paradigm (Fisher 1985), which has a long tradition in the social sciences, is based on the assumption that we make sense of our experience through narratives, stories or drama (Cunliffe & Coupland 2012): 'the primary human mechanism for attaching meaning to particular experiences is to tell stories about them' (Brody 1987, p. 5). Though, sensemaking and storytelling are not synonymous, sensemaking implicates storytelling and storytelling implies sensemaking (Colville et al. 2012). Collective narratives create shared meanings around events (Boyce 1995). Shared stories provide a framework to interpret common experiences, to deal with conflicts and to confirm moral values (Abma 1999). Forester also underlines the importance of practice stories (Forester 1993). Story-telling may explore the practice-based tacit knowledge (Balogun et al. 2003).

The nature and purpose of narratives in organization studies are theorized in various ways (see for instance Orr 1986; Rouleau 2005; Weick 2001; Boje 1995; Currie & Brown 2003; Rhodes et al. 2010; Cunliffe 2002). The common theme is that narratives are the means by which we organize and make sense of our experiences and evaluate our actions and intentions (Cunliffe & Coupland 2012). Weick and Suthcliffe, who take the position that the concept of sensemaking fills important gaps in organizational theory, refers to the link with time and action: 'sensemaking involves turning circumstances into a situation that is comprehended explicitly in words and that serves as a springboard into action' (Weick & Suthcliffe 2005, p. 409). Cunliffe and Coupland state that sensemaking is temporal in at least two ways: 'in the moment of performance we draw on past experiences, present interactions and future anticipations, and second, we plot narrative coherence across time' (Cunliffe & Coupland 2012, p. 83). Story thus shapes and conveys sensemaking Narratives and storytelling are seen as a crucial part of identity work in that we are constantly engaged in trying to create relatively coherent narratives of our life (Cunliffe & Coupland 2012; Watson 2009). It helps us understand how we fit into larger narratives (Czarniawska 2006). Mills considers identity construction to be 'at the root of sensemaking' (Mills 2003, p. 55): 'identity shapes the story as the story shapes identity' (Cunliffe & Coupland 2012, p. 83).

In this study we use the concept of habitus for the professional identity to bring our findings in line with the results of our earlier research of medical leadership in the hospital organization (Witman 2007 / 2011).

The concept of habitus stems from Pierre Bourdieu (Bourdieu 1990). Bourdieu's most important, interconnected concepts are field, habitus and capital. The concept of field refers to social space. It is to be considered as a 'world', like the medical world. A field is a relatively autonomous space, with an internal logic of its own. A field can be called a field when there is something at stake and people are willing 'to play the game' (Bourdieu 1989). While the concept of field denotes the external social structure of a world, the habitus can be considered as the internal model of social reality. The habitus develops in a process of socialization and can be defined as a system of dispositions: durable, subconscious schemes of perception and appreciation that activate and point the way to practice (Pels 1989). Under common conditions, a common habitus comes into being, such as the medical habitus. In our earlier research we distilled four dispositions of the medical habitus: the clinical, the scientific, the professional and the collegial disposition (Witman et al. 2011). The habitus ensures that people in their social practice have a 'feel for the game' and they take their social world for granted. Elias speaks of a 'second nature' (Elias 2001).

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In Bourdieu's concept of habitus we recognize the aspects of sensemaking – perception and appreciation – and intrinsic motivation to act in a specific way: dispositions of the habitus ' activate and point the way to practice'. Indeed, the socialization process in which the habitus comes into being is therefore to be considered as a form of social control: during the hidden curriculum, external rules become internalized and also the power relations are transferred.

Design of the research

The try-out with the GoodWork toolkit took place in a Dutch university hospital. In consultation with the board of directors, two medical department heads and a resident we decided to work with four groups in non-hierarchical contexts:

- A group of six department heads, experienced medical specialists, medical professors of a specialty and trainers of residents;
- A group of seven residents, young doctors training to be medical specialists;
- A group of nine interns, future doctors in training;
- A group of five nurses.

In this paper we focus on the three groups of medical professionals.

The toolkit and our program

We developed the program of the sessions, mostly based on the toolkit GoodWork (see appendix I). We worked with each group in four sessions of three hours. The first session was an introduction on the theme of good work. In the next three sessions we explored the three core themes of the toolkit: excellence, ethics and engagement. Each session ended with a written reflection on the basis of a few questions (see appendix 2). In the last session we evaluated the whole pilot.
We added the exchange of professional experiences – in fact case presentations – as an integral part of the sessions to the program. Though, story-telling as such is not a explicit part of the toolkit, we presumed that stories about the practice - exchanging and reflecting on the core values of the profession and its strategies and dilemma's – give participants words and language for the experiences of work (see also Sennett 2008).

Analysis

The sessions were taped and transcribed. We coded the material inductively. We chose a narrative approach, aimed at the meaning of narratives and the function of narratives as well. We answer the first question – what is the yield of these sessions? – by means of the analysis of the functions of story-telling. The second question – what is the meaning of good work for these professionals? - is answered through the analysis of the meaning of the stories.

The functions of story-telling

We elaborate on the different functions of the stories that become apparent during the sessions and that we derive from the evaluation results in the end. But we start with the motivations to participate.

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Reasons to participate

Firstly, the participants in all the groups mentioned that they 'were asked to participate' by a specific colleague. That says something about the power of expression of the colleagues who invited them: respected, engaged colleagues coming from their own group, and for instance not imposed from the organization. Besides this argument, the participants formulated various reasons to participate: to dwell on their motivation, commitment and on the core values of the profession; frustration about the growing bureaucracy; the wish to put their values into words, to change things, and to give a new impetus to the commitment and professional pride of their colleagues.
The differences seemed to be connected to the position and the experience of the participants. The department heads felt responsible for their colleagues, the training of residents, patient care and the organization; for residents and interns the most important issue was to become a good doctor. All of them felt the risk that their engagement would get lost in the pressure-cooker of daily work.

The sessions

The sessions evoked inspiration and motivation; this was especially linked to the examples of excellence. After his colleague's story about excellence a department head said:

> "In the meantime I also have a story. I think the engagement, the social engagement, the moral…. Such a person radiates an immense integrity. Indeed, he does not go for the money and all these things, but really for the interest of the patients."

We hear the admiration in this description and we assume that the storyteller's specialist functions as a role model, as a person with whom the department head identifies. Striking is the fact that the respect and admiration concern not the clinical expertise, but the moral attitude: to put the interests of the patient first. We can link this to the professional disposition, to feel personally responsible for the patient. A resident made the function of the role model even more explicit after his story about an excellent specialist: *"I can only hope that I will be a natural at something like that in the course of time. I think that all these qualities make a doctor excellent."* These excellent role models, and the discussion about these examples as well, are inspiring and provide motivation to also become excellent.
There was the function of mutual recognition and confirmation, as for instance the remark of a department head about their discussion showed: *"The funny thing is, that there emerge many parallel reasons and final results."*
Another example was the discussion after the story about a department head who decided to leave:

> Department head 1: "However, loneliness regarding a specific decision, though this a very big and difficult decision, of course you experience that on a small scale too".
> Department head 2: "We often experience this ourselves too, yes."
> Department head 1: "At that moment when you don't know whether it has to be A or B, then you feel very lonely. Then you would like to have someone else to ask: what do you think?"

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The mutual 'suffering' might help to enlighten the individual burden of the responsibilities of these department heads, and strengthen their leadership disposition and their bonding. But there is also the function of 'action-orientation': to make up your mind for the future. The shared dialogues about dilemmas in the sessions seemed to increase the consciousness of other options. The residents, who also mentioned in their reflections the mutual dialogue as a yield of the sessions, concluded sometimes after the discussion of their cases that they would solve these cases differently in the future.

Evaluation

In general the participants described the sessions as pleasant and very inspiring. More specifically they mentioned that: it was good to think and talk in a structured way and with one another about the core values of their profession, about the importance of motivation, about their own practical experiences, and to find the right words. They also stated that the sessions gave rise to a sense of community and solidarity.

Some quotations about the yield of the sessions:

- "It is in my system again"
- "I realize what a great job I have, that I again wants to propagate to pupils"
- "That you are proud again and that you like it that you're a doctor"
- "Recognize what motivates us"
- "So that you can better pass on your knowledge"
- "The core to achieve what we pursue, is to generate involvement, recognition, what motivates us"
- "It is not so much the final outcome, but the mutual discussions themselves"
- "It's about examples in your own practice, that you really occupy"
- "Groups that matter to define *what it is really all about*"

The phrase 'what it is really all about' refers to the meaning of the stories. I explore this topic in the next part.

The meaning of the stories

In their stories participants talked about the professional issues and the dilemmas that really matter to them. These were often beautiful and touching stories about 'the heart of the profession'. The meaning of the narratives / stories became especially clear in the cases based on their own experiences regarding the topics excellence and – dilemmas in – responsibilities.

Excellence

In the group of department heads the meaning of the topic 'excellence' was especially related to the dealing with their different responsibilities with regard to the patients and their leadership:

Quote 1: a department head in his written reflection after the session about excellence:

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> The definition {of excellence}: it is about integrity and morality. In any case good professional skills, but on top of that extra qualities of which integrity is number one, and which has nothing to do with money / power.

Quote 2: a department head concluded after his story:

> "So, what makes someone an excellent doctor or leader? (…) A basic standard with that is to realize what is best for the patients. I think that is important for us."

In quote 2 we recognize the significance of the professional disposition: to perceive oneself as personally responsible for one's patients. That means the interests of the patient come first (*A **basic** standard with that is to realize the best for patients*). Another issue mentioned here is the leadership dilemma of the department heads that we also mentioned in our earlier research: the feeling that they have to choose between the (individual) patient and the money (Witman et al. 2011).

The examples in the stories of excellence of the department heads are role models with whom they identify, and who have the utmost professional capital regarding the professional and leadership dispositions. These dispositions are especially about their felt responsibilities. The other dispositions with regard to clinical and scientific skills as a doctor seem to be a 'sine qua non'.
The narratives of the residents and the interns about excellence were about excellent doctors and tutors:

The story of two residents about their excellent example of a psychiatrist:

> We think that she is an excellent doctor because she combines many good qualities in herself. She has tremendous knowledge. She is a very good communicator, she can build a contact with the most troublesome or difficult patients; with respect for the patient; and without denying herself or her own ideas on the situation. And that takes a lot. It is also true that she can explain very well. She is very engaged. She really does things out of concern for the patients. She also puts in extra effort, as you can see in this particular case. She could have said: "just let the boy leave the department, too much trouble, we won't put in any more effort on him." That is not the position that she would take.

These residents in psychiatry explained how this engaged specialist upheld the interest of a complicated patient –related to the professional disposition - and how she showed her expertise through predicting the course of the disease, the contact with the patient (the clinical disposition) and her knowledge (the scientific disposition). They also think that she was excellent because she transferred her knowledge to them, the residents. This topic was significant, also in the other groups. Specialists can feel responsible for the training or perhaps rather for the quality of their future colleagues. In this way this responsibility is closely linked to the responsibility for the patient and hence to the professional disposition. The doctors and specialists in training, who are dependent on the willingness of these specialists, are particularly sensible to this responsibility. As an example, they identify with the specialist, and in this socialization process the professional disposition – to feel responsible for the patient – is transferred.

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Dilemmas

In the stories of department heads where dilemmas played a major role, the dilemmas were related to colliding responsibilities, for instance between the responsibility for the patient, for the profession and for their department or the society. One department head introduced his story regarding colliding responsibilities with the title “to serve the business, not the patient”. He told about his decision to reject a patient category, for which the operation costs were too high. He explained how he felt responsibility from the point of view of his leadership for the dilemma of choosing for the department and the hospital organization, versus choosing for the responsibility of the patients, because it was a nationwide problem. There was much resistance from the nurses and doctors involved. In the discussion that followed after his story, the emotions were visible even in the critical questions of the colleagues.
Another department head restricted the treatment with expensive medicines against the wish of the patient, because of the lack of scientific evidence. The department head felt the dilemma of choosing between ‘the easiest way’: to give the patient what she asks for, but then to violate his societal and scientific professional responsibility; and to take the hard way: to refuse to give the medicine, and to risk reputation damage and going to the disciplinary council.

In the dilemmas of the residents we can see how their own personal values might be in conflict with the medical professional ones. In the following story a pregnant resident tells about performing an abortion on a child with Down syndrome:

> Only at that moment I thought it was a very confrontational decision because at the same time I did the vaginal examination, I felt the child kicking against my fingers. And the only thing I could think was: "I’m going to kill you now." And I found that really hard. (…) And I thought about it regarding my own pregnancy. If I had a Down with no physical abnormality, then I would not terminate my pregnancy. Would that then mean that I would not do that with other people? No. (…) For myself I make another assessment, yes. My strategy is that I want to do well. And I see that I do well there, through the fact that I still do it.

The resident wants ‘to do well’ as a doctor, although that means that she has to perform a procedure on a patient that she would never experience herself. She also faces the dilemma of choosing between the responsibility for the mother and the child.

In the beginning of their training the residents identify more with *the patient as a person*, like they are themselves, while later on they acquire the clinical disposition, which means they see *a person as a patient*, and the professional disposition with the professional responsibility. This identification with the patient as a person was even more notable with the interns.
The significance of their own training – to become a doctor – was for the interns more prominent than with the residents, especially in the stories about dilemmas.
The responsibility for their training can collide with the responsibility for the patient or for the department. An intern experiences a tension if she wants to attend a special delivery, when she is asked

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to perform a specific task. She learns nothing from this task, however she realizes that in doing so, she can contribute something to the busy department.

In two stories the storytellers were concerned about a colleague (intern) who was mal performing in their eyes. They did not know if the mal-performance was known by the supervisors and considered the possibility of telling them. However, on one hand they were afraid of violating the loyalty towards this colleague; on the other hand: *"If he does something like this, he will also not take his responsibilities in other situations. As a future doctor, I would not trust him."*
The topic of these stories was the dilemma of the loyalty for the colleague – related to the collegial disposition - versus the responsibility towards – future – patients, the professional disposition.

Discussion: sensemaking of professional experiences

> 'To deal with ambiguity, interdependent people search for meaning, settle for plausibility, and move on. These are moments of sensemaking' (Weick et al. 2005, p. 419).

What is it really all about?

In the sessions the participants exchanged practice stories, and through the stories they made sense of their professional experiences. In these stories *'what it is really all about'* they reveal their habitus: the way they perceive and appreciate the world around them, and the actions that follow naturally from that. Dealing with – dilemmas in – responsibilities was the most important subject of the stories in all the groups, regardless of the subject of the sessions. The mentioned dilemmas can be considered as moral dilemmas, which always comprise various values. Decisions can then give rise to undesirable situations, also for others. Therefore the choice cannot be made on a logical base, but has to be made on a personal base. In daily practice they sometimes have to struggle to make this responsibility work out well in challenging situations with conflicting responsibilities.
The different narratives in the different phases of training – and of socialization process – illustrate also the development of the habitus itself. In the examples of excellence we recognize for instance the different role models who personify the people the participants want to become. It is in the future. Role models and examples are important and inspiring for all the professionals, not only during training, and regardless of their position.
The narratives about dilemmas in responsibilities reveal with whom the storytellers identify in the present. The residents, and even more the interns, at one end of the scale, try to bring their responsibilities as fellow human beings of patients in line with the professional responsibility they have to acquire. They are in the process of mastering this new logic: their medical habitus is developing. On the other hand the medical habitus of the department heads seem to be most internalized, including their engagement, and the professional disposition is herewith 'taken for granted'. Their dilemmas in responsibilities arise when the responsibilities in their leadership clash with those for their patients.
The responsibility for their patients with all the corresponding dilemmas is related to the professional disposition that we earlier described as the professional science. Exactly this moral responsibility is part of the heart of professionalism, and the professional logic. It is about a normative professionalism (Van

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den Ende 2011), that is more suitable to conversations and stories that offer the professionals the opportunity to give meaningful words, and once more, to explicitly say 'what it is all about'.
The significance of the moral aspects for excellence of these professionals – whether it concerns the responsibility for patients, pupils or the department – resonates with the concept of social expertise (Sennett 2008). Experienced craftsmen with sociable expertise are able to treat others as whole persons in time; to feel comfortable with mentoring; and to turn outward professionally, i.e. 'they hold themselves to account and can also see what the work means to others' (Sennett 2008, p. 249, also referring to Gardner et al. 2002).

The yield of the sessions: good work….?

Through sharing the stories and the common sensemaking of significant professional experiences, not only did the individual professionals feel empowered in their professional habitus, but also their common habitus is confirmed. The mutual recognition gives rise to feelings of self-consciousness, professional pride, and feelings of community and solidarity. Sharing meaningful stories stimulates their intrinsic motivation, to aspire something that someone has not yet mastered, for the profession, for good work, but also to teach their pupils.
The sensemaking of professional experiences as it happened in the sessions is meaningful and contributes to good work. In telling and sharing stories the participants discussed and reflected especially on one of the core issues of the medical profession: their responsibility for their patients with all the corresponding dilemmas.
Dilemmas in responsibilities are to be considered as turning points, where professionals learn and develop their professional conscience (Van den Ende 2011). The participants mentioned 'discussing dilemmas with colleagues' as an important strategy for future cases. Therefore just like the review meeting, we can consider the sessions regarding good work as a form of 'reflective practice' (Schön 1983, 1999; Witman & Smid 2009). The face-to-face sharing of information may function as a work ritual that explores tacit knowledge and glues people together (Sennett 2008). Regularly sharing meaningful stories may contribute to the on-going professional socialization process, the professional habitus and function as a form of internal social control (Witman 2010). Herewith it may contribute to the self-regulation of medical professionals. The focus on the intrinsic motivation – more space for the sharing of practice stories regarding a normative professionalism - may / might restore the balance with the current dominant technical instrumental understanding of professionalism (a spreadsheet and control-oriented reality), with mainly external control systems, in a positive way. It is also in line with the argument of Freidson for 'institutional ethics', which is to be considered as a moral consultation on the organizational level, because there is a larger distance between the individual doctor and the decisions that affect both the individual patient and groups of patients (Freidson 1999). These institutional ethics need to ensure that the professional conscience of the medical world plays a significant role in the organization to protect the trust in doctors and hospitals.

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Some considerations, limitations and future research

The Goodwork toolkit has proven to be a good framework to talk about the core values of the medical professionals. Though outside the scope of this paper, this was also the case for the nursing staff. In the toolkit a difference is made between the topics ethics and engagement. However, in the sessions for the participants 'responsibility' was a more appropriate concept than 'ethics'. Moreover, in the stories and narratives the topics responsibility and engagement were inextricably related.
The participants argued unanimously in favor of the implementation of the toolkit broadly based in the organization. However, despite the enthusiasm of the professionals and the positive evaluation, it is very difficult to find 'space' and a creative design for these initiatives that are time consuming without 'hard' results. Our findings were limited in that way. Our research was done with just a small group of selected, motivated professionals, in one particular hospital organization, who participated in their spare time. We 'missed' a group of medical specialists without a leadership task and the project was too short to claim results regarding good work.
Therefore further research should be done on the yield of these sessions regarding good work in the hospital organization. It is a real challenge to make an organization design that uses the range of thought of the toolkit. One might apply the toolkit in the narrow sense, like we did with different groups. Another interesting option would be the use in a broader sense: to integrate the sharing of stories in current practices.

I conclude paraphrasing Weick: 'the sessions were perhaps micro-level actions, but they are small actions with large consequences' (Weick et al. 2005, p. 419).

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Appendix I: program of the sessions

In the general framework of the sessions we started with the personal views of the participants on the theme at hand. After that we discussed a case story from the toolkit, originating from another profession. Then we went back to the profession of the participants and asked them to describe stories, 'cases', regarding the topic concerned. Each session ended with a written reflection on the basis of a few questions (see appendix 2). In the last session we evaluated the whole pilot.

Session 1: introduction

- Introduction / expectations
- Interviews in couples regarding the topic a good professional
- Participants fill in a questionnaire (toolkit) regarding good work in other professions
- Reflection / discussion on stimulating and compromising factors for good work
- Participants sort a set of values (toolkit) in order of relative importance to their personal and professional lives
- Written reflection

Session 2: excellence

- Presentations assignment regarding examples of excellence (outside the medical world)
- Debate in two groups about a narrative (toolkit) regarding excellence
- Reflection / discussion on narrative (toolkit) about relation excellence and moral responsibility
- Narratives participants about their examples of excellence in the medical world
- Written reflection

Session 3:

- Individual reflection on professional responsibilities
- Discussion about a narrative regarding an executive director and divided loyalties
- Narratives participants about their examples of colliding responsibilities
- Written reflection

Session 4:

- Interviews in couples regarding the topic of engagement
- Reflection / discussion: What do you want to transfer to pupils?
- Role-playing about change starting from the perspective of another person
- Written reflection
- Participants sort again a set of values (toolkit)
- General evaluation

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Appendix II: evaluations

Session 1:

1. What did this session yield you?
2. What did you learn about the definition of good work?
3. How do professional criteria for good work relate to your personal notions?

Session 2:

1. What did you learn about the definition of excellence?
2. What are possible strategies as standards of excellence conflict with what others expect from us?
3. What did this session yield you?

Session 3:

1. Out of which responsibilities are you acting?
2. What are possible strategies as your responsibilities collide with each other?
3. What questions did occur to you with regard to ethical work?

Session 4:

1. What did you learn about the value of working out of engagement, intrinsic motivation?
2. Does this contribute to good work and if so how?
3. What can stand in the way?

About the author

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