The International Journal of
WHOLE PERSON CARE
VOLUME 2 ● NUMBER 2 ● 2015 ● 5–14

ON TEACHING THE SUM WHILE PAYING ATTENTION TO THE PARTS: WHOLE PERSON CARE THROUGH ETHNOGRAPHY IN MEDICAL EDUCATION

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KEYWORDS: Family medicine, Medical education, Ethnography.

TRANSITION TO CLINICAL PRACTICE

The Ethnography Practicum – herein referred to as the 'Practicum' – is part of a Transition to Clinical Practice (TCP) curriculum. TCP begins in the second year of undergraduate medical training. It consists of a series of learning activities structured around better understanding of clinical organization and the importance of interdisciplinary care[1]. As such, the TCP aims are twofold:

1. To instill in students the concept of patient-centered care that is relevant to all medical graduates regardless of career choice; and
2. To promote family medicine as an academic discipline and a career option among medical students.

The Longitudinal Family Medicine Experience (LFME) is the first observer-mentor activity conducted in

family medicine clinics. It takes place in the first year and offers an introduction to the organization of family medicine and primary care in the city of Montreal, and across the province of Quebec generally. The Practicum— a component of the TCP program discussed in this paper —follows the LFME (Fig. 1).

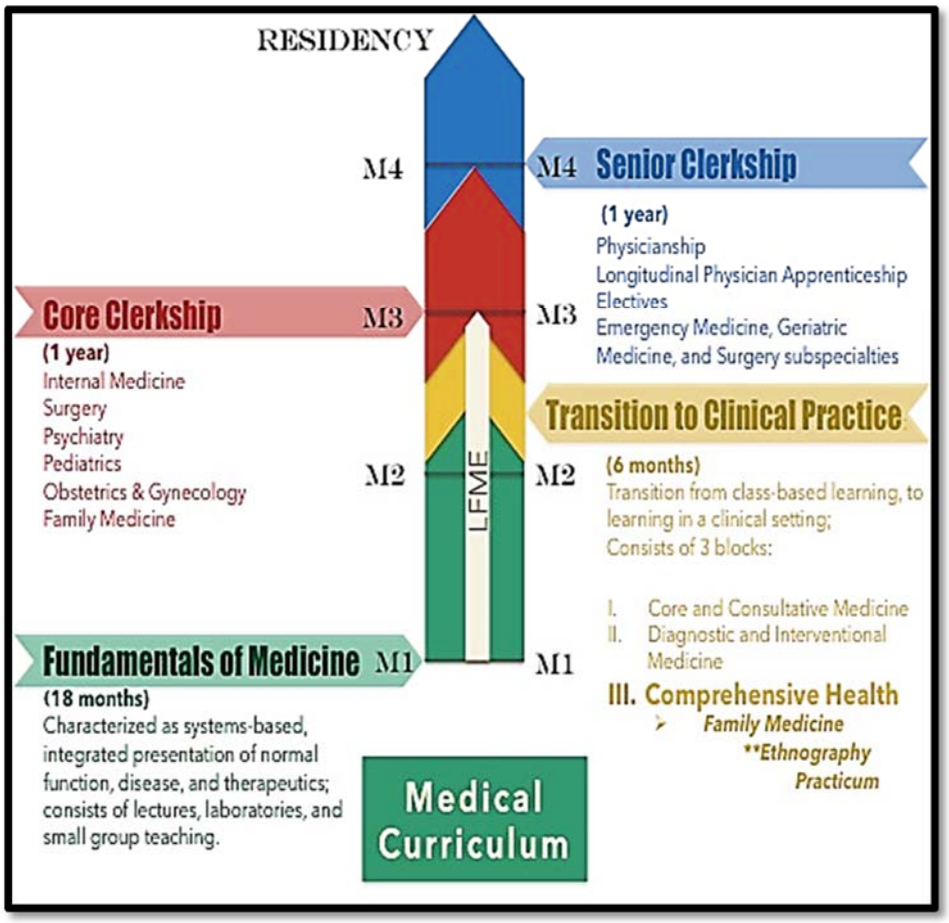

Fig. 1 The three first years of the medical curriculum are dedicated to the Fundamentals of Medicine, the Transition to Clinical Practice program, Core Clerkship and the Longitudinal Family Medicine Experience (LFME). Taken together, these components comprise a three-year, compulsory curriculum in Family Medicine that is embedded within the larger curricular trajectory at the medical school. The LFME is a continuous family medicine-specific program that is initiated at the start of students' M1 year and concludes in M3.

The LFME and the Practicum are two early elements of the TCP program, which is itself embedded in a three-year compulsory Family Medicine curriculum for medical students (Fig. 1). This new curriculum was the product of reform at the Faculty of Medicine to address both a province- and institution-wide decline in family medicine residents[1,2]. The reform paralleled international trends forecasting shortages of family physicians by 2025[3]. Such changes to the medical curriculum coincided with major reforms to the primary

care infrastructure in Quebec through two proposed bills. Curricular changes were in part motivated by concerns that students could be further dissuaded from entering family medicine as a result of future budget cuts to teaching and research, among others. More importantly, the reforms could also complicate the organization of family medicine practice as well as the current medical curricula supporting it. Influences from the sociopolitical climate in the province could therefore challenge whole person care, its relation to family medicine and the ways in which it is taught in medical curriculum.

The Practicum is spread over 8 weeks, and includes a total of 30 hours of combined lectures (6 hours), small group tutorials (15 hours) and participant observations (9 hours). It focuses on healthcare organization, and builds on concepts such as coordination of care and interdisciplinary professionalism. Students are required to conduct a participant-observation project, which immerses them in an assigned field site (i.e. a family or community medicine clinic). Students take detailed field notes pursuant to an ethnographic focus on organizations that can include daily activities and interactions between healthcare professionals. Through this experience, they negotiate their presence in the field, take and analyze field notes and write a formal report about their findings. Students are also asked to provide recommendations for the clinical sites, which facilitates thoughtful reflection on practice and organizational function. The Practicum introduces students to the complex organizational dimensions of family medicine, while teaching the principles of observation-based methodologies and their relevance for organizational research in primary care settings. As small group leaders for the Practicum tutorials, we construct lectures and develop lesson plans that guide students in their final assignment.

The following sections discuss why didactic learning strategies—that is lecture-based, unilateral information dissemination from teacher to student evaluated using performance metrics—proved inadequate for the Practicum for two primary reasons: i) there are inherent debates around notions of objectivity and subjectivity in ethnographic methodology, and ii) the nature of the specific competencies the TCP program facilitates do not cohere with performance-based assessment *per se*. In the process of guiding students through their ethnography project, we carved a space where students could reflect on their experience of medical education, the new family medicine curriculum and voice apprehensions surrounding competencies required of a practicing physician in their transition to the clinic.

EPISTEMOLOGICAL SPECTRUM (DIS)ORDERS

Ethnography utilizes a set of methods (i.e. surveys, participant observations, interviews, focus groups, etc.), to explore, among other things, what people do and the possible explanations for their behavior(s). It uses a researcher's 'eye,' partially shaped by the researcher's own socio-cultural and historical background, as a tool to collect data about a social phenomenon[4]. Ethnography has historically played an important role in

medicine, either through the study of medical students' behaviors[5], elucidating professional culture(s)[6,7,8], investigating social determinants of health[9,10], and patients' experiences of illness[11,12] or moral issues[13].

Dharamsi and Charles[14] summarize a number of methodological tensions at the heart of ethnography, which we inescapably attempt to reconcile in our teaching as well. These debates emerged between 'positivists' and 'post-positivists' typified in post-war academic ethnography*. A dichotomized view of ethnography overlooks that ethnography is not, and was never truly a unified or standardized research practice. It oscillates between the expectations of objectivity demanded by most scientific endeavors, and the 'subjectivity' involved in the construction of phenomena of interest. This tension questions whether a researcher can report *object*ively about social phenomena where people act *subject*ively. Whereas all ethnographies give rise to such questions, the balance for ethnographers between producing a "veracious description"[15 p.183] on the one hand, and recognizing one's own input and biases on the other, may vary from ethnography and ethnographer. Acknowledging these competing ideas gives clinical ethnography a dual potential. It can be both a rigorous method of inquiry, and an opportunity to contribute a critical perspective on patient-centered care or quality improvement, for example[16].

Ethnography aims to capture social reality as it is, rather than under controlled conditions. Likewise, establishing conditions and rigid guidelines dictating how students should conduct their organizational ethnography is contradictory to the epistemological foundations of the methodology itself. Students were therefore expected to embrace 'uncertainty' inherent to conducting their ethnographies in dynamic settings, and to reflect on their own 'subjective' biases. The variability and diversity of students' experiences at their field sites was evident during our in-class discussions. Some students directly observed provider-patient interactions or attended inter-professional conference case meetings. Other students were invited to shadow a clinician or team, or were restricted to public spaces such as the waiting room. The role of researcher 'subjectivity' and its invitation within qualitative traditions, including ethnography, was also a recurrent debate. For example, one student witnessed unprofessional communication with patients that could have been qualified as negligence. Other students questioned how such communication could be 'objectively' classified as (un)professional or negligent. Such discussions underscored students' propensity towards accepting 'objective' evidence as universal truths—findings which can be measured, reproduced and standardized.

This example demonstrates how we, as small group leaders, realized that we were also grounded in the aforementioned debates. We found ourselves presenting ethnography as a qualitative research method; a

*Representing 'traditional' ethnography in social anthropology, positivism aims to collect facts and evidence through objective observations with limited interference on the groups under study. In contrast, 1970s 'post-positivists' argued that researchers cannot provide an 'objective' account of others' experiences; nor can they present neutral descriptions that are unmediated by their own socio-cultural background[14].

health intervention assessment tool; a way to study clinical professionalism; and a self-reflective exercise centered on the organizational aspects of healthcare. Perhaps most challenging in the Practicum was expecting students to embrace uncertainty inherent to the organizational nature of healthcare settings and in the conduct of ethnographic observations, both of which were novel for most of our students and has been studied in some depth by Atkinson[17]. Students therefore frequently voiced their confusion with regard to assuming their simultaneous roles as participant observers and clinical learners. The next section will elaborate this tension as it relates to the medical curricula and the TCP.

DOCTOR WHO?

Medical curriculum is a conduit of professional identity formation for students[18] and has undergone important transformations in the last decade. It integrates scientific knowledge; the development of humanistic, communicational, and interpersonal skills[19, 20]; abilities to reflect on one's own position and role as a physician; social capital; and aptitudes for interacting with multidisciplinary and inter-professional networks[21]. Medical students must also draw on competencies defined by normative expectations of good physicianship. Hodges[22] categorized these competencies into four groups that he argues have emerged since the 1950's: (1) *competence-as-knowledge,* transmitted through course lectures that teach 'facts,' 'foundational knowledge,' or 'basic science;' (2) *competence-as-performance*, popularized in the 1960's and consists of observations and demonstrations of skills in simulated or real medical settings; (3) *competence-as-reliability*, emphasized in the 1980's as the rigor of teaching, assessment and enhancement of the validity, reliability, generalizability and standardization of medical practice; and lastly (4) *competence-as-reflection*, which emerged in the mid-1990's whereby the teacher becomes a mentor who guides students through self-directed learning using diaries or portfolios.

A number of these competencies are explicit and directly associated with medical expertise and practice. Others are implicit, and their contribution to the quality of patient care or the improvement of the profession is subtler[23]. Student views concerning the purpose of simulated assessments vis-à-vis objective structured clinical evaluations (OSCE) testifies to this. Many of our students expressed that they felt a heightened pressure to perform technically well in OSCEs, but did not feel a commensurate pressure with real patients. This generated an animated discussion regarding the utility of OSCEs as an assessment strategy to prepare students for entering the clinic, namely how to help students adapt to the uncontrolled and often dynamic environment that additional healthcare personnel and real patients add in clinical practice.

We adopt the posture of Whitehead[23] and Goldie[24] in our teaching, who advocate for medical education that does not over-emphasize one competency over the rest. Rather, like Whitehead and Goldie, we support curricula that facilitate students' ability to employ an appropriate competency at the most

appropriate time. Competencies are learned progressively in our view, as medical education is structured by different transitions in learning environments, curricula and instructors. These transitions represent shifts in learning processes and aspects of medical practice.

In this regard, the Practicum marks a transition in students' professional identify formation that is made obvious by a departure from didactic medical traineeship—centered on teaching technical competencies and professionalism—to experiential learning with real patients—often involving shadowing and observing practicing clinicians and other care providers. The literature suggests this transition from pre-clinical studentship to apprenticeship can be most disruptive to the status quo of medical traineeship characteristic of the first two years[25,26]. Indeed, apprehensions about inaugural encounters with patients and anxieties about meeting professional standards during clerkship were frequently discussed among our students.

For example, when discussing the format of their ethnographic report, some students expressed their discomfort with providing 'recommendations' to their assigned clinics. Some feared their recommendations would reveal certain clinical incompetence on their part, could be based on "poor" observations, that is, non standardized or unsystematic, or might expose them as critics of allied professionals with whom they might collaborate in the future.

The literature identifies other unique aspects of professional identity formation that deepen our understanding of our students' situations when they enter the Practicum. The TCP program also renders changes to students' lifestyles and workloads. It brings about new pressures relative to professional socialization as they transition to performing in real medical environments surrounded by future peers and colleagues. Patient exposure in various rotations can also highlight the reality that medicine—and by default physicians themselves—cannot save or cure patients in all cases[25]. Furthermore, some students may be less motivated to learn about administrative or extraprofessional aspects of care, for example, that do not involve direct interactions with patients[26,27]. The Practicum also aimed to imbue some of this learning as a result.

Following Hodges' categorization, the Practicum embodies the passage from a mode of clinical learning where 'knowledge' prevails, to one where 'performance' prevails. This passage accentuates the need for professional reflexivity, whereby empathy, personal experience and self-knowledge facilitate physicians' holistic understanding of the patient's health[28]. One student relayed a personal anecdote about the ways in which their observations of overworked residents revealed their reliance on performance as defined by Goffman[29] to maintain an image of absolute competency to their superiors, nurse managers and, most importantly, to patients. Given that students are placed in different frontline medical settings and are invited to pay attention to organizational specificities, the Practicum encourages students to wrestle with issues inherent to the standardization of healthcare. These issues can include how different healthcare settings

offer the same quality of care, are equally safe for all individuals, and work according to compatible and interoperable rules. As a result, Practicum students often apply—albeit it unsuccessfully—lessons taught in pre-clinical years to their ethnographic observations. Put simply, the Practicum does not adhere to the didactic teaching styles of the pre-clinical years, which demand that students master technical definitions and reproduce specific techniques. Not only are such approaches incompatible for teaching ethnographic methods, they are antithetical to the epistemological foundations of ethnographic methodologies. In contrast, as mentors, we asked students to confront the organizational realities of healthcare settings, generate data and analyze it without clear technical guidelines. Moreover, we asked them to pay attention to topics such as the patient care implications of (dis)organization in first line clinical settings; administrative redundancies and/or permanencies; and the congruence (or lack thereof) between physician responsibilities in theory and practice. The aforementioned expectations of our students exemplify how the Practicum runs counter to the pedagogical norms of their pre-clinical medical education, and ultimately accentuate the transition to clinical practice.

THE ORGANIZATIONAL PARTS BEHIND WHOLE PERSON CARE

Despite these departures from pedagogical norms, we view the Practicum as a work-in-progress. Students become engaged actors in situations where unique learning and teaching opportunities for whole person care are revealed. The Practicum's focus on healthcare organization forces medical students to consider and appreciate the diversity of clinical expertise intrinsic to multidisciplinary healthcare teams.

In the process of categorizing, interrogating and understanding organizational cultures in various family medicine settings, students realize physicians alone cannot provide whole person care. The organization-specific requirements of the Practicum draws students' attention to elements that are essential to a truly collaborative endeavor they may have previously dismissed as 'trivial'. A number of student comments in class discussions and in their written assignments reflect this. Students interested in the dynamics of case presentations and management, for instance, provided detailed descriptions of how whole person care is operationalized through care coordination across disciplines and clinical spaces. Other students identified how healthcare professionals often take on roles that extend beyond their professional scope in their promotion of whole person care. In some cases, they observed physicians taking on case management roles when social workers were unavailable, or nurses acting on behalf of public health agencies to ensure compliance with certain safety standards.

These examples illustrate the current landscape of whole person care-inspired family medicine in the TCP curriculum. Acknowledging the myriad social, political and economic forces underpinning the creation of

this Practicum and the TCP generally is, for us, an opportunity to become better ethnographers who are culturally sensitive to the contemporary realities of being a medical trainee.

CONCLUSIONS

The Practicum invites dialogue among qualitative researchers, medical educators and medical students. The dialogues stem from the various purposes and aims of ethnography that appeal to positivism, self-reflexivity and critical thought; the personal, professional and educational experiences medical students embrace in their burgeoning professional identify as practicing physicians; and the multiple clinical and managerial challenges faced by the organization of whole person care in Quebec's health care arena.

We do not claim the Practicum has been able to identify and resolve all such issues, nor that students are expected to do so. Rather, our aim is to share how our involvement in the Practicum highlighted the necessity of discussing such challenges in active partnership with medical students. There is a need for medical educators to mirror the complexity of whole person care in their teaching by adopting pedagogical strategies that are simultaneously didactic, dialogic, critical, and (most importantly) practice-oriented. This could support medical students during important curricular transitions, such as at the onset of the TCP, prepare them for the inter-professionalism required of whole person care, and for the challenges they are likely to face in their practice as family physicians or specialists.■

ACKNOWLEDGEMENTS

The authors wish to thank Dr. Gillian Bartlett for her editorial and conceptual contributions to earlier versions of the manuscript.

COMPETING INTERESTS

The authors declare no competing interests.

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