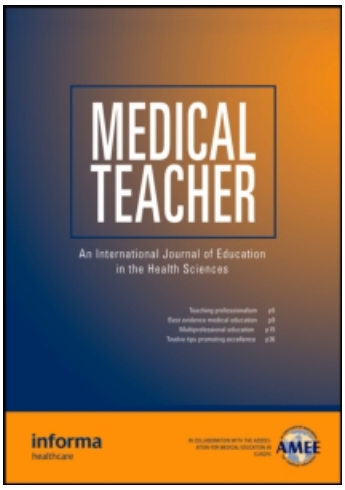

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The wounding path to becoming healers: medical students' apprenticeship experiences

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The wounding path to becoming healers: medical students' apprenticeship experiences

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Abstract

Background: This article responds to repeated calls in the literature to teach medical students how to treat the whole patient, not just the disease. It focuses on the educational experiences of medical students in a Canadian university in an effort to clarify the determinants of "caring" in medical education.

Method: Nineteen (19) second-year medical students volunteered to keep weekly journal entries during the first five months of their medical apprenticeship. In journal entry analyses, the authors identified themes through a consensus-building coding process detailed in the work of Maykut and Morehouse (1994) and Huckin (2004). For this article, the authors focus on those themes most closely related to the students' caring experiences during their apprenticeship.

Results: The data highlight components of the medical system which made it difficult for students to engage in caring practices during their apprenticeship: the competing discourses of empathy and efficiency, the objectification of patients, the power of the medical hierarchy, and the institutionalized practice of wounding.

Conclusion: The authors argue that returning medical care and students' experience to a balance of attention to curing and caring is a complex undertaking requiring a re-conceptualization of the process and goals of medical care.

Introduction

There are repeated calls in the medical education literature (Association of Professors of Medicine 2000) to teach medical students more humanistic skills in their care of patients, skills which focus on treating the whole patient, not just the disease. Given the increasing demands of medical education due, for example, to exponential increases in the pharmacological information students must assimilate (Charap et al. 2005) a narrower focus on disease rather than the whole patient is not surprising. According to some authors, medical education may actually have an adverse effect on medical student social competence (McCue 1985), and moral and spiritual growth (Brody et al. 1995; Patenaude et al. 2003). Some authors suggest that medical students should be immunized against some of the tacit values learned through the 'informal curriculum' of medical school, that is, the behaviours and attitudes transmitted to students through medical discourses, tutors, and other role models outside the formal classroom setting (Ratanawongsa et al. 2005; Rose et al. 2005).

To explore the impact of the informal curriculum in our medical school, we conducted a study using parallel charting (journaling with specific attention to the students' reflections on their interactions with patients) and discussion groups as a way of providing support to medical students at the beginning of their clinical apprenticeship. The study's explicit purpose was to explore the feasibility and efficacy of these reflective practices during the apprenticeship phase of the medical school curriculum. A second and implicit purpose of the study was to understand how medical students are impacted by the informal curriculum during clinical apprenticeship and how that experience encourages or hinders their development as caring physicians.

Practice points

- Caring attitudes do not necessarily translate into caring practices in the context of medical education.
- Medical students often percieve caring attitudes and practices as competing with efficient patient management and effective disease-focused learning.
- Barriers to caring practices in medical student apprenticeships can be addressed by balancing attention to curing and caring in medical education.

Methods

A brief explanation of the study's focus and methods was presented to second-year medical students in a Canadian university during one of the medical school's required courses immediately preceding their clinical clerkship. Of the approximately 150 students, 22 volunteered to keep a journal and participate in regular small-group discussions led by three teacher-clinicians over the first five months of their clinical apprenticeship. All but three of those students (19) remained in the study for its full duration.

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Participating students were allocated to one of three discussion groups. Each group was joined by a teacher-clinician (including two of the investigator/authors). In the first of those discussion group meetings, the students were giving the following prompt for their journal entries: "reflect on and write about what's happening to you when you see patients". Subsequent discussion group meetings were facilitated but not directed by the teacher-clinicians. Rather, the discussions focused on whatever questions, issues, or vignettes the students brought to the group meetings. While the parallel charting (journaling) was intended to encourage ongoing reflection on the part of the students, it was not the subject or focus of the discussion group meetings except to the extent that the student participants shared with the group any questions or concerns about which they had written in their journals.

The journal entries varied widely in number and length from one participant to the next. Some of the students wrote on a weekly or even daily basis throughout the 20-week apprenticeship; others cited an over-full schedule as the reason for writing less often. Overall, we received 169 weekly journal entries (approximately 170 pages of single spaced text). The content of these journal entries provided the data analysed in this article.

Drawing on the data-analysis techniques described by Maykut & Morehouse (1994) and Huckin (2004), we began by engaging in a consensus-building coding process for each journal entry. Two of the authors independently read half of the data set and made note of repeated or otherwise pertinent topics related to how and what students were implicitly and explicitly taught during their apprenticeship. Next, we combined and refined those topics into umbrella themes for which we wrote definitions. We then grouped and analysed the coded data thematically and wrote a synopsis of how each of those themes informed the students' apprenticeship experiences. For this article, we pay particular attention to the students' experiences and interpretations of caring and wounding practices.

Results

Our data included frequent examples of students expressing caring attitudes and some evidence of students engaging in caring practices. Most of the students' caring attitudes and practices came out of their attempts to understand the patient's experience of, perspective on, and location in the medical system.

> Yesterday, we saw a patient in the CCU who was kind enough to let us listen to her heart. She was young, had died red hair, and had her hand gripped around the bed rail when we came in. She was also on a respirator and dialysis. In a way, because of all the machines she was on, and because she couldn't talk, it was easier to talk about her heart sounds, and we didn't feel as intrusive (although we should have) because the whole atmosphere of the room was just more 'medical', and almost allowed us to talk as if she wasn't in the room. On the other hand, her died red hair spoke of her individuality to us, and we couldn't ignore it. And her hand gripping the railing spoke of her anxiety, or maybe her struggle to keep fighting. Also, it's very strange to see a machine breathing for a person. I think I'm very fortunate to have seen her grip the railing in my first exposure to a respirator. And that her hair reminded me that there's a personality, and an individual for which the machines are attached. That could be so easy to overlook. (Richard/6)[1]

To the rich, hands-on, individualized learning that many medical students are fortunate to experience, Richard brings a particular awareness of how easy it is to lose sight of the human being for whom medical technologies and other interventions are intended. His insights are testimony, in part, to the keen observational skills that medical education encourages, and the ways in which those skills can be employed to teach caring.

> An elderly couple drive into the ER from where they live, a considerable distance up North. The wife is concerned about her leg that is swollen and painful. I was able to make a diagnosis of DVT, but most importantly explain to them what this meant, what would be involved in the care of it and how to prevent this and other consequences of it from happening in the future. I had the fortune of being able to see them a couple of days later to find out how her treatment was going. To be able to see the relief on their faces when that unexplainable pain that they have been having has been explained, the smile that lights-up a person's face when they see that you are taking the time to explain something to them and participate in their care is thrilling for me. (Samuel/4)

Samuel's caring behaviour captures what another student described as a basic principle of the physician–patient relationship: "engage their humanity with your own humanity so that dignity is honoured, then proceed to do whatever the situation requires" (Shalomar/9).

Attitudes and practices such as those expressed in the previous excerpts were found throughout the weekly journal entries. However, more abundant and perhaps more striking were the many examples of barriers to the practice of caring inherent in the apprenticeship experience: the competing discourses of empathy and efficiency, the objectification of patients, the power of the medical hierarchy, and the institutionalized practice of wounding.

The competing discourses of empathy and efficiency

Most of the students expressed the importance of empathy, sensitivity, and patient-centeredness and wrote of wanting to maintain that stance in their practice as they developed into physicians.

> I really, really hope that I can remember to summarize things with my patients, so that they at least know what action is being taken on their behalf, no matter how much of a hurry that I'm in. Patients must

> feel so powerless when they are left like that. (Aileen/4)

However, the students also seemed to believe that getting to know patients was a luxury that would disappear with the extra demands and time constraints of residency.

> I know that later on I probably won't have the luxury of having the time and the energy to get to know my patient and I do enjoy this privilege of being a student. (Elena/6)

Several students described desensitization and time constraints as an inevitable part of becoming physicians; some expressed concern that the caring attitudes and behaviours they had been taught to value prior to the apprenticeship would eventually be lost to cynicism and the time/efficiency agenda of hospitals.

> The more I spend time with certain physicians, the more I see that many of them are jaded, and the more I feel like I'm naïve . . . I realize everyday that I still have a utopian idea of what medicine is and how it works. I guess it never occurred to me before that perhaps not everybody who works in this field enjoys it and is driven by a strong desire to provide any help they can to the sick. There's a voice deep down inside that tells me that many of us will crack under the pressure of clerkship and start thinking and acting that way too. And I want to believe that I will be strong enough to resist that weariness, and come out of it as a better doctor, as a better person. (Katherine/3)

The objectification of patients

> As I walked out of the (*hospital*) library I saw a young guy, about my age, in cargo pants and a nice shirt standing over a book and reading. What struck me was that he had an IV in his arm. You don't often see a patient in a hospital wearing street clothes, and the fact that he was probably reading up on his condition in the library served to humanize him as a patient. I realized how dehumanizing it is to make people don the gown; at first glance, this was just some guy in the library doing some research. Then you see the IV and he crosses over to the other side as someone who is "treated". I suppose in most cases it makes practical sense for the patients to wear a gown, but it also serves to divide them as people from everyone else who doesn't wear a gown. (Paul/8)

Paul's description of the hospital gown as marking those who are "treated" highlights the ways in which gowns objectify and homogenize patients emphasizing their disease-centred sameness rather than their illness-centred individuality. Several other students expressed similar concerns about the apparently inevitable ways in which medical interventions and technologies seem to favour disease- rather than patient-centredness.

The power of the medical hierarchy

> Probably my most disturbing day thus far. Surgeon J our surgical tutor brought us into an examining room. One of his pts [patients], Mr. K, walks in, an elderly, and is surprised to see us – through his body language, I think he expects us to leave. Surgeon J tells Mr. K, briskly, to "drop" his pants. Mr. K, looking at us, embarrassed, lies down on the table, fully clothed. Surgeon J walks over and while telling us about the pt's illness, begins taking off the patient's pants. Surgeon J asks med student D to do a testicular exam. Med student D asks Mr. K for consent; before Mr. K could respond, surgeon J begins to rant about how the patients "owe it to us" to allow us to learn, and we should not have to ask for their permission. Med student D does his exam, Mr. K holds his hand to his forehead, obviously embarrassed. Leaving, Mr. K calls after surgeon J about some lab tests – surgeon J replies he hasn't seen them and walks away quickly. Mr. K had an exasperated, frustrated look on his face. I'm sure he had many more questions. (Michael/1)

In this excerpt, Michael draws attention to the surgeon's evocation of a values hierarchy in which medical education/knowledge trumps respectful, humane treatment of patients and informed consent. The surgeon is able to insist on this values hierarchy largely because of his position of power in the structural hierarchy of the health care system. Because medical students need to acquire the specialized knowledge of their physician (and resident) tutors, and because they are always subject to their tutors' evaluations, the students in the study often expressed feeling powerless to challenge their tutors or the values hierarchy which prioritize the pursuit of medical knowledge over humane treatment of patients and attention to their illness experiences.

> At this time he turned to me and said that he was shaking and that it was so good to see my face . . . I didn't know what to say . . . and the last two students were leaving and I knew I needed to leave also . . . so I caressed his hand and said that I had to go and thanked him. I thought for many hours after this that he was obviously scared and had wanted someone to talk to . . . why did I, a med student, with really no obligations ever feel the need to leave the room since my tutor was waiting? I started to realize the sense of being rushed and not being there for patients. All I needed to do was talk to him and ask him how he was doing, how he was feeling, why didn't I stay? The next week I was to learn that he had passed away. (Lindsey/4)

In the above instance, the student expresses regret and some confusion about having abandoned an anxious, suffering patient in order that she not keep her tutor waiting. Concerned about holding up the scheduled rounds and possibly the tutor's informal assessment of her behaviour, Lindsey is put in the awkward position of having to choose between accompanying a patient (caring) and continuing on the tutor's rounds.

The institutionalized practice of wounding

> As physicians and medical students, we are given tremendous liberties to poke, prod and examine our patients. Once we are licensed physicians, the poking and prodding actually benefits the patient. With our current training, we are at best bedside companions who briefly relieve the boredom of a lengthy hospital stay. At worst, we are nuisances who subject individual patients to discomfort and indignity in order to learn. (Sophia/6)

The students' journals describe various ways in which they are routinely encouraged by their tutors specifically and the medical system generally to engage in wounding practices, practices which "subject patients to discomfort and indignity in order to learn."

A particularly disturbing group of journal entries describe practicing medical techniques on unconscious and non-consenting patients as part of this collateral damage.

> One of my friends also has had a urology session last week, a couple of days after me. He came back telling me the story of their tutor – not the same one I had – encouraging them to practice the digital rectal exams on patients in the OR. Apparently, when they're anaesthetized, they're relaxed, and it makes everything so much easier! I could hardly believe that he'd said that. How inappropriate! There was no mention of any asking the patients prior to their surgery or even letting them know afterward what you had done (not that that would be right either. . .). Can't help but think of that story at [another university] where students were performing pelvic exams on anaesthetized female patients . . . I wonder if I'll be exposed to that kind of teaching too . . . (Katherine/1)

Katherine's hearsay account of such unethical approaches to medical students' hands-on learning is unfortunately corroborated by Lindsey's direct experience of being told by her tutors to practice inserting IVs on unconscious patients.

> A component of anaesthesia is to practice certain skills, for example, IV's, intubation, bagging and masking, etc. Given there is only one week, and a certain number of patients in an operating room a day, there is not a lot of time to practice. Throughout the week I was doing my best to practice, however, IV's surprisingly were the hardest for me. So I was always asking to do the next patient for practice. My favour was fulfilled, but to the extent that they would ask me to practice on their arm after being "put to sleep." I was a little taken aback . . . at times it was necessary to find a vein in the arm afterwards because the IV needed to be changed, but when not needed I was surprised. They always remarked that the best practice was on one that was not aware. (Lindsey/15)

It appears that Lindsey was being allowed to perform unnecessary IVs in order to perfect her technical skills. This pedagogical practice raises several questions: To what do patients consent when they enter a teaching hospital? How are patients informed about the role of medical students in their care while in the hospital? How are medical students informed of the nature of patients' consent? In the previous excerpt, Lindsey's need for hands-on learning is unquestioned. Reconciling the benefits of hands-on learning with the wounding such learning can cause (to both patients and students) was a constant struggle for the students. In the next excerpt, this reconciliation seems impossible.

> So, just as I was about to finish the physical exam, after the patient told me he really did not want a DRE [digital rectal exam], because he had already had so many done on him before, one of the residents came in and asked how I was doing. I said I was about finished, he asked me if I did a DRE, I said no, as it was the patient's wishes, and the resident told the patient he had to let me do a DRE. The patient insisted that he didn't want one and the resident told the patient to get on his side and allow me to do the procedure. I was very uncomfortable as the resident told me to do the DRE. I am starting to wish that I could disappear or vanish into thin air at moments while in the hospital during uncomfortable situations. (Lindsey/10)

Discussion

The experiences of this self-selected sample (19/150 second year medical students) may not represent those of the class as a whole. Should their participation reflect increased personal levels of anxiety regarding the learning of medical skills, they may tend to over-report the problems they experience. On the other hand, the clear description of serious barriers to caring interactions cannot be ignored.

The data suggest that having the appropriate caring attitudes did not mean that the students were able to follow through with caring actions or behaviours in their relationships with patients. Barriers such as the competing discourses of empathy and efficiency, the objectification of patients, the power of the medical hierarchy, and the institutionalized practice of wounding made it difficult for students in our study to engage in caring during their medical apprenticeship. They frequently experienced the caring behaviours of presence, empathy, accompaniment, active listening, and clear communication with patients as competing with time-driven pressures of efficient patient management and effective disease-focused learning. As a result, the students witnessed and engaged in wounding practices as part of their medical training. Equally disturbing was the students' evident lack of perceived power to do something about the unethical behaviour they witnessed, a

phenomenon which is not exceptional to the institution in our study (Christakis & Feudtner 1993).

Conclusion

It seems that the promotion of caring in the education of medical students will require more than the teaching of caring attitudes and skills. We will also need a concerted effort to attend to the barriers to caring that students frequently experience in their clinical apprenticeship. This process will require continuing medical education for attending and resident physicians and agreement to see medicine as comprising two equally important goals (curing and caring).

Assuring that medical care and students' experience will involve a balance of attention to curing and caring is a complex undertaking that raises several important questions: Who selects the patients that students will examine? How are these patients asked/informed? How are residents and physicians trained to communicate with patients about medical students' involvement in their care? How are medical students informed about the nature of patient consent in a teaching hospital? How might training in caring practices for residents and physicians help address some of the concerns raised in our data?

That our data reflects students' keen sensitivity to the caring component of medical care is a hopeful sign for the future. Clearly the cultures of medicine and medical education have room for improvement; but there have been some good developments as well: calls for more attention to caring component of medical education, improved accreditation standards, and the establishment of patient rights and advocates are just a few. Furthermore, the university in which this study was conducted has begun a multifaceted initiative including a revised medical school curriculum, psychosocial and physical distress simulations, a mentorship program for students throughout all four years of medical school, faculty development, and research all aimed at reincorporating caring as an integral part of the 21st century medical mandate. The goal of this caring initiative is not simply the addition of another body of expertise for students to learn, but a re-conceptualization of the process and goals of medical education.

Notes on contributors

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Note

1. Pseudonyms are used for names of people and places in order to protect the anonymity of the participants.

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