

HEALING ENVIRONMENTS THAT FACILITATE MEDICAL STUDENT TRAINING: FROM URBAN TO RURAL SETTINGS

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As I looked at her scan results, I knew it was bad. Multiple hepatic metastases, although the primary cancer remained unknown. A kind, gentle 85 year old woman, newly widowed, who only recently had felt ill and had no idea. As I watched my attending staff break the news and sit with her as she cried quietly, I was overcome with sadness. Over the next four months, I had the privilege of caring for her on the hospital wards, and in the emergency room, as I coincidentally happened to be doing shifts when she came in, in another acute decline. Even when I was not directly caring for her, I would run into her in the hospital and we would chat as we crossed paths in the hallway, she looking more gaunt and jaundiced, but more at peace, every time I saw her. As I saw her progress on her journey, the meaning she gave to her life and time remaining began to filter down to me as well. Whereas at the start of our time together I had been preoccupied with the futility of our treatments, I began to simply listen and accompany her as our time together went on and her acceptance grew. During one of my last weeks on the hospital wards, I glanced down at the patient list and was happy to see her name, though knew it probably meant she had further deteriorated. I was not shocked when I learned she was now receiving palliative care, and likely had

a week or two remaining. Towards the end of my rotation, I went in to see her –somberly preparing myself for what was probably our last meeting. I was met instead by a celebration in her room with all of her children, grandchildren, and their partners. Everyone had gathered from near and far to say goodbye. She introduced me to them all, and as I was readying to leave, she said, “Thank you so much. All of you have made my time here so special. I was so scared four months ago, but I’m ready to go see my husband now.”

Healing has been defined as a relational process involving movement away from suffering and towards an experience of integrity and wholeness, which may be facilitated by a caregiver’s interventions but is dependent on an innate potential within the patient¹. There is an increasing recognition within the medical profession that facilitating this healing process is very much within our mandate, as much as diagnosing, and managing illness. Simultaneously, the qualities of empathy and compassion have been recognized as skills central to physicianship and professionalism.

As professionals who serve people in distress, it can be argued that we have a moral imperative to participate in, and facilitate the healing of our patients. On a more practical level, creating a space for our patients’ healing through compassion and connection has been shown to increase patient adherence and satisfaction². It is crucial to include the art of healing in curriculum training, and equip future healthcare professionals with tools to facilitate this central role. While medical schools have begun to incorporate this in the way they select medical students and now include changes in their curriculum to reflect this, it is only through action that we learn. And it seems that doing, in fact, seems to un-do much of what we have learnt.

Contrary to what one would expect, studies have shown that empathy and the ability to be compassionate decreases markedly over the last two years of medical school as students spend more time interacting with patients. Some theories proposed to explain this phenomenon are compassion burnout, personal and professional distress, work climate, lack of professional role modeling, and the lack of continuity during clerkship³.

Being familiar with the statistics on compassion burnout, especially during clerkship, I was apprehensive about my own ability to accompany patients on their healing journeys. I already knew from personal experience that a busy urban tertiary hospital system was an environment where I risked losing sight of my reasons for going into medicine, getting caught up in the daily work of administering care rather than relating to patients. With this in mind, I opted to complete my core clerkship year at a rural satellite community hospital - a smaller center where I would be at a few sites over the course of the year, rather than at multiple large training centers. By doing this, I also hoped to be integrated better in the health care team.

This experience exceeded my expectations. I found myself facing challenging, rich human experiences while being rigorously trained, and given more autonomy than at a larger center. I was able to sit with my patients, have heart-centered interactions with them, hold their hands when they were scared, and debrief

with attending physicians after emotionally complex encounters. At the end of the year, while still only beginning on my journey of clinical training, I felt more human and at ease with the healing paradigm than I had anticipated. And this was not a unique experience – several of my peers felt the same.

Herein I will tease apart the various aspects of this smaller community hospital experience that contributed to my, and other students' ability to participate actively in patient treatment, and their healing.

GEOGRAPHY

A smaller cohort of students – twelve - we were the only students on any given service, and worked, at most, at three small community hospitals. Since the program is relatively new, we were a bit of a novelty in a system used to attending staff physicians who worked independently, and residents being the only junior trainees. We quickly became known in the hospital as additional hands that could contribute to patient care, and were integrated into care teams early in our year. Becoming familiar with the geography of the hospital, and the personnel – everyone from physicians to the housekeepers – gave us a sense of stewardship over the healthcare space. This came with a responsibility – for our patients' well-being as much as the overall well-being of the health care team. Being based out of only three hospitals added to the security and stability we felt.

An important element in this setting was the lounge shared by physicians, allied health professionals and students. This common area where we stopped for lunch served as a place to contact specialists informally, foster conversations, sometimes on joint patient care, and deepen personal connections among the healthcare personnel. For us, as students, being included in the same space deepened our sense of belonging into the daily life of the hospital.

Seemingly banal, knowing where we were going every day, how the hospital system worked and being included in the physical and interactive spaces of the entire health care team played a subtle, albeit important, role in our sense of belonging, and our ability to invest in all aspects of patient care.

WORK CULTURE

The health care team, which included nursing, auxiliary staff, allied health professionals, and physicians, was, in itself, a unit which functioned in a wholesome manner. The work culture was reflective of the cordial nature of the surrounding town. Overall, people got along well, treated each other with respect, and were uniformly committed to patient care. This culture extended to include us, positively influencing our behaviours by setting examples, and applying positive peer pressure. To rush off without addressing the concerns of a patient, to not take the extra time to assure a patient's comfort or to treat another member of

the health care team poorly seemed so out of place that, even if tempted in moments of impatience or fatigue, we did better.

FEELING HUMAN

We were encouraged to eat lunch, leave if work for the day was finished, debrief after difficult encounters, and take the time needed to address more than the physical symptoms of our patients. By being in touch with our own humanity it was easier to extrapolate what the very human needs of our patients might be. Additionally, perhaps because there were fewer learners, there was a diminished sense of hierarchy, and we were expected to take responsibility for our patients' health and well-being, always within the limits of our training. This was key in teaching us to explore, with our patients what could best facilitate their healing journeys.

Our attending staffs were always available but expected us to build relationships with our patients autonomously. They were receptive to our input, recognizing that we may be most familiar with these whole persons. Our supervisors themselves were excellent role models, often taking the time to sit with patients and their families, and explore what made them the people they were and how they viewed their lives changing in the context of their illness.

An important aspect of our relationship with attending staffs was the longitudinal nature of our Family Medicine rotation, where we were matched with a supervisor who oversaw our training. For some of us, they became a mentor – someone who helped us view our clinical experiences in the larger context of longitudinal practice.

WHAT MADE THIS EXPERIENCE POSSIBLE?

My intent is not necessarily to romanticize my clerkship experience. However, there were some very concrete realities that made this patient and learner-centered approach to healthcare possible. My core clerkship year was spent in a community hospital, with a small number of beds, and a more reasonable healthcare personnel-to-patient ratio. This community hospital was also not used to receiving medical students; the closest comparison they had of us was to medical residents, and so, most personnel had high expectations of us, expectations to which we hopefully rose.

We were a small group of medical students and residents, which made for more intimate teams, and ease of scheduling at the training sites. It was less of a logistical challenge for administrators to ensure that every student receive adequate clinical exposure in all the different areas of training. It was also possible to base students at fewer training sites for the entire year and offer them flexibility in their schedules. There are a

number of these qualities unique to a rural community-based training centre, but likely a number of these characteristics which can be carried to larger urban-based training centers.

CAN WE PRACTICE MEDICINE CONGRUENTLY?

Hutchinson and Dobkin consider the possibility of medical practice in a compassionate manner which is congruent with our own personhood, and that of our patients⁴. We know the value of our humanity in the practice of medicine, and the importance of encouraging physicians' wellness and emotional intelligence. Mindfulness meditation, and narrative medicine are just two of the tools being taught in medical schools as means to equip future physicians. There is simultaneously a recognition of the micro- and macro vicarious traumas that health care personnel face every day, which hopefully, is an incentive for health care teams to debrief honestly about inter-personal conflicts and difficult situations that may detract from creating a healing environment, for both patients and personnel in hospitals⁵.

There has been increasing recognition of the value of longitudinal curricula and mentorship which provides students with geographic stability as well as a deeper context to clinical experiences over the long term⁶. Other interventions which have been suggested include the integration of self-reflection practices into clerkship⁶. Importantly, there has been a call for a cultural shift, with a move towards truly inter-disciplinary healthcare teams, and healthier ways of communicating within these teams.

As for me, clerkship, despite its steep learning curve, was one of the most rewarding years in my training so far. I discovered more about being human in that year than in the rest of my life. It underscored the importance and the possibility of practicing medicine in a more authentic manner where I could be more present with patients, transcending the traditional disease model. Since then, I have completed electives in a number of different settings; I have seen some remarkable examples of healing, as well as dismal instances where patients chose to leave the encounter rather than carry on with a particular physician.

As medical students, we have the privilege and the advantage of being able to observe and learn from those around us as we transition in our professional development. We can adopt behaviours that enhance our practice and learn from exceptional healers. Clerkship showed me that we can learn to retain our humanity as we go about our busy work life, creating healing spaces for our patients and ourselves, and how much this contributes to the practice of medicine, something we are only now beginning to quantify. So now, when people say they are too busy to sit with a patient any longer, or I see careless expressions of anger in the professional setting, I know that another way is both possible and necessary.

DR. SMILOVITCH'S RESPONSE

This commentary describes a student perspective on the clerkship experience in a community hospital setting.

In examining the various factors that contributed to the positive training experience in this setting, much can be learned about what is required to help create a working environment that encourages development of professional identity in trainees while at the same time providing optimal health care. Role modeling and mentorship from attending staff members with allowance for graded responsibility from students was recognized as an important element in the student experience. Positive interprofessional relationships with a variety of health care and support staff was also recognized as contributing to a sense of community and shared responsibility.

A physical space where colleagues often gathered for meals, the lounge, provided a setting which facilitated the informal exchange of information often related to patient care, and further strengthened personal relationships. Working in an environment in which students felt involved, supported, accountable, and appreciated contributed to their sense of self-esteem and resilience. Resilience has been defined as the ability of an individual to respond to stress in a healthy, adaptive way⁷ and to meet problems as opportunities for growth⁸. Resilient students believe that what they do can have a positive impact on a situation⁹, and this was reflected in the experience of students in this setting.

What can we learn from such positive experiences in a community hospital setting that we can apply to our larger training centers? We need to encourage and support teaching staff and students in a culture and environment that recognizes and validates the roles and responsibilities of all team members.

Longitudinal clerkship curricula and mentorship should be explored at all training centers as an opportunity for enhanced learning experiences.

While relationships between members of different disciplines may occur with greater ease in a smaller hospital centre, inter-professional development is an important element in creating a sense of shared responsibility and should be encouraged in larger centers as well, where professionals in various disciplines are often distanced or isolated from each other. Attention to physical space and hospital geography in order to encourage informal contact among colleagues should be addressed in designing or modifying our workplaces.

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Can this be achieved in our larger training facilities? It is a challenge and opportunity that we must strive toward in order to provide and promote healing and the well-being of patients and healthcare workers alike. ■

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