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HOW DO JUNIOR MEDICAL STUDENTS LEARN ABOUT THE DOCTOR PATIENT RELATIONSHIP?

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ABSTRACT

Junior medical students have the capacity to engage well with patients at an early stage in their training. With careful coaching, students can also write moving and accurate accounts of their significant learning experiences. In this article, we describe an innovative learning programme at Otago University in New Zealand, and present carefully chosen extracts from student essays. These extracts illustrate students' early exposure to, and challenges in, the student-patient relationship, a precursor to their own professional relationships. Writing reflective narratives can help students internalize foundational interpersonal concepts such as meaningful engagement, self-awareness, the role of other health professionals, and the need for self-care. This early orientation towards narrative competence and whole person care may be helpful grounding for future clinical practice.

KEYWORDS: Medical students, Doctor patient relationship, Experiential learning, Reflective practice, Whole person care, Narrative medicine

INTRODUCTION

"It was an unnerving experience. It was as if this piece of physical contact had directly injected into me a dose of the reality of the man's condition. Here was a man who was in his most vulnerable position, and here I was, an untrained, unqualified stranger taking off his pants." (Student B)

Written by a junior medical student, this is a key passage in his reflections on working in a nursing home for the elderly. Since curriculum revision in 2008, first year students at our University are now required to undertake 'clinical placements' where they work as apprentice care-assistants in residential facilities or resthomes.[1] Students are placed alongside nurses and professional care-assistants to provide personal cares for elderly and highly dependent patients, usually referred to as 'residents'. This article is based on students' reflective accounts about this experiential learning.[2]

EDUCATIONAL CONTEXT

After the influential Flexner report of 1910[3], undergraduate medical training was largely divided into two phases: preclinical and clinical. While this structure provided a more thorough grounding in basic medical sciences, it also created difficulties in students' transition to the care of real patients. In recent decades, various initiatives have emerged such as problem-based learning, community-based training and earlier acquisition of clinical skills; all educational responses to the problematic divide between the preclinical and clinical phases of training.

One of the key components of these initiatives is authentic early experience (AEE), based on significant interactions with real patients.[4] Organizing meaningful clinical contact however, is structurally and logistically challenging. Junior students have insufficient knowledge or skills to contribute to medical care, so an intermediate step for them is to interview patients about their health problems. These early interviews help students link particular diseases back to theory: they practice communication skills and how to maintain confidentiality; they gain professional confidence. In brief, 'early experience helps medical students socialize to their chosen profession.'[5]

However, students are mostly 'spectators' in these clinical experiences; there is less emphasis on the 'potentially important role of responsibility' within this early learning.[6] Scavenius et al noted how students tended to develop 'patient-centred relationships' if they were provided with opportunities to take responsibility in some way for patient care. Furthermore, while the identified outcomes from AEE continue to increase[7], there remains less emphasis in the educational literature on what or how students are learning about whole person care or the doctor patient relationship.

In response to these pedagogical challenges, we now provide our early medical students with opportunities to be more directly involved in the care of elderly residents, at least in relation to activities of daily living. In

doing so, students learn first hand about a range of medically related topics such as frailty and dependency, incontinence, care of the dying and interprofessional teamwork, all issues that can impact on the student-patient relationship.

Each student is assigned to a local residential facility to complete 20 hours of assistant care work under direct supervision of the nurse manager and various care-assistants. Students work weekends (2 eight-hour shifts and one of four hours) or weekdays (5 shifts of four hours).

On completion of their placements, students write reflective narratives (1500-2000 words) about their learning, including accounts of their interactions with particular residents.[8] Each tutorial group of 10-11 students has a faculty tutor who provides detailed feedback on their capacity for adequate description, understanding and 'critical reflection.'[9] Consistency of feedback over the last eight years has been achieved through comparisons between tutors and benchmarking.

In 2014, we reviewed essays from five tutorial groups (53 of 290 students in the first year class), looking for student reflections on significant interactions with various residents. Extracts chosen here are located within the emerging discourse of narrative medicine in which clinicians have the ability 'to acknowledge, absorb, interpret, and act on the stories and plights of others.'[2] In particular, these extracts illustrate narrative competence within the student patient relationship.

FIRST PATIENT INTERVIEWS

Early clinical contact starts in the first few weeks of medical school, when pairs of students visit patients in their own homes. This first interview is a retrospective look at patients' experiences of illness and their interactions with the healthcare system, particularly focusing on comments about health professional relationships.

Here, a student reflects on her first patient interview and how her preconceived ideas were swiftly challenged.

Student A: "A change in direction from my preconceptions"

> *"Early in the year we were given the opportunity to interview a patient in her own home. While I originally thought it wouldn't be that interesting to interview someone from a retrospective view instead of having actual patients currently experiencing their illness, I quickly changed my view when our patient started to echo a multitude of concepts we had learnt. In class, I had not really given much thought to developing doctor-patient relationships and how I would try to show empathy without being patronising.*

> *The interview had a powerful impact on me as I was listening to someone from the community with no med school bias stress the importance of these concepts and how much of difference can be made by treating people with respect. I learnt from her that if the doctor is compassionate and approaches the patient the right way, patients can still be grateful and appreciative when receiving bad news. I thought it was a privilege to have the opportunity to share the intimate details of a complex medical and personal history with her.*
>
> *While our interview was not perfect, I think it was beneficial for us to make our mistakes early on with a forgiving patient since it shocked us and ensured we would not make similar mistakes in the future. The feedback I received reflected this, and overall I learnt effective ways of teasing out all the information from a patient in a respectful manner to develop a full story about a person."*

This student admits that her first interview might be of minimal interest, viewing her preparation by the medical school as 'biased'. However, the patient's unprompted and authentic story is very helpful; she acknowledges the importance of respect within an orientation of whole person care.

EARLY EXPERIENCES OF THE STUDENT-PATIENT RELATIONSHIP

After several interviews, students start their clinical placements as apprentice care-assistants in local resthomes. The following passages are extracts from students' narratives about their significant interactions with elderly residents, where they are taking responsibility in some way for patient welfare. These narratives cover a wide range of issues, being students' first lived experiences of the professional-patient relationship.[8] All extracts are used with student permission and patients are de-identified to preserve confidentiality.

Despite their prior misgivings about working with elderly and very frail people, these early students have the capacity for considerable depth of engagement. This narrative is from Student B, a 21-year-old male. In his first experiences of dementia care, he writes eloquently about a specific moment between the patient, the care-assistant and himself.

Student B: "The duty of care"

> *"Sometimes it takes a moment of physical contact to bring a stunning realization that the craft we are learning will profoundly affect our patients in ways that we had never imagined. This is what happened to me.*
>
> *It was on my second day at the rest home that we were called to shower an elderly man who was new on the ward. His daughter waited outside. I could tell immediately that he was severely demented. He was lying in bed looking at us with a confused and fearful*

expression. I felt sorry for him; from the vast amount of books placed in his room he had obviously been a man who prided himself on having an active mind.

We approached the man slowly: "We're going to give you a shower, Poppa."

"Ehhh uhh, what now?" His voice wavered with fear and behind his eyes I could see his mind working as fast as it could, trying to process what was happening. We told him that we were going to take his clothes off and put him in the hoist. He could hardly make any coherent response.

"We're here to help you, my friend." It was as if the man was continuously waking up from his confusion in a foreign environment. I thought about how I might feel if this was the case for me – being surrounded by strangers trying to take your clothes off and not being able to understand what they were saying or be able to say anything yourself. I did not blame him for being frightened.

We needed to roll the man to his side so we could get his trousers down. When we rolled him over it happened. The man grabbed my arm with a firm, trembling grip and looked into my eyes with fear, not making a noise. His grip gave me a jolt of shock. I hadn't expected that to happen and until then I hadn't had much physical contact with the residents at all. He locked eyes with me right until we had finished undressing.

It was an unnerving experience. It was as if this piece of physical contact had directly injected into me a dose of the reality of the man's condition. Here was a man who was in his most vulnerable position, and here I was, an untrained, unqualified stranger taking off his pants.

Overall it was quite a sad experience. It highlighted to me the hazards of dementia and ageing, how someone who must have lived such a proud, happy life can be reduced to this vulnerable state. Also however, it reinforced my belief that we as health professionals, who are privy to these vulnerable moments, must show the utmost integrity in our actions. This is our duty. Minutes later the same man was humming as we washed him in the shower. He had forgotten the incident."

The student illustrates an initial empathy with this frightened old man, being conscious also of the man's daughter just outside. He wonders about this person's previous life and feels sad about the current situation. As he helps the care-assistant prepare this man for a shower, there is a sudden and extraordinary moment of intense physical contact. While the patient may have forgotten this later, the student was powerfully affected by this unexpected engagement, where he understood what it might be like to be so frightened

and confused. Significantly, this student was able to hold himself steady within the moment, not shying away from the intimacy of direct eye contact.

In our coaching of students about reflective writing, we stress they need to extend their writing beyond simple descriptions of what happened, to what they are taking away for their own learning. The implications for this student were not about biomedical knowledge, but about his understanding of the need for respect and integrity, given his growing awareness of this man as a previously independent person.

Other students also strive to achieve similar moments. However, a quite different range of feelings, including disappointment, characterizes the next student's narrative. This is from a student who wanted to achieve more connection with 'N', an elderly female patient.

Student C: "A reflective experience"

> *"The first time I noticed 'N' was on my first day at dinner. Dinner was spaghetti and meatballs, a plate was placed in front of N and I heard her announce, "I do not eat spaghetti under any circumstances". The dislike toward N from the caregivers was immediately clear. They all muttered something about 'Princess N' under their breaths and then one person sternly said "Fine, someone else can have your dinner" and it was passed on…*
>
> *In bed, N looked so vulnerable and precious, "Quick, quick" she said, "take my hand", her hand outstretched I took it as silent tears ran down her face. The caregivers left promptly and we were alone. It was at this point I felt there was more to N than her demanding surface.*
>
> *The worst* [sic] *her mind is still capable enough to know what is happening and is very aware of her surroundings to notice the hostility towards her. I feel she was very grateful for the time I spent with her, as it seems no one spends any more time than necessary with her. When I left her room, I was told that she was very manipulating; it was hard for me to understand why they treated her like this.*
>
> *Sadly it was two weeks before I could go back again, but N was deteriorating, she had begun to hallucinate; she was dying. The worst no one seemed to care, it was almost like it was relief to them. I feel like I have no right to judge as I have been there a measly 12 hours and they work every day, dealing with residents on a day to day basis. I don't know what she is really like, but I wanted to know. N was no longer with us by my fourth shift, this was a bit upsetting for me because I felt like I lost the opportunity to really get to know her. N would have appreciated someone taking the time to talk to her about what she had done in her life, as it was not very often that anyone would spend more time than necessary with her.*

> [This experience] *has taught me that you need to approach everyone differently and with an open mind. I learnt to not let what other people have told me influence the way I treat different people."*

This sad and elderly woman was intriguing, but the student is disappointed in not getting to know her further. However, she shows remarkable maturity in her reflections on the other caregivers' attitudes to this elderly patient. She also recognizes the tension between being influenced by more experienced staff and staying with her own intuition.

'INTERACTIONAL' CARING

These rest home placements enable the students to take responsibility for providing physical care for the residents. They also help students engage in what Scavenius et al termed 'interactional' caring: listening, comforting, providing physical contact and close attention.[6]

In the next narrative from a female student with an arts background, this approach is clearly articulated.

Student D: "Wisdom is applied knowledge"

> *"These interactions validated the residents as people. They were not only residents who had meals, pills, showers to give and toileting to be attended. I was not at any point able to transition past the value that was theirs as people, despite their inability to contribute through their performance. I didn't fit the rest home shape where in word we value all our residents, yet in action they are a task to fulfill because we don't have the time to relate. I had time.*
>
> *I am struck more and more as I think about these experiences that this placement was the highlight for me this year. It wasn't so much for the learning as being able to give something that is me to a part of society. I wasn't just a student. I was a human having a meaningful human interaction. I felt alive, just as I have prior to being at University where there are places to exchange value to another and it be keenly noticed by its normal absence."*

The student realizes that residents are much more than just a series of tasks to be performed, finding herself at odds with the caregivers' work schedule. However, she also recognizes that as a visiting student, she has the luxury of time that care-assistants do not. She is able to provide both physical and interactional cares, fulfilling her altruistic ideals. For this student, the implications are once again less to do with learning biomedical knowledge, and more to do with the importance of authentic engagement and whole person care.

We first mooted these early clinical attachments in 2008. Initially, we had a considerable task to convince some of the more skeptical students (and even some faculty colleagues) that the idea had merit. The following student illustrates an unexpected positive outcome from these early clinical attachments.

Student E: "A whole new perspective"

> *"Sometimes I wonder why I'm here [at medical school]. I start most days by running late. I attend lectures that usually go over my head and sit through torturous pathology tutorials looking at different images of what seems like the same pink stain. At the end of a long day, I wander home and attempt to understand just some of what was covered during that day. I'm relieved when it's finally time for bed, even though I will wake up only to do it all over again tomorrow. It is not easy and it is not always fun. So why am I here? My craving for success or the satisfaction of finally understanding something new and the opportunity to make a difference in even one person's life makes the gruelling hours of confusion worthwhile."*

This student then reflects about her experiences of helping to shower 'M', an elderly resident.

> *"I had never helped someone in such an intimate way and knew that the best way to learn was from such a considerate resident. I constantly asked M if she was dry enough, or if there was a different way she would prefer me to do things for her. She was very direct, but also very patient with me. I tried to keep the conversation flowing by asking about her family life and children. Once she started chatting, there was no stopping her. It was touching to hear her talk about her family with so much pride and enthusiasm. It was hard to believe that a person so full of life depended on me to get her up and dressed that day. Yet I, so inexperienced, was depending on her to show me how.*
>
> *I am fortunate to have this incredible opportunity to someday help people in my career as a doctor. I realise the road ahead will be a challenge but it is thrilling to think of what I could be capable of. Although it is rewarding to achieve a really high grade, it is just as rewarding to have a resident tell me; "You will make a wonderful doctor because you have such a beautiful smile." Sometimes I wonder why I'm here in medical school, but these experiences remind me why."*

This student gained considerable confidence from her clinical placement. Putting aside the day-to-day tedium of classroom based learning, she links a rewarding interaction with M to her motivation for choosing medicine as a career.

The next student further explores the 'culture' of medical training, perhaps reflecting the benefit of a prior background in political studies.

Student F: "Lifelong learning in the classroom and practice"

> *"I was so excited to start medical school. I thought that I would be entering a stimulating, collaborative programme where students and staff strive for excellence and are motivated by the desire to contribute to their communities, to science and to social wellbeing. Overtly, this is what the course offers, and we are told that we will develop into professionals that reflect the noble pillars of excellence, altruism, humanism and accountability.*
>
> *I question, however, the extent to which these pillars are reflected in the culture of medical school, and my feeling is that largely they are not. This year I have learned a lot of new facts about the human body, but I have found that there is little opportunity for critical thinking or personal growth, and that hard work is often perceived as "trying too hard". Though subtle, I think that the characteristics of maleness, independence, apathy and arrogance are more discernible in my classes than humanism or altruism, and I am disheartened by this.*
>
> *Fortunately, my rest home placement, as with my other community-contact experiences, reminded me that the pillars of excellence, altruism, humanism and accountability are significant when exercised in practice. I am very grateful to have had these practical experiences to remind me what it is that attracted me to medicine in the first place, and to help me consider what kind of doctor I eventually want to be."*

Despite the increasing diversity of entrants to medical school and that female students now outnumber males, this student suggests that a traditional 'male' ethos of training might still be present. Fortunately however, these practical experiences helped her to reconnect back to her own personal values.

LEARNING FROM ROLE MODELING

Students watch and learn from other healthcare workers on their placements, quickly making judgments about 'good' or 'poor' clinical interactions. The following student was impressed by the capacity of P (a care-assistant) to provide high quality, individualized care for SE, a highly dependent patient. She also comes to an important realization, that developing effective doctor patient relationships may take considerable time, especially given the norm of brief clinical encounters within hospital training.[10]

Student G: "Sometimes, a little means a lot"

> *"Throughout the year, we had been taught about identifying the causes of what the patient is suffering from, to communicate and connect with them to accurately gauge the severity and type of their struggles. I was never aware of the fact that there would be patients who*

can't portray their suffering to us. Over the 3 days I was there, I wasn't able to understand how I could make SE's life more comfortable. The caregiver P, on the other hand seemed to innately know what SE needed.

I now understand that there is more to being able to truly know a person than just having a one-off, long and meaningful conversation. I only had 3 days with SE, P had 2 years. In professions like caregiving and even medicine, the amount of time we have available to spend with a person is limited. It may take several sessions - to be better able to know a person's needs and to understand their unique cues.

During my initial meeting with SE, I was worried about my ability to treat future patients like her. Now, it gives me comfort to know that a sturdy and effective doctor-patient relationship may take months to years to develop. I feel that if I put in the effort and time, I may learn to know my patients like P knows SE. By knowing a person well, I would be more likely to give him/her the treatment that is more effective and something they consent to. I am comforted by this thought even though I wasn't able to connect with SE."

This student is fortunate to have been provided with positive role modeling quite early in her training, especially given her capacity to observe and acknowledge it so carefully.

FROM CARING FOR PATIENTS TO CARING FOR THEMSELVES

As we have already seen, students' placements in rest homes often trigger ideas about their clinical years ahead, recognizing that being a junior doctor can be challenging. Student narratives often highlight how relationships with residents and observing patient suffering can initiate more personal questions. Here is a representative extract.

Student H: "Avoiding emotional fatigue"

"Talking with Mr. T reminded me so much of one of the members of own family. A similar age and with similar job demands. But I do this with everyone. This is the loophole to my own 'protective wall' system. Will I survive in such a cutthroat profession as medicine?

How do the caregivers bare [sic] *to watch the physical and mental decline of their charges and still come back day after day? Some have been here for decades. 'Someone has to do it', they say. "Better us who know the people and the fastest way to comfort for each of them." It's true. I was lucky to work with some incredible people. They do their job well. With compassion, and with a smile for every resident. I tried hard to mirror their actions. To literally be their shadow. For three days I fed, washed, chatted and entertained. At the end of it I was emotionally exhausted. Completely wiped out. But I didn't have to go*

back on day 4, or day 5, or the following week. I am discovering that resilience is achieved in different ways by different people.

I am worried that my resilience is not strong. Not as strong as I thought it was at least. I am also worried about making that 'wall' stronger. Part of what makes me, me, is my ability to relate to others. I've worked with those with emotional fatigue. Teachers, dragging their feet to every classroom of the day. They are there to efficiently do a job and put on a good face while doing it. But they no longer see the people they are working with. At what point do you reach that stage? At what point does watching a highly educated man [Mr T] roll balls across the floor because 'there is nothing bloody else to do' become too much? What other ways are there to cope when working in these situations day after day, besides shutting them out and hoping you come through the other side unscathed?

I believe there is a fine line between resilience and emotional fatigue. To get the dose just right is going to be as challenging as memorizing all the muscles, vessels and nerves in the human body but no less valuable. I always want to be the kind of person whose smile reaches their eyes. One who genuinely listens when someone takes the time to talk to speak with him or her? My mentors, those special people you meet only once in a lifetime and who you never forget, can do it, and that's what I aspire to."

After feeling considerable empathy for a particular resident, this student asks some challenging questions. The decay of Mr T's formerly sharp mind and his current suffering has a profound effect on the student, becoming almost too much to bear. She asks herself: "How do other caregivers endure this?" She recognizes that in her future role, she will have to respond to her patients' suffering on a daily basis: will she be able to cope? She acknowledges the need to be resilient and that her current method of having 'a protective wall' may not be sufficient.

PEDAGOGICAL BACKGROUND

These student narratives illustrate the value of experiential learning. Each student is exposed to a unique set of clinical challenges leading to a wide range of learning opportunities and outcomes. Our educational stance is that their insights will be facilitated by focused, careful reflection. Reflection leads to better understanding of their own role and interpersonal dynamics within these early professional relationships; ideally, these students are demonstrating an orientation towards narrative competence and whole person care.

Over the course of the year, tutors provide students with focused and structured feedback, helping them move from merely 'descriptive' to more focused and reflective writing. Kember et al describe 'critical reflection as a change in perspective over a fundamental belief.' This is the level that our students are

encouraged to write to: 'personal insights that go beyond book learning.'[9] The next student acknowledges that writing about her clinical experiences was crucial to gaining more personal insight.

Student I: "The little things do matter"

> *"If I had to sum up what I have learnt from this year (apart from things like pharmacology), it is that the little things you do can make your patient feel more comfortable. These happen to be the most important and most positive things in the silent curriculum, things you do not realise you are learning until you start writing a reflective essay on it. They are things that you continue to learn throughout your life. The little things really do matter."*

LIMITATIONS

There are limitations to this review of student narratives. We specifically searched for reflective accounts of student patient relationship, but as we only reviewed about 18% of essays in 2014, the extracts used here may not represent the learning experiences of the whole cohort.

CONCLUSIONS

The narratives above illustrate how junior students are intrigued by these early clinical placements, where they interact compassionately with elderly patients. We contend that student learning about health professional relationships can be initiated quite early within medical training. Written narratives from medical students illustrate their capacity for thoughtful engagement, well before they have sufficient clinical skills to provide competent medical care. Student writing illustrates the ability to reflect carefully and usefully on their early clinical experiences.

In these first opportunities for taking responsibility for another person's welfare, students are exposed to a range of feelings, both the patient's and their own. Reflective writing helps them recognize and acknowledge their own professional and personal responses within the student patient relationship. This reflective work contributes to 'emotional intelligence' within the medical setting, where students learn to identify and respond to the usual roller coaster of personal feelings.[11,12] Regardless of each student's future specialty, these early authentic learning experiences are helpful grounding for their future therapeutic relationships.■

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