The International Journal of
WHOLE PERSON CARE
VOLUME 1 ● NUMBER 2 ● 2014 ● 51-61

"BUT WHAT AM I GOING TO SAY?"

SOME ADVICE TO MEDICAL STUDENTS ABOUT DEALING WITH FEELINGS OF INADEQUACY

John H. Kearsley[1*], Eric J. Cassell[2]
[1*] Corresponding author: University of New South Wales, Sydney, St. George Hospital, Kogarah, Australia
John.Kearsley@SESIAHS.HEALTH.NSW.GOV.AU

[2] Weill Medical College of Cornell University, New York, USA

KEYWORDS: Medical students, Stress, Role conflict

INTRODUCTION

Having spoken to many hundreds of young medical students before, and during, their rotations through oncology and palliative care, we have become increasingly aware of the many clinical issues that distress medical students. The following quotation seems to sum up the concerns that worry students most of all. It goes something like this:

"I feel so inadequate. What am I going to say (to a 'cancer patient')? What if I make the patient emotional? I really don't want to be the cause of even more distress to patients who are already suffering in an overburdened health system. After all, I am only a medical student".

The quotation contains a number of important concerns that distress many medical students. The central issue, we think, is the feeling of inadequacy in the presence of the sick patient and the demand to act for the patient's benefit. The quotation, in our opinion, occurs frequently in response to many common clinical encounters. For instance, what advice should one give to students when the patient suddenly bursts into tears, or when the patient tells the student that she would rather die than carry on, or when the patient is critical of the medical care which is being provided? The student is suddenly "put on the spot"; he or she

wants to respond in some helpful way, yet "being helpful", or "caring in a therapeutic way" is not necessarily in the "job description" of a junior clinical student. Their task, by and large, is usually defined as "to learn", and not to be directly concerned with providing support for patients in their distress.

We believe it useful to discuss these overlapping concerns by dissecting the quotation point-by-point, in the context of advice that may be useful to students who feel this way.

"I feel so inadequate."

Feeling inadequate is a problem which physicians face their whole life.

We all feel inadequate at certain times, especially when we need to deal with "difficult" clinical situations in which "bad news" is discussed or in situations where the outcome is difficult to assess accurately.

Why is it that many medical students, and even senior doctors, feel "inadequate" and powerless many times in their career?

If we are such "bright" and intelligent people, how is it that we could ever feel "inadequate"?

In an attempt to help students resolve some of their feelings of inadequacy, we suggest that students reflect on the following issues:

1. DEVELOPMENT OF A PROFESSIONAL IDENTITY FROM MEDICAL STUDENT TO DOCTOR

You may be feeling inadequate simply because you are not yet a qualified doctor. This is an issue about the gradual development of a professional medical "identity". So, if you are a 1st year medical student, you will probably have only a limited understanding of what "being a doctor" means, and knowing how a doctor might behave when you are in a real situation with a patient. In contrast, a final year medical student will usually have a more fully-developed concept of himself/herself as a "doctor" because of the varied experiences of being a medical student over several years. This process of developing your self-concept of what it is to be a doctor will come gradually as a result of your experiences in the clinical environment as a medical student, reflecting on your experiences (both positive and less-positive) in the clinical environment with patients, identifying good role models, and being exposed to the prevailing medical culture.

So, developing an understanding of your professional medical identity and how a doctor functions in the clinical setting is important in becoming more confident with patients at the bedside. However, developing a professional identity should also be informed by your interactions with your patients and how you develop therapeutic relationships in the care you offer. Despite your inexperience and junior status, you have a legitimate role as a healer. In taking the opportunities to embrace this concept during your training, you can develop a professional identity from the perspective of the patient as well as the clinical environment.

2. DOES "HEALTH PROFESSIONAL" MEAN, OR IMPLY, BEING "DETACHED"?

Be aware that becoming a medical "professional" does not imply that you should relate to patients in a cold, detached fashion. Many of your teachers may have been advised in the past "not to get too close to patients" and this advice may continue to be promoted and emphasised in your medical training. Over the years, however, most of us now recognise this to be a maladaptive way of relating to patients which may contribute to poor patient satisfaction, a poor doctor-patient relationship, and doctor burnout[1]. To do the best for your patients (and yourself), it is important to learn how to relate to patients as "persons". Be aware that you (as a person) are also an important component of the therapeutic relationship, just as much as your knowledge and skills are, in providing the best care[2].

Have you ever asked yourself why some doctors believe that it is "professional" to deal with patients in a detached fashion? Why does this happen? Maybe it is because some doctors see "patients", not "persons"; maybe, also, they see "patients" as "diseases to be fixed". Maybe others see themselves primarily as "scientists", and patients as "experiments" in the great laboratory of Medicine.

3. THE PROBLEM OF UNHEALTHY PERFECTIONISM CONTRIBUTING TO FEELINGS OF INADEQUACY

What do we mean by "feeling inadequate"? Where is the proof that you may be "inadequate"? What are the emotions that we experience when we feel "inadequate"? Do we suddenly feel inadequate, or have we grown up feeling inadequate? Is "inadequacy" for us just a way of life? Do we feel "inadequate" because we have a touch of "perfectionism" about us? Achievement of perfectionism in high school study

is often a pre-requisite to gain admission to a medical faculty to undertake medical studies. The pursuit of perfectionism is one of the major concerns of modern medical training [3,4].

As a result, we may develop the sense that we are always falling short and that we will never be quite good enough. What, if any, has been the role that our parents and teachers have played in engendering feelings of inadequacy in us in the past.

4. THE PRESENCE OF CLINICAL UNCERTAINTY

Fear, ignorance and uncertainty are always present in the midst of sickness. The fear of not knowing the "right" way to respond to the patient's predicament may contribute to a sense of inadequacy? Examples of such questions may be: "Will the bleeding stop, and what happens if it doesn't?" "Why is this pain getting worse when things are supposed to be getting better?" "What will my liver function tests be like tomorrow?" "The doctors say there is nothing more that can be done; so, what happens now?"

Despite the factual knowledge you learn either as a medical student or as a specialist doctor, a sense of uncertainty may continue to be present in certain clinical scenarios. In your whole life in Medicine, the same three issues will be present in the background. There is always more to know; therefore, there will be ignorance. The more you know as you progress in Medicine, the more you know what can go wrong; so, there may be a sense of fear. The more experienced you are, the more you are aware that there is not usually one correct answer; so, uncertainty often accompanies you. In addition, none of us can ever predict accurately the course of a particular patient's illness. Even within the same disease "label", there will be many different journeys and outcomes that the patient experiences.

5. THE GOALS OF MEDICINE

It's sometimes useful to think about what we believe our goals are in Medicine. What, in fact, is the whole aim of being a doctor? Why are we studying Medicine in the first place? What have been our expectations in becoming doctors? Does the medical curriculum provide a good balance, and equip us to both "cure disease, and heal the sick"? How do we respond to the many clinical situations that may not be "fixable"?

Similarly, it is useful to consider what patients think the doctor's role should be. Years ago, one of us (EJC; personal communication) tried to find out the answer. After trying out a range of sophisticated questions and questionnaires, EJC settled for the simple question, "What is the doctor's job?" After studying the responses from a large group of "well" people in diverse cultures, EJC got virtually the same answer from everybody: "to make me better!" Nobody mentioned the technical skills by which doctors often measure themselves.

What were the respondents trying to tell us? Yes, we doctors know a lot of technical and factual information about treating patients, and so will you. These are our tools of trade. They are not, however, the treatment itself. Carpenters, for instance, do not confuse themselves with their tools. Why do we? As our contemporary tools have become more and more sophisticated, and often so effective, many doctors have forgotten (if they ever really knew) that essential to the treatment is the doctor, him- or her-self! In our view, how the doctor uses him- or her-self is a critical aspect of medical care.

Some of the issues that we identify during our discussions with patients are complex and some are beyond our understanding, or our ability to fix or solve. We all feel inadequate in these circumstances. But, maybe, our job is more than understanding the problem, and more than fixing "medical" problems – maybe, there are times when the best thing to do is just to be there, to endure with the patient whatever he or she is feeling. As Professor Balfour Mount said many years ago, sometimes "you make a difference when you take the time to sit down and listen, when you stay there in the face of unanswerable questions."[5].

In becoming more aware, and more attentive, by reflecting on our own fears, ignorance and uncertainty, and how those situations make us feel, maybe, strangely, we may discover our own sense of adequacy.

6. THE DOCTOR-PATIENT RELATIONSHIP VERSUS THE "SCIENCE" OF MEDICINE

For centuries, the practice of Medicine has been regarded as both a "science" and an "art". That is, successful health outcomes often depend as much upon the personal qualities of the doctor and the application of medical expertise and experience to meet the needs of individual patients, as they do upon core scientific and technical skills and knowledge. And yet, a lot of our training in Medicine is focused on Medicine as a science, dealing with the diagnosis and treatment of physical disease. As long as we treat human beings, the practice of Medicine as an "art" is always likely to remain within the medical mandate.

But, how well-equipped do we feel practising the "art" of Medicine. In all our attempts to "cure disease", have we forgotten the skill-set that we need to "heal the sick"?

The really important point to make is that you need to see yourself as part of the therapeutic equation in treating patients (who are also, fundamentally, persons). In time, you may learn that your presence can have a profoundly-positive effect on the patient's predicament[6]; even though clinical skills are fundamental, whom you are as a person and how you relate "person to person" may be equally as important as what you know as a doctor[7]. Without this insight, the traditional role of doctors "to heal the sick" will be an aim beyond your reach.

"What am I going to say (to a 'cancer patient')?"

What would you normally say to a person whom you had never met before? Maybe "hello, how are you?" would be a good start. What about just introducing yourself, and asking the person some open-ended questions? Remember to be curious. "How are you feeling?" "Why are you in hospital?" "What's been happening to you?" "What's the worst thing about being in hospital with this disease?" "Do you have a family?" "What do you do for a living?"

There is now a great deal of very useful literature, as well as interactive courses, which deal with communication skills training[8, 9]. However, much of the success in effective communication is based on "listening", not "saying".

Why treat patients with cancer any differently from anyone else whom you might meet on the street, in a shopping centre etc.? Maybe, it's about what "cancer" means to you? What *does* it mean to you? Is it always a "death sentence"? Whom have you known with cancer? What happened to them? And, how did you feel about that, deep down?

Try to find out about the person, and where they are at in their lives at the present time. What are their main concerns? What are their sources of strength? How are they coping? What are their limitations? What can't they do that they want to do?

Don't worry about the fact that they might have cancer. The conversation will flow. You will discover that people with cancer, in general, have a great need to tell you about themselves and their experiences. And they are generally very grateful that you show interest in them.

And, often you don't have to say much at all. Many sick people, especially people in hospital, have a great need and desire to talk to someone. Listening can be one of the greatest skills that you can develop.

So, listen, listen, listen. If the person is distressed, ask what they are distressed about. Then listen, really listen to the answer, and make sure you really understand what the patient is saying, or asking. Ask simple, short questions to clarify the main issues. The patient's response is often not crystal-clear; so, ask the patient what they mean. When you really understand the response, or the question, the answer is usually not too difficult. So, listening to what the patient is really asking can be much more important than trying to prepare for what you might say next. Patients' biggest complaints about doctors, in survey after survey, is that doctors do not listen.

Try also to listen without a sense of judgement, and without trying to fix or solve the problems that you are hearing. If you feel uncomfortable with what you are hearing, then try to sit with it for a while; an appropriate time of silence can be quite powerful, and you don't have to respond straight away. Later, perhaps with the help of a mentor, it may be worthwhile trying to figure out why you were feeling so uncomfortable; the next time a patient triggers those feelings, you are more prepared, and may be able to tolerate the situation a little easier.

"And what if I make the patient emotional?"

This is another situation in which even senior, experienced doctors become uncomfortable.

It is a false premise that "you" are going to make a patient emotional. If you are rude to people, if you are dismissive of them or ignore them, then yes, you might make patients feel angry, frustrated and fearful.

But you are unlikely to do any of these things. Many of you have come into Medicine with the aim of helping to make sick people feel better; offending people, making people feel worse, is unlikely to be your way of relating. Therefore, it is unlikely that "you" will make a patient feel emotional.

On the contrary, if the patient becomes emotional in your presence, then you have probably developed a relationship, or made a connection, in which the patient feels safe to become emotional, and to share with you how he/she feels about life.

So, how might you manage an interaction with an "emotional" patient?

What would you do in normal life if an acquaintance of yours becomes suddenly emotional? Would you run away? Or, would you stay and try to understand and, along the way, provide support and comfort? Why should it be any different with a patient who has cancer?

Try to stay there, even when you would rather run away. Be aware of the positive impact that your presence can have. Learn to be an engaged witness to what is happening, even if you still have the task of "taking the history". You, as a student, can be the person who is available to provide compassion to a patient.

You don't need to say anything much, most of the time. An emotional patient is unlikely to hear what you say. So, it's often best to stop talking, and to let the conversation continue in silence.

Try to offer support in the form of gentle touch, a few thoughtful empathic statements, combined with empathic listening. Most of all, be yourself. Sometimes, a period of silence may be very powerful. Don't be too quick to shove a box of tissues in the patient's face to stop them crying. And don't be too quick to break your bond of silence with the patient. It isn't as if nothing is happening during those silences.

Patients with cancer (or any other chronic disease) are usually not expecting that you can "fix" what's wrong with them. But they certainly do like companionship, and having the sense that they are being supported as persons. They need to know that someone is there, and is prepared to stay and hear them. Loneliness, feeling lost, or feeling abandoned to the unknown, can be eased if you are prepared to stay. But, it's often not easy.

"I really don't want to be the cause of even more distress."

It is highly unlikely that you will be the cause of even more distress. In fact, quite the opposite. Even as a student, you might be just the person whom the patient has been seeking out all day. Someone to talk to when others are too busy, or distracted, to take time to pay attention. Don't forget, the distress which a patient experiences is not about you. It's about their illness, it's about their disease, it's about how they want to protect their loved ones from the pain that they feel, it's about their loss, it's about their loneliness – but, it's not about you. It's also all about what the name of their disease "means" to them. One of us (JHK) recalls a patient who was relieved to be told that he had lung cancer, rather than being told that he had the "scourge" of tuberculosis!

For a number of reasons, sometimes patients don't talk frankly with senior members of the medical team. Patients may perceive that some doctors may feel hurt, or even disengage from them, if they express

their doubts and fears openly; this behaviour is sometimes described as the patient "looking after" the doctor.

Therefore, rather than causing "more distress", you might be just the person for whom the patient has been waiting, someone who can remind the patient that their life is not all about their disease and their illness. You can use your communication skills and your presence to help sick people feel better. You can remind them that they are more than just a compendium of their test results. When our conversation with patients is all about their disease and its treatment, what are we really communicating? Sometimes, despite our best intentions, we may be reinforcing fear and uncertainty.

"To patients who are already suffering in an overburdened health system"

You are correct. There are many patients in hospital who seem to suffer. However, there are also many persons who suffer, and yet, are not hospitalised. We just don't know the exact figures – the studies to assess the prevalence of suffering, whether in hospital or whether out of hospital, have never been done.

What is true, however, is that hospitalisation changes people, and it may be a cause for suffering. Just think of what happens to people when they are hospitalised. The hospital ward can become a strange land, filled with even stranger routines, a strange language, and with strange people, many of whom wear uniforms. People often suffer from depersonalisation, sometimes even de-humanisation within the healthcare system. Many patients are regarded as "diseases", not as "real people". Just think of the many ways in which hospitalised people become depersonalised as "patients".

So, patients in hospital may suffer for a variety of reasons. They suffer because of their disease, they suffer because of their treatment, they suffer because of what their disease means to them, they suffer because they are "strangers in a strange land". And doctors can sometimes make their suffering worse. Patients may become known more for their test results, for their diagnosis or their treatment plan, rather than for whom they are as persons. They can be ignored, disregarded and marginalised. For instance, how often do we ignore, and walk busily away from, the stories that patients need to tell? How often do we ignore the lamentations of illness, yet only hear "complaints" of "difficult" patients?

As a medical student, your presence may be able to alleviate some of this suffering.

The secret is not to run away (even though you might like to). And, remaining present is not just a matter of being "strong"; it is a matter of being "human", being "normal", and allowing yourself to be vulnerable. It's about bearing witness to the truth of experience. That's when you really make a difference.

"After all, I am only a medical student."

Yes, you are a medical student. Yes, you are still learning the thousands of facts that the system demands of you. Yes, you have a lot of skills to learn and to practise in order to be a competent doctor.

But, you are something else, beyond the label of "medical student". Who else are you? Why did you choose to become a doctor? What attributes do you have to help sick people feel better? Can you smile? What about offering a reassuring touch of support? Can you empathise with someone else's sadness or joy? What are those other personal attributes that you bring to Medicine?

You are much more than a label. Even though you might not yet have the knowledge, nor the technical skills, nor the abilities of your senior colleagues, you are who you are. You have unique personal attributes and abilities. You may even have those communication skills and those healing abilities that are often found wanting in many of your more senior colleagues. The degree to which you connect with someone does not depend on how junior or how senior you may be.

You will always be much more than the labels that others put upon you.

Like it or not, you are part of the therapeutic equation.

Isn't this why many of you chose to become doctors in the first place? ■

REFERENCES

1. Coulehan J and Williams PC. Vanquishing virtue: the impact of medical education. Acad Med. 2001;76(6):598-605.
2. Cassell EJ. The nature of healing. Oxford, UK: Oxford University Press; 2013.
3. Shapiro J. The inner world of medical students. New York: Radcliffe Publishing; 2009.
4. Peters M & King J. Perfectionism in doctors can lead to unhealthy behaviours in stressful work situations. BMJ. 2012:344:e1674.

5. Hamilton J. Dr Balfour Mount and the cruel irony of our care for the dying. Can Med Assoc J. 1995(3):334-336.
6. Kearsley JH. Wal's story: reflections on presence. J Clin Oncol. 2012;30(18):2283-5.
7. Remen RN. Kitchen table wisdom. Sydney: Pan Macmillan Australia; 2010.
8. Clayton J, Hancock KM, Butow PN, Tattersall MH, Currow DC; Australian and new Zealand Expert Advisory Group, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. Med J Aust. 2007 Jun 18;186(12 Suppl):S77, S79, S83-108.
9. Mauksch L, Farber S, Greer T. Design, dissemination, and evaluation of an advanced communication elective at seven US medical schools. Acad Med. 2013;88:1-9.