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"It Is Not a Disease We Treat, But a Person": Medical students' reflections on their first rotations to an oncology and palliative care unit

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INTRODUCTION

The vast array of technologic advances in medicine has transformed traditional medical practice and education. However, these advances are not without their critics (1-7). Some medical educators and students suggest that the "final product" of medical education has many of the characteristics of the applied scientist (2) rather than those of the humane physician-healer (8).

Many medical students bring to their studies an idealism and an empathy that, for many, is quickly eroded over time. According to Bellini and Shea (4), they may never fully recover their empathy. Several studies have concluded that a significant decline in empathy occurs during the third year of medical school, a time when empathy is most important because students are having their initial interactions with patients (6, 9). Shapiro has written extensively on current limitations in medical education (7, 10, 11). These include: an overemphasis on logico-scientific thinking, problem solving, and control; a devaluation of personal identity; a discounting of personal experience; and the practice of encouraging medical students to create a distance between themselves and patients. Such factors have significant implications for the way trained physicians will see their patients, for the quality of vocational satisfaction they will experience, and for their sustainability within the healthcare system (12).

In 2009, the undergraduate medical curriculum at the University of New South Wales in Sydney, Australia, was expanded to include (*inter alia*) a

significant component of reflective practice in students' clinical activities. As a result of this curricular change, undergraduate medical students are now required to submit written reflections on their learning experiences. This compulsory report documents students' impressions of their first four-week rotation and their exposure to patients in an oncology and palliative care setting.

The aims of the current study were to analyze students' reflections in order to determine the personal/professional impact of the rotation, to report on student responses to the new teaching curriculum, and to identify additional steps that could be taken to support students' learning activities.

METHODS

The written reflections of 54 undergraduate medical students in the Faculty of Medicine at the University of New South Wales, Sydney, were reviewed following the students' initial four-week exposure to patients in an oncology and palliative care setting. The majority of these students had entered the faculty from high school and were in their early 20s. The student rotation in third year includes small group tutorials, ward rounds, outpatient clinic visits, and visits to patients' homes. At the end of the term, students completed a clinical assignment on one patient and provided a one-page, unstructured written reflection on their learning experiences. From 90 consecutive reflections, one of us (JHK) selected 54 reflections based on the criteria that each had to contain a significant amount (more than 50 percent) of personal rather than technical insight. Ethical approval was sought from the university's human research ethics committee, which decided that the study was exempt from ethical review.

We used the thematic content analysis approach to examine the written reflections. The reflections varied in length from one page to a page and a half. Both authors read each one independently several times. Analysis was undertaken by repeatedly reading sections of each student's reflection and conducting a line-by-line analysis of this data. Recurring words and phrases were coded and the data linked together to develop themes (13). Major and minor themes were identified and discussed, and agreement was reached. Data saturation was considered achieved when ideas were well developed and there was both repetition and variation in the data patterns (14).

RESULTS

Five themes were identified: the value of listening to patients' stories; the importance of communication; the importance of seeing the patient as a whole person in the context of his or her entire life and providing that individual with whole-person care; increased confidence in building rapport, being empathic, and being able to discuss death and dying; and a change in view toward palliative care — that is, moving from seeing palliative care as a failure to seeing the importance of making patients as comfortable as possible.

Listening to Patients' Stories

Students reported that they found it challenging to talk to a patient with a poor prognosis. This was due to the individual student's preconceptions about cancer, personal experience of cancer, or lack of confidence in his or her communication skills.

"The past four weeks of engaging with cancer and palliative care patients has profoundly affected my ability to interact with patients with a life-threatening or terminal illness. Before this, I was petrified at the thought of interviewing someone with cancer, as I was afraid of unintentionally upsetting them with overly sensitive questions. What I have come to realize is that I am able to employ effective communication skills in situations where I feel uncomfortable."

While they expressed their fear of saying the wrong thing and causing more distress, the students also felt confronted by their own mortality.

"It was very unpleasant to be confronted with the idea of one's mortality, but I can honestly say the experience gave me the opportunity to reflect on my own values and how they shape my practice of medicine."

The students reported that they had initially approached patients with the idea of taking their medical history; however, many students com-

mented that the patients were more than just a clinical history and that listening to their stories was a more effective way of establishing a rapport.

"During the interview, [BH] was keen to tell us about his life story, much of which was not relevant to this assignment, but important to him as a person. Initially I was tempted to interrupt and focus on relevant aspects of the medical history, however, I soon realized that he loved company and the least I could do was to listen. At the end of our interview he conveyed his extreme appreciation for my attention."

Communication

The importance of communication was a major theme in students' reflections on their approaches to patients with terminal illness. The students reported that at first they used avoidance, blocking, and distancing techniques but then learned that "patients can be teachers," and that talking to patients helped them to form a more holistic picture.

"On commencement of this oncology term, I was afraid; afraid of speaking to patients at the end of life, afraid of touching patients, afraid of knowing nothing and being of no use whatsoever to those at need in an overloaded healthcare system. But I knew that textbook medical knowledge alone wouldn't help patients; it's a professional manner, empathy, and communication skills that allow you to give the best holistic care."

The students observed that using silence, listening to patients tell their own stories, giving time, using body language, maintaining eye contact, setting up the room in a way that enhanced communication, and being empathic and respectful made communication easier. Communicating in a situation of distress was challenging. Many students highlighted the importance of "just listening." Several referred to the communication-skills training they had received in earlier modules and said that it was helpful to them in approaching patients and patients' families in this context.

"A communications tutorial in which we practised dealing with strong emotions using professional actors was incredibly useful in this real situation with [a patient's wife] who was upset and crying; prior to this I would have 'escaped' and left the room at the earliest opportunity, however having had the prior practice with the actors, I instead simply sat with her, allowed her time to compose herself, and didn't try to say anything to make it better. I think it helped her to sit and talk with someone who had no vested interest in any aspect of her husband's

care. I was very moved by their story and felt privileged that they both allowed me to share it."

Providing Whole-Person Care

The students wrote about how they had come to see patients as more than just their disease. They acknowledged that a patient's medical history is only half the story, and that getting to know a patient and that patient's psychosocial history is important.

"In speaking privately to Mrs. [T] she became quite emotional, expressing concern about how she would cope after her husband's eventual passing away. I immediately realized that I had become so focused on his physical problems that I neglected to consider all of the other significant issues."

They acknowledged that "patients are more than their disease," that "patients are not statistics," and that while diagnosis and management are important, physicians must "treat the person, not the disease"; this means obtaining information on patients' sociocultural backgrounds.

"[AB] is a remarkable man whose optimism and cheerful outlook have been inspiring for me. I found that getting to know him and his wonderful family was therapeutic, which has really exemplified to me that the only way to practise self-care in medicine is to engage with patients even if their prognosis is sad — the experience was truly rewarding."

Increased Confidence

Some students reported that their confidence in taking patients' medical histories had grown; most believed that their confidence in their ability to talk to patients, to build a rapport with them, to be empathetic toward them, and to discuss death and dying with them had increased.

"Prior to this term, I was scared of oncology and have been surprised to find that I enjoy it very much. People living with cancer are no longer to be avoided, but they are people from whom I can learn. I was able to gain a much more holistic picture of [JC's] experience and overcame my fear of talking to people living with cancer."

Change in View

Many of the students had entered the term with a negative impression of palliative care, which they regarded as a failure. However, over the course of their placement they moved from focusing solely on being trained to cure to acknowledging the importance of making palliative care patients as comfortable as possible.

"I was really upset until I sat down with [KJ]. His comfort and eagerness to share his story led to the

most enjoyable chat with a patient I have yet had. I felt healed by his extremely positive outlook on life. I will certainly make time in future to actually talk to patients apart from trying to extract information, having witnessed how incredibly rewarding it can be."

Several of the students described how their fear of approaching a patient was due to their own experience of cancer or of having lost someone to cancer. They remarked that simply talking to the patient and listening to what that patient had to say defused their fear and apprehension and increased their empathy. Only one student reported responding emotionally to a patient's situation and then feeling that such a response was unprofessional; that student resolved to "try to learn to distance myself from the emotional situations that I may find myself in so as to avoid being misunderstood as unprofessional."

DISCUSSION

A significant finding of this study was that the students perceived that they had undergone a positive personal transformation following their exposure to oncology and palliative care patients and their families. At the beginning of the rotation, most of the students had expressed varying degrees of fear and anxiety about the content of the rotation and the experiences that they imagined they would have in the course of it. Yet our data suggest that by the completion of the rotation, many of their negative, preconceived personal and professional attitudes had been positively affected. The importance of medical students' reflective narratives has been highlighted by many authors, as these writings are a rich source of information about elements of the informal and the hidden curricula (10, 11, 15, 16). Branch and colleagues (15) comment, in particular, on the way in which student narratives demonstrate firsthand the struggle students experience between reclaiming their empathy and submitting to the process of medical acculturation. Feedback and reflection are seen to be important teaching methods in the development of empathic medical practice (17).

Our results are consistent with those of Boyd and Myers in their examination of the role of transformative learning in adult educational theory (18). Unlike Mezirow (19), who views the ego as central to the process of perspective transformation, Boyd and Myers use a framework that moves beyond the ego and its emphasis on reason and logic to a definition of transformative learning that is Jungian and that involves extrarational subconscious influences (18). The outcome of transfor-

mative education is not primarily rational clarity but a commitment to an altered way of being with oneself in the world. Through the process of discernment, transformative learning leads to a contemplative insight, a personal illumination gained by putting things together and seeing them in their relational wholeness.

Students commented favourably on the value of communication skills training (CST). It led them to a greater self-awareness and an increased self-confidence in their ability to have meaningful conversations with patients beyond the traditional medical history encounter. They also commented that the rotation taught them a different way to listen: rather than always listening for factual information in order to extract a history, they learned to listen empathically, and in so doing they were able to establish an interpersonal connection instead of merely compiling a list of clinical facts. This person-centred way of listening is often at odds with the traditional way in which medical students are taught to interact with patients (20).

Although CST is now widely offered, one aspect of it that appears to be underemphasized is that it affords students the opportunity for personal and small-group reflective practice. Back and colleagues (20) make the point that "by walking the walk, one becomes a different person." It is clear that for many students, CST provides not only practical skills, but also a chance to rediscover meaning and purpose in daily study and clinical routines. Comments such as "this rotation opened my eyes" or, "these were eye-opening experiences" suggest that the students had the kind of "awakening experiences" described by Yalom (21) or the "boundary situations" referred to by Jaspers (22, p. 226). Andre (23) refers to the "moral blindness" associated with medical training and suggests a number of initiatives that could help medical students to reclaim a moral vision of patients as persons. Novack, Epstein, and Paulsen (8) maintain that self-awareness, personal growth, and well-being are fundamental requirements for the physician-healer, and that the development of these characteristics — which will help physician-healers to provide care for the whole person — should be integrated into medical education. Many students indicated that their experiences were personally validating, which is particularly important for third-year students, who have reached the stage in their training when they are most likely to experience an erosion of empathy and an increase in cynicism about clinical medicine or even start questioning their choice of medicine as a career (6, 9). A few students reported that they felt

ashamed that they had lost sight of the very reasons they had entered medical school in the first place.

As a result of their experiences, many of the students appeared to appreciate that palliative care is an active initiative to improve symptom management and optimize quality of life for patients. Although their experiences with patients with life-threatening disease were still challenging, the students came to understand that good palliative care can have a positive impact on efforts to alleviate patient suffering. After completing this rotation, several of the students expressed a vocational preference for oncology and/or palliative care.

The issue raised most frequently by the students was how they dealt with the emotional impact of the rotation. In the course of the rotation, they not only worked to come to terms with the array of emotions displayed by the patients, but they also struggled with the deep emotions that the patients' stories and circumstances evoked in them. However, researchers have only recently begun to examine the emotional lives of medical students. Reflective writing, narrative medicine, mindfulness meditation, and elective courses on topics such as spirituality have been incorporated, to varying degrees, into the curricula of a number of medical schools to help students to reflect upon and evaluate their emotions and to develop the skills for managing them (24, 25).

The results of our study suggest that there is a need for clinicians to watch out for students who are experiencing challenging clinical scenarios and feeling emotionally threatened. While most teaching hospitals and medical schools provide counselling services, students may be reluctant to engage with such services on a formal basis. As our study demonstrates, those who are affected emotionally find it helpful to reflect on their experiences, either individually or as part of a small group of fellow students. Clinicians need to foster a culture that is conducive to reflective, supportive practice and offer empathic listening opportunities — for example, structured debriefing or mentorship — in order to facilitate the resolution of the kinds of negative or disturbing emotional issues to which medical students are vulnerable.

LIMITATIONS

Given the confidential nature of the students' written reflections on their learning experiences, we were not provided with students' demographic data; in any case, if we had been given access to this data, then the students might have been less willing to offer their candid reflections.

Undergraduate medical students are younger and may have had fewer significant life experiences, so it is likely that the same study conducted with postgraduate medical students would have demonstrated that the personal transformations that took place were less profound.

We also acknowledge the limitations of a theoretical qualitative research approach and recognize that the students' responses may have reflected the intentions of the curriculum rather than any lasting change. However, while we were unable to follow the students longitudinally to assess whether their perceived positive personal transformations endured, our results do indicate that exposing students to patients with life-threatening disease may lead to personal insight and transformation. Later in their careers, the students may well recall what happened to them during the rotation, even if the emotional impact of the experience dissipates over time.

CONCLUSION

In the context of recent curricular changes, this study highlights the role of an oncology and palliative care rotation in providing medical students with experiences of illness and experiences of caring. We propose that these experiences play an important role in helping students — many of whom will train as applied health scientists — to become aware that they can use both their cognitive abilities and their personal attributes to promote positive health outcomes for themselves and patients. To facilitate this process, we suggest that the curriculum continues to foster communication-skills training for students, enhance opportunities for individual and small-group reflection, and give emotional support to students who have negative experiences as a result of difficult clinical encounters.

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