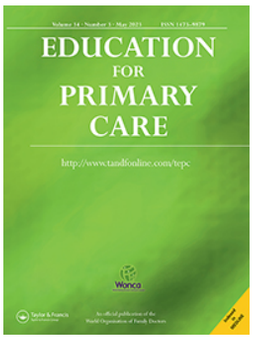

Education for Primary Care

ISSN: 1473-9879 (Print) 1475-990X (Online) Journal homepage: https://www.tandfonline.com/loi/tepc20

Meeting real patients: a qualitative study of medical students' experiences of early patient contact

Anette Hauskov Graungaard (General Practitioner and Senior Researcher) & John Sahl Andersen (General Practitioner and Senior Researcher)

To cite this article: Anette Hauskov Graungaard (General Practitioner and Senior Researcher) & John Sahl Andersen (General Practitioner and Senior Researcher) (2014) Meeting real patients: a qualitative study of medical students' experiences of early patient contact, Education for Primary Care, 25:3, 132-139, DOI: 10.1080/14739879.2014.11494263

To link to this article: https://doi.org/10.1080/14739879.2014.11494263

Published online: 07 Oct 2015.

Education for Primary Care (2014) **25**: 132–9

Meeting real patients: a qualitative study of medical students' experiences of early patient contact

Anette Hauskov Graungaard MD GP PhD
General Practitioner and Senior Researcher, University of Copenhagen

John Sahl Andersen MD GP PhD
General Practitioner and Associate Professor, University of Copenhagen

WHAT IS ALREADY KNOWN IN THIS AREA
- Communication is essential for good clinical work.
- Communication has to be taught continuously throughout medical study.
- Understanding patient perspectives is of growing interest in early patient contact (EPC) courses.

WHAT THIS WORK ADDS
- Medical students profit substantially from early patient contact in the first year of the curriculum.
- Meeting a 'real' patient' is a challenging and personally inspiring experience for medical students that turns 'patients' into 'persons'.
- Medical students have to learn that 'communication' is something other than just talking to people.
- Medical students' expectations of the medical profession are challenged and broadened by experiencing early patient contact.

SUGGESTIONS FOR FUTURE WORK OR RESEARCH
- How are theory and practice better integrated in the course to sufficiently support students' experiential learning?
- How are students' understanding of patient perspectives retained and refined during medical study?
- How are EPC experiences transferred to future clinical situations by medical students?

Keywords: communication skills, primary care, undergraduate education

SUMMARY

Teaching communication skills is an important task in the medical curriculum. It is widely agreed that the ability to communicate with the patient is just as important as biomedical knowledge and technical skills. We present data from an early patient contact (EPC) course with integrated theoretical and practical skills inspired by modifications of Kolb's learning cycle. Our objective was to examine first-term medical students' personal experiences and challenges with EPC.

A qualitative design was adopted, with data from written logbooks and focus group interviews with medical students who had recently completed an EPC course. Data were analysed with a grounded theory approach.

We found that meeting with a real patient – a person – was a central point of learning. Students' perceptions and reflections on their future profession and personal skills were broadened. Students became respectful of a patient's life and illness experiences, and their understanding of communication as central to a doctor's daily work increased.

Our results deepen the current knowledge of students' benefit from EPC by taking it into first-term students' perspectives and focusing on the personal experiences and challenges that the students met during the course. Further integration of the patient in the learning processes is recommended.

INTRODUCTION

Excellent communication skills are essential to medical professionalism[1] but teaching these 'doctor skills' to medical students is complicated. In many leading medical schools early patient experiences are now integrated into medical study.

The UK consensus statement on the content of communication elements in the undergraduate medical curriculum (2008) states that '… students need to understand that effective communication is part of an integrated approach to practice in healthcare and that it stands alongside and is as important to good practice as clinical knowledge and practical skills'.[2] In *Medical Education in the New Millennium*, Rees[3] also argues that '… communication between doctors and their patients should be placed at the heart of medicine' in the medical curriculum. In several studies, early patient contact (EPC) is reported to enhance students' understanding of the patient, to increase motivation, and to support professionalism.[4–9] A systematic review from 2006[10] showed that EPC supported students to learn more about the healthcare system and biomedical and behavioural/social sciences. In an update to this review, 'understanding patients' perspectives' was identified as another benefit of EPC.[11] Literature on the role of the patient in the medical educational process is limited.[12] Whether students in the first years value real patient contact as a tool for recalling subject matter, as senior students do,[13] remains to be investigated. Students' reflections on their personal development and insights through EPC have been sparsely evaluated.

The aim of this study was to explore first-term medical students' reflections on learning and the challenges they face when conducting interviews with patients at home in an established EPC course.

METHODS

Design and material

We adopted a cross-sectional qualitative design and collected data from focus group interviews and written logbooks from first-year medical students just after completion of an EPC course. All data were anonymised and the study adhered to national ethical rules.

Background and theoretical basis of the EPC course

Our EPC course design is inspired by Kolb's process of learning (Figure 1).[14] He described this as a process related to personal experience and reflection, rather than aiming at a specific outcome. To gather insight it is necessary to conceptualise experiences and integrate theoretical perspectives. Every stage in this process needs support, however, and different learning styles as well as the situation of the course in terms of place and time must be taken into consideration.[15] The course is developed and conducted by general practitioners (GPs) and patient-centred communication is inherent to all parts of the course.

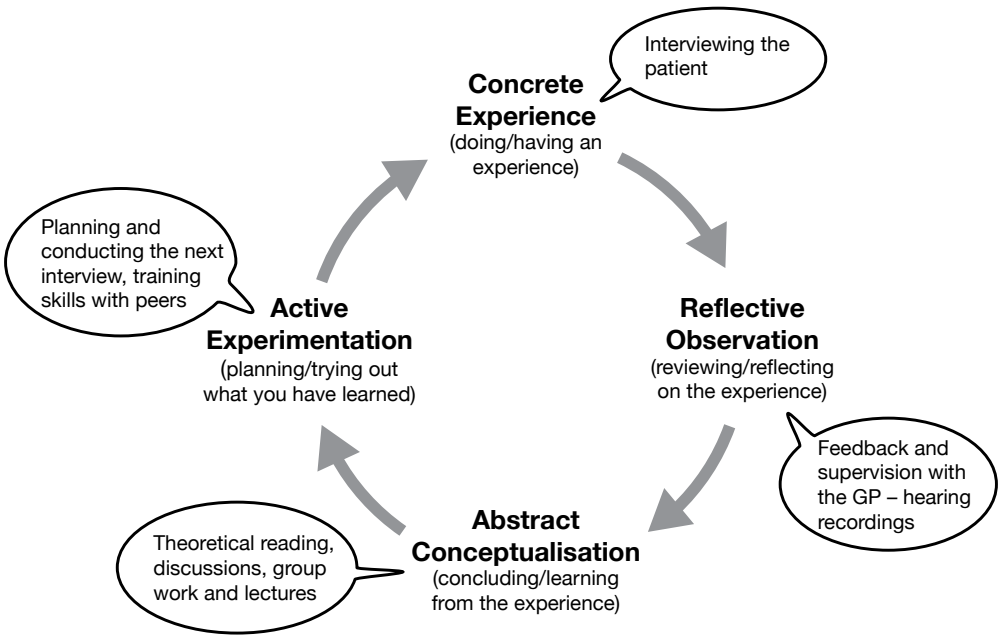

Figure 1 Illustration of Kolb's learning cycle modified to illustrate the intentions of the EPC course (Kolb's learning cycle, by kind permission of Clara Davies, University of Leeds).

Course setting and content

At the University of Copenhagen, the medical school has an intake of 550 students each year, and an EPC course was initiated in 1986.[16] Since then, the course has undergone continuous evaluation and development. The EPC course is mandatory in the first term. The course objectives are for students to:

- develop their professional identity
- gain knowledge and understanding of the patient's role and patient-centred medicine
- be introduced to basic communication skills
- have some training in basic communication skills (Table 1).

The main focus of the course is the learning experience students gain from three interviews with a patient in the patient's home concerning his/her life and health history. Each visit is scheduled to last 1–1½ hours (Table 2). Groups of five students are allocated to a GP, who recruits a patient for each student. Parts of the patient interviews are digitally recorded for use in supervision and report writing, with proper regard to maintaining patient confidentiality. The patients are often elderly with chronic diseases, but there are no specific demands regarding the selection of patients. The students meet with the patient's GP three times during the course and receive feedback from the previous interview and support in conducting the next interview.

Table 1 The theoretical content of the course

Learning aims	Content
Healthcare laws and regulations	Patient confidentiality, patient autonomy, ethical rules for doctors
Communication techniques	Verbal and non-verbal communication skills, open and closed questions, guiding the conversation, level of interaction, transactions between the student and the patient
Planning professional interviews	Behaviour when approaching patients. Framing, setting and planning of patient encounters
Doctor–patient relationship	Patient-centred communication. Compliance/adherence, doctors' roles and identity
Causes and interactions in health and illness	Biopsychosocial model of disease, social class and network related to health, illness-disease model
Patients' understanding of health and illness	Stress related to health and health behaviour, coping and resources, health beliefs
The healthcare system and the patient	The structure of the health service and patients' relations with the health service

Table 2 The content and structure of the EPC course

Patient interviews	Supervision with the GP	Course week	Topics in group sessions	Plenary lectures
		1	Introduction to the course, confidentiality and ethics	Introduction to patient communication
	First meeting	2		
First interview		3	Communication theory and training	Prevalent diseases in the Danish population
		4	Doctor–patient relationship and roles	Stress, disease and coping
	Second meeting	5	Implications of the biopsychosocial model of illness	Theories of the biopsychosocial model of illness
Second interview		6		The difficult consultation – views from the hospital priest
		7	Patients' beliefs about their health and coping strategies	Empathy and dealing with patients' feelings
		8	Analytic and reflexive report writing	Structure and function of the healthcare system
Third interview	Third meeting	9	Patients' interaction with the healthcare system	Doctors without borders – another kind of doctors' work
		10		
		11	Evaluation of theoretical and personal learning	Integrating theory and practice

Concomitant weekly classes are held for groups of 24 students at the faculty, where theoretical, ethical, and practical issues regarding patient experiences and communication are discussed. The teaching is based on the students' forthcoming experiences with patients and uses written patient cases, patient videos and role play. Furthermore, eight plenary lectures are given on the healthcare system, doctors' work and patient experiences. All teachers and tutors are, with a few exceptions, GPs. The students write a report of their experiences with analysis and reflections that combine the theoretical and practical elements of the course, including a short transcript of the interviews to illustrate communication issues. A discussion of the report forms the basis of an oral examination completing the course.

Formal course evaluation

Each term, the EPC course is evaluated with 15 questions using a 7-point Likert scale, where 1 is very bad, 4 is acceptable, and 7 is very good. Selected questions and ratings are shown in Table 3.

Table 3 Students' evaluations of EPC course

Question	Rating
'How do you evaluate your outcome of the patient meetings?'	5.65
'How do you evaluate the relevance of the course for your future work as a doctor'	5.79
'How do you evaluate your outcome of the theoretical classes?'	4.40
'To what extent are you satisfied with the content of the course?'	4.61

Data sampling

Four focus-group interviews were conducted with 24 medical students (six in each group) shortly after the EPC course was completed. We aimed at recruiting students from many different classes to get opinions from students with different teachers and GP tutors. We verbally invited all students in the autumn semester of 2008 to participate in the focus groups. We handed out written information to those students interested in participating and we obtained their written consent. We developed the interview guide initially with very broad themes related to the aims of the course (identity, skills, doctor–patient relationship, and personal reflections) and we tested it in a pilot focus group. The guide was subsequently revised to focus more on the student's personal experiences with the course. We conducted a preliminary analysis after the first two focus group interviews. As a result, we revised the interview guide again in order to specifically explore central issues about the learning process, students' personal skills, and reflections on the student–patient relationship (Box 1). All interviews were included in the analysis.

Box 1 Content of interview guide

- What have you learnt about professional communication?
- What have you learnt about being a patient?
- Did the course alter your motivation, perception of the doctor's role or interest in other topics in the medical curriculum?
- What do you think characterises a 'good' doctor?
- How did you feel about visiting the patient?
- Did you feel suited to undertake the interviews?
- How did you react to the patient's difficult emotions or social situation?

An additional 24 students were randomly selected and invited to complete a written logbook during the EPC course. These students were asked to reflect on the following questions after each meeting with the patient:

- How did you feel when leaving the patient?
- What thoughts did you have?
- What did you learn from the patient?
- What did you learn about yourself?

Twelve students returned the completed logbooks after the course.

Analysis

The focus groups' interviews were transcribed verbatim and all data (transcripts and logbook data) were analysed collectively. The first author (AG) analysed the data using a grounded theory approach[17] where main themes were identified. The core category and main themes were related to the theory and stages in Kolb's learning cycle in order to elicit challenges and identify the learning process at different stages during the course. Results were validated by repeated discussions with the second author (JSA) and other experts in the field.

RESULTS

The main finding was that meeting a real patient was the central point of learning for students. Meetings and communication with a patient essentially challenged and influenced the students' perceptions and reflections on their future professional identity, their personal skills, and their respect for patients as fellow human beings. Also, students reported a sharpening of their awareness of communication as central to doctors' work. See Box 2 for the main results.

Box 2 Main results

Practical experience – planning and reflecting
- Interaction of new theoretical skills and practical experiences
- Talking to someone is just a natural thing
- Turning the social meeting into a professional communication
- Relating to patients' feelings

Conceptualisation and learning from the experience
- Good and bad role models
- Reviewing personal skills

Learning processes and changing assumptions
- New insights in future professional life
- From patient to person
- Learning about life from the patient

Integrating theoretical skills and practical experience

Many students were nervous before the interviews and relieved to be met by a positive patient who wished to help students to become good doctors. Students varied widely about how much training in communication they would like to have had before the first interview. However, during the course most students understood the learning principles underpinning the course and actively used their 'mistakes' in the learning process.

> You go out and make a lot of mistakes, and the more mistakes, the more you get this 'Aha' experience when you go to class or meet with the GP. (Focus Group 1 (FG1))

The opportunity for reflection during supervision with the GP and in class meetings was highly appreciated and led to reflections on how to conduct future patient interviews.

> If I were to do this again, I would have done it completely differently. (FG3)

Talking to someone is just a natural thing – turning the social meeting into professional communication

It was an eye-opener to most students that in professional encounters communication is *something else* than ordinary talk. They realised that they got more relevant information and became better listeners when they used communication tools.

> The practical part of this course was very, very rewarding to me, because I made these giant mistakes at the beginning, and really hated to hear myself on tape, so it really stuck as to how to guide a professional conversation. (FG3)

Students reached this insight at different points in the learning process. Some felt discomfort using communication tools and chose not to use them consciously; others found them very useful in improving the content and form of the patient interviews; still others used them mainly for analytical and reflective purposes during and after the course.

> When the course started and I was going to talk to my patient I thought it was a little weird with all these communication tools because I thought that … well talking to someone is just a natural thing. (FG4)

> I actually think I only used them (communication tools) when I wrote the report and then I realised I maybe should have thought a little more about it before. (FG1)

Relating to patients' feelings

Relating to patients' feelings was a main concern for the students before and after the interviews, especially if the patient showed strong negative emotions of sadness, hopelessness, or loneliness. Students were personally affected by how to act if the patient was in tears.

> We had got a really good relationship, a mix of a personal and a professional relationship, and I wanted to put my arm around her to comfort her, but out of fear of crossing her personal boundaries I didn't do it. (FG3)

Respecting the patient's personal boundaries for sharing personal experiences was a major challenge to the students. They were either afraid of getting too close, or of being too persistent when patients were reluctant to share intimate and painful memories.

> I have learnt a little more about when it is OK to confront the patient and when to let it go when the patient withdraws from the topic; it's a very fine line. (Logbook 1 (LB1))

Conceptualisation and learning from experience

Good and bad role models

When students were responsible for communication with a patient, they became aware of how doctors they have met communicate with their patients. Students realised that communicating with patients

was not a simple task, and mistakes may be unavoidable. Good and bad role models were reflected on and integrated in the students' planning of their next patient encounter.

> She [the GP] just had time for her patients … and for us, and she knew a lot of our course and she had an incredibly good relationship to her patients. My patient, he could hardly say anything bad about the healthcare system because he knew it through her and he simply loved her … she was simply a very good person. (FG4)

Reviewing personal skills

Students' personal skills and preparedness for patient communication were part of both the preparation and the reflecting processes during the course.

> I talked to my patient about the skill of communication, and she said she thought I was good at it, and I was happy about that. (LB1)

The personal chemistry between student and patient preoccupied all the students, and they also reflected on the mechanisms behind this.

> I think it's hard to define 'the good doctor' because it always depends on who the patient is. (FG4)

> As I have said, there are surgeons and researchers who do *not* need those psychological skills. (FG4)

From patient to person

Students clearly expected the patient with multiple diseases to be the most interesting person to interview at the start of the course. During the course this changed as patients became people. Challenges in communicating with the very talkative or the more reluctant patient became obvious and the patients' lives were unfolded during the interviews.

> It became clear to me that even if a patient maybe doesn't have a biological disease the patient may be ill anyway and this has to be taken seriously too. I have learnt that you have to show every patient respect. (FG3)

Learning about life from the patient

A central finding in all focus groups was feelings of respect and admiration for patients, who had often endured many traumas and setbacks during life, yet still maintained a positive attitude. For young students relatively inexperienced in life's adversities, the meeting with a person who had a much longer life perspective was a powerful experience.

> 'Think positively and remember to be optimistic', my patient did not say it directly but I thought to myself several times 'she has lots of energy – I hope I will be like that when I get to her age'. (LB5)

> My patient seemed very calm considering her situation – very admirable. (LB6)

Learning processes and changing assumptions

New insights into future professional life

The meetings with the GPs introduced students to the close relationship with patients in general practice and most students related their EPC experiences to their expectations of future professional life. Some felt that close personal contact with the patient was not what they had expected, others that this was exactly their motivation for choosing to study medicine. Some students found the experience central for their future studies.

> I really think that it is very beneficial that students very early in the study are allowed to get out and see what they are studying for. (FG3)

A few students felt the course was irrelevant. They found it too difficult for first-term students to be responsible for professional communication. To some students EPC was a real challenge or even a challenge to their beliefs about the conduct of a doctor.

DISCUSSION

Generally students' former assumptions about a doctor's work and the experience of being a patient were challenged and broadened by the course. The students' experiences when meeting a patient became the main motivator for learning communication skills. Students' former experiences, both as users of the healthcare system and as student workers in different environments, played a role in their perspectives. Often the patients became role models for the students in the ways that they lived with illness and adversity. These outcomes, as well as the initiation of a developing professionalism and an increasing motivation, are supported by other studies on early patient contact.[18] Littlewood *et al* found that early experience fostered self-awareness and empathic attitudes towards sick people, boosted students' confidence, and motivated them.[7] This is reflected in our findings, but we also found some doubts about the relevance and the

necessity of actually having *to learn* how to talk to other people. The importance of meeting a 'real' patient is supported by Clever *et al*,[1] who found in a comparative study that first-year medical students rated their experiences with real patients significantly higher than with simulated patients. Bokken *et al* also reported authenticity as an important advantage of real patients.[18] Spencer *et al*[12] stated that '… the importance of what can be learnt from the 'patient' has been repeatedly emphasised, but the literature of the role of the patient in the educational process is limited'. We found that students learned about life experience, coping skills, and resilience from the patients and experienced communication challenges related to different patient personalities.

Students in our study had serious concerns regarding how to approach and handle patients' feelings but gained confidence in coping with this situation through supervised experience. Likewise Hajek *et al*[19] examined student concerns about patient interactions and 'the patient starts crying or becomes angry with me' was the strongest concern; this concern was reduced after a communication course. Furthermore, a review from 2007 by Satterfield and Hughes concluded that empathy and supportive behaviours *can* be taught and retained by medical students.[20] Interviewing a patient about his or her life may be an appropriate starting point for this learning process.

Implications for the future and teaching in EPC

The simultaneous experience of patient communication and theoretical reflective classes motivated the students' learning process. Meeting a real patient was essential. Two challenges in teaching early patient contact were found: some students questioned the need for communication skills training at all, and some reflected on how to integrate theoretical knowledge naturally into the practical experience. These objections were expressed by a minority of the students. Reflecting and integrating theory are rather complicated cognitive skills. The learning argument of Kolb's cycle supports the process, but the principles may have to be clarified for students. There may be a need for specific training and feedback on how to reflect and improve insight.[21] Furthermore, reinforcing the relevance of learning communication skills alongside human anatomy and physiology may need even more attention by putting the patient at the centre of learning and combining clinical and communicative aspects of the patient's case.

Methodological considerations

In gathering participants for the focus groups we aimed at diversity, but we cannot claim that all opinions on the topic have been heard. It could be that only the most interested students signed up to participate in our study. Furthermore, both authors are familiar with the students' reactions through many years of teaching: this may be both a strength and a weakness due to the possibility of interpretation bias. By including individual logbooks we aimed at triangulating the findings and eliciting more private opinions.

CONCLUSION

Students profit from meeting real patients and learning from their life stories and personalities. The concomitant learning of biomedical and communication skills was to some students unexpected, but to others it was highly appreciated. It is important to teach how to integrate theoretical and practical skills in order sufficiently to support the students' outcome from early patient contact. Our study indicates that early patient contact helps to turn patients into people with experience and life values who have found ways of coping with illness.

Ethical approval

The Danish Committee on Health Research Ethics decided that this was an interview study and so ethical approval was not required.

References

1 Clever SL, Dudas RA, Solomon BS *et al* (2011) Medical student and faculty perceptions of volunteer outpatients versus simulated patients in communication skills training. *Academic Medicine* **86**: 1437–42.
2 Fragstein von M, Silverman J, Cushing A, Quilligan S, Salisbury H and Wiskin C (2008) UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education* **42**: 1100–7.
3 Rees LH (2000) Medical education in the new millennium. *Journal of Internal Medicine* **248**: 95–101.
4 Baerheim A, Hjortdahl P, Holen A *et al* (2007) Curriculum factors influencing knowledge of communication skills among medical students. *BMC Medical Education* **7**: 35.
5 Valkova L (1997) First early patient contact for medical students in Prague. *Family Practice* **14**: 394–6.
6 Dornan T and Bundy C (2004) What can experience add to early medical education? Consensus survey. *BMJ* **329**: 1153–9.
7 Littlewood S, Ypinazar V, Margolis SA, Scherpbier A, Spencer J and Dornan T (2005) Early practical experience and the social responsiveness of clinical education: systematic review. *BMJ* **331**: 387–91.
8 Muir F (2007) Placing the patient at the core of teaching. *Medical Teacher* **29**: 258–60.
9 Goldie J, Dowie A, Cotton P and Morrison J (2007) Teaching professionalism in the early years of a medical curriculum: a qualitative study. *Medical Education* **41**: 610–17.

10 Dornan T, Littlewood S, Margolis SA, Scherpbier A, Spencer J and Ypinazar V (2006) How can experience in clinical and community settings contribute to early medical education? A BEME systematic review. *Medical Teacher* **28**: 3–18.
11 Yardley S, Littlewood S, Margolis SA *et al* (2010) What has changed in the evidence for early experience? Update of a BEME systematic review. *Medical Teacher* **32**: 740–6.
12 Spencer J, Blackmore D, Heard S *et al* (2000) Patient-oriented learning: a review of the role of the patient in the education of medical students. *Medical Education* **34**: 851–7.
13 Bell K, Boshuizen HP, Scherpbier A and Dornan T (2009) When only the real thing will do: junior medical students' learning from real patients. *Medical Education* **43**: 1036–43.
14 Kolb DA (1984) *Experiential Learning Experience as a Source of Learning and Development.* Prentice Hall: New Jersey.
15 Yardley S, Teunissen PW and Dornan T (2012) Experiental learning: AMEE guide No.63. *Medical Teacher* **34**: e112–15.
16 Lassen LC, Larsen JH, Almind G and Backer P (1989) Medical students experience early patient contact in general practice. A description and evaluation of a new course in the medical curriculum. *Scandinavian Journal of Primary Health Care* **7**: 53–5.
17 Strauss A and Corbin J (1998) *Basics of Qualitative Research* (2e). Sage: Thousand Oaks, CA.
18 Bokken L, Rethans JJ, Jobsis Q, Duvivier R, Scherpbier A and van der Vleuten V (2010) Instructiveness of real patients and simulated patients in undergraduate medical education: a randomized experiment. *Academic Medicine* **85**: 148–54.
19 Hajek P, Najberg E and Cushing A (2000) Medical students' concerns about communicating with patients. *Medical Education* **34**: 656–8.
20 Satterfield JM and Hughes E (2007) Emotion skills training for medical students: a systematic review. *Medical Education* **41**: 935–41.
21 Aronson L (2011) Twelve tips for teaching reflection at all levels of medical education. *Medical Teache*r **33**: 200–5.

Correspondence to: Dr Anette Hauskov Graungaard, CSS, Oster Farimagsgade 5, Postbox 2099, Copenhagen 1014K, Denmark. Tel: +45 35 32 75 94; fax: +45 35 32 71 31; email: angra@sund.ku.dk

Accepted 13 January 2014