

Stories Medical Students Tell

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This paper presents a content analysis of informal medical student stories that were by-products of a course on the Art of Doctoring. The stories are divided into negative and positive categories. In the former category, stories of loss, helplessness, and disillusionment were identified. In the latter, stories of renewal, heroism, and transformation predominated. Students told stories as an act of reflection, a cry for help, a way to reduce isolation, and an invitation to activism. Over time, trends in the direction of increased flexibility and positivity were observed. Storytelling served as a method for healing students' initial sense of dislocation and purposelessness. Through their stories, students began to reconcile disillusionment with hope for their future as physicians.

Jerome Bruner (1986) helped us understand that narrative is a fundamental mode of thought, a method shared by all humans to order experience, interpret reality, and make sense of chaos. Its more informal cousin, storytelling, is unconcerned with theories of literary criticism or ethical principles, and is simply the dominant way that human beings communicate with both themselves and others. Stories can be relational (ways of connecting people); explanatory (ways of knowing); creative (ways of organizing reality); historical (ways of remembering); and predictive (ways of visioning the future) (Honos-Webb, Sunwolf, & Shapiro, 2001). In these capacities, they can act as a container to deal with troubling or even traumatic experiences. Telling stories helps us reconcile or at least to confront the discrepancies between what we expect from our experience and what actually occurs (Garro, 1994). We tend to tell stories about situations that are disturbing or morally ambiguous (Garro & Mattingly, 2000). The narrative thrust of a story attempts to help us identify significant connections between people and events, and thus to create meaning (Taylor, 2001) and moral sense (Nelson, 1997). In this way, stories are personal testimonies that attempt to convey their own particularistic truth about experience (Avrahami, 2003). As Frank (1995) suggests, storytelling is a way of recovering one's life in situations where it seems to have been taken away.

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In recent years, stories have found new respect in medicine. There has been renewed interest in the stories of patients, both in terms of what they mean for doctors and what they mean for the patients themselves. We also have recognized that, despite the current enthrallment with evidence-based medicine, doctors themselves are constantly engaged in the process of telling stories to each other and to their patients (Hunter, 1991).

It has been observed that medical discourse is monological, largely omitting the patient's voice (Aull & Lewis, 2004). Another relatively neglected voice is that of the medical student, especially as he or she attempts to reflect on and make sense of the process of medical education. Medical training in general tends to silence personal voice (Poirier, 2002; DasGupta, 2003), and students as low-status members of the hierarchy are especially vulnerable to this suppression. As has been pointed out, medical students occupy a liminal position between full-fledged physicians and laypersons (Henderson, 2002). For this reason, they may be perceived as unimportant or irrelevant, their role in the medical hierarchy transitional and transitory. Often, they are not included in their own stories. Personal stories represent one way that students can examine their experience and see more deeply into its possible meanings (Spatz & Welch, 2000). I contend that we can learn much of importance by creating space for students to tell their stories and listening more carefully to the stories they tell. These stories can represent origin myths for students—i.e., “this is where I became a real doctor” (Stein, 2001). The attitudes of physicians originate in their medical school years. The physicians of tomorrow emerge out of the medical students of today.

Scholars who have analyzed student stories, whether told verbally or in writing, have identified many common themes. Students' written stories generally focus on maintaining and expressing empathy and compassion for the patient, how to be a caring person (Branch, 2000). Anderson (1998) divided medical student stories into four categories: 1) those that encode the knowledge necessary to become a physician; 2) those that create and maintain identity; 3) those that problematize the normative world of medicine; and 4) those that heal the teller. Many student stories focus on issues that generate great personal suffering, such as how to break bad news to patients and how to deal with their own anger and frustration with the limitations of medicine (Poirier, Ahrens, & Brauner, 1998). Other themes include role confusion, exploration of professional identity, consideration of medicine as a calling, physician privilege and power, the limits of medicine, death and dying, and identification with the patient (Hatem & Ferrar, 2001). Students learn to tell one kind of story, the case presentation of the patient, using a highly technical vocabulary and a prescribed format

based on clinical reasoning (Good and DelVecchio-Good, 2000); this medicalized retelling of the story of illness inevitably objectifies and dehumanizes the patient (Brody, 1998). But students also tell different kinds of stories, when the context changes in ways which privilege emotions, particularity, and self-disclosure. In the hospital environment, experience becomes medicalized. Students lose the ability to reflect on what is happening to them from a human perspective, to explore the dissonance they endure as they try to connect their personal values with their clinical training (Branch, 2000).

It is possible, however, to create a space in which student stories, normally of no importance in the medical hierarchy, matter. In such an environment, students know that they have permission to tell non-normative, distinctive stories about their lives and training. By changing the "rules" of who is allowed to tell a story and what can be told (Ochs & Capps, 1996), students can consider their lives from other perspectives, and in the process perhaps begin to heal the confusion and distress inherent in the medical education socialization process. In this approach, there would be no clear rules about what was relevant or irrelevant, what belonged or what should be omitted in the student's story (Greenhalgh & Hurwitz, 1999).

The stories discussed below grew out of a 20-week seminar for 3rd and 4th year medical students, "The Art of Doctoring," taught for two consecutive years in 2003-4 and 2004-5. In total, fifty-six students completing the clinical training years of medical school enrolled in the class. The focus of this elective course was to increase learner attitudes of compassion and caring toward patients. However, on a weekly basis, during the 2-hour seminar sessions, students provided numerous anecdotes detailing issues of concern to them that occurred during their training on hospital wards and in outpatient clinics. Faculty noticed that, perhaps because of their intersubjectivity, one story usually led to another story (Connelly, 2002).

The faculty facilitators attempted to adopt an attitude of "thinking with" the students' stories instead of "thinking about" them (Frank, 2004), allowing the group to resonate emotionally to the stories rather than analyze them. Instead of seeing these informal stories as objects to be intellectually dissected, we encouraged students to consider each story as a part, albeit a sometimes unrecognized part, of themselves and their own experience in medical training (Morris, 2002). Thus the goal was to honor rather than fix the stories offered up by their peers (Frank, 1998). Rather than trying to "carry away" the salient facts, or a message, as is taught in medical school, we tried to stay with the stories we heard, and to live in them (Brody, 1997). We tried to allow the students' stories to "hail" us, in the sense of calling out to us and claiming us for a moment (Frank, 1997).

These “mini-stories” were documented immediately after each class session by the author. A total of 105 stories over a two-year period were annotated. A grounded theory content analysis identifying first key words and phrases, then categories, and finally larger themes (Lincoln & Guba, 1985) was subsequently utilized to organize and interpret the major preoccupations of students as expressed in these stories. This analysis identified three negative and three positive story themes that appeared frequently among student accounts, which may be understood as *adaptation to physicianhood*. The negative themes include stories of loss; stories of powerlessness; and stories of disillusionment. The most common positive themes were stories of support and renewal; stories of empowerment and heroism; and stories of transformation. All themes were identified inductively, based on the content of the stories told and accompanying self-disclosures of the medical student-narrators. Since content analysis is necessarily a hermeneutic process, it is possible that other explanations may apply. The interpretations offered are what made most sense to the author in the context of her review of the literature and 25 years’ experience teaching medical students.

Models of Storytelling in Medicine. Two major models of medical storytelling have been recorded in the literature. One defines categories of pathography, or illness stories, identified by Anne Hunsaker Hawkins. These include testimonial or didactic pathography offered for the benefit of others; angry pathography, focusing on the disjunctive experience of the patient in contrast to “official” versions of illness; and what she calls “myths” of journey, battle, rebirth and transformation. Arthur Frank created a typology of illness stories as narratives of restitution, in which what was lost (health, normalcy) is regained; chaos narratives, where the suffering and alienation experienced by the patient are almost incapable of being shared or articulated; narratives of quest and transformation, in which the patient experience is a kind of heroic journey during which s/he is transformed on significant personal dimensions; and finally narratives of testimony that are simply a witnessing of disturbing, even devastating truths otherwise ignored or rejected.

Both these models were developed with patient narratives in mind. Clearly, no one would argue that being a medical student is the same as contracting a serious illness. Yet it is true that the sense of dislocation, moral challenge, and threatened identity are similar. Thus, some of the themes identified below in medical student stories bear a distinct resemblance to these conceptual categories, suggesting that under stressful conditions of threat and disruption, all human beings tend to generate analogous stories.

Stories of Loss. These stories expressed concern about personal changes students observed in themselves that they attributed to the process of medical education and that they evaluated negatively. These stories are similar to Frank's chaos narratives in their inarticulate suffering. These stories focused on the loss of positive personal attributes. Students who told these kinds of stories used language that portrayed themselves as becoming less empathic and more detached; less patient and more entitled; less tolerant and more judgmental; less playful, lighthearted and concomitantly more cynical and disillusioned. In these narrative self-representations, they noticed that they were caring less about the person of the patient and focusing more exclusively on clinical symptoms; putting less emphasis on talking/connecting and overvaluing efficiency; relying less on negotiation and collaboration and more on pressure and even coercion of patients in order to get them to comply with medical advice; identifying more with residents than with patients (a shift in preferred group identity), and therefore less likely to be caring and more likely to make fun of patients; losing ideals of commitment to poor and underserved and thinking more about how they could be compensated for all that had been taken away from them.

A typical story of loss told by one student involved his returning to his small hometown and observing his attitudes of superiority toward former friends who had achieved less professionally, as well as his sense of entitlement in being catered to and indulged by his family. Another story involved a student who attempted to elicit more information from a patient with a longstanding history of drug abuse and alcoholism. When the student went out to write a chart note, several residents familiar with the patient were standing outside the room, trading humorous remarks about the patient's lack of cleanliness and generally disheveled state. Instead of objecting, the student joined in, to his subsequent shame. In these stories, students were preoccupied with a sense that they were becoming different people, that medical school was changing them in ways that frightened them and that they could not control.

Stories of Helplessness and Powerlessness. These stories, also similar to Frank's chaos narratives, were characterized by intense resentment of the vertical power distribution typical of the medical educational hierarchy. Some students told stories of feeling invisible to the health care team. The point of other stories was that, as medical students, their opinions were consistently devalued or ridiculed. When students attempted to stand up for themselves or voice concerns they were labeled as "whiners" and "complainers." Their perception was that questioning and dissent from less powerful voices were systematically stifled. In one such story, a Native American patient had end-stage renal disease, but

cultural reasons the family refused to allow physicians to inform the patient of the prognosis. The student felt strongly that the patient knew she was terminally ill, and that the silence surrounding her condition only added to her suffering. Yet the student felt powerless to protest because of his bottom-rung status on the medical ladder. Students felt especially helpless about grading and the entire evaluation process. Many stories revolved around a poor test score contrasting with excellent clinical performance that nevertheless determined their overall residency grade; or complaints about the subjectivity of resident and faculty evaluations.

Another rather different manifestation of student vulnerability included feeling emotionally overwhelmed by patient suffering and being helpless to change poor treatment of patients, particularly those who were uninsured or perceived as undesirable. A representative story illustrating these points was one told by a female student in which she dealt with a patient dying of metastatic breast cancer. The patient kept asking the student if there wasn't something more that could be done to prolong her life. The student felt guilty because "there was nothing more I could do." All these elements of powerlessness and vulnerability combined so that in these stories students portrayed themselves as victims of the medical educational system.

Stories of Disillusionment and Disappointed Expectations. These stories focused on the student narrators' profound disappointment resulting from their encounters with negative resident and attending role models. In their strident, irate tone, they share something in common with Hawkins' angry pathographies, especially in their rage that the "official" version of medical education is significantly at variance with their lived experience. Emblematic stories presented the exploitation of patients for resident or student learning; faculty who were not familiar with evidence-based standards of care, or who practiced medicine in unethical or impersonal ways; physician arrogance, particularly evident in the inability to admit limits and the failure to acknowledge mistakes; and attendings and residents who made fun of and ridiculed patients behind their backs. One particularly awful story involved a surgeon opening up a patient in the operating room only to discover widespread metastatic ovarian cancer, who then remarked to the surgical team, "Well, no shopping in bulk at Costco for this one."

Sometimes they were disappointed with their performance on an exam, or choosing to party rather than study. However, most of these stories expressed frustration that they had betrayed or abandoned personal standards of behavior, or core ideals that they considered foundational. One such story concerned a student whose grandmother was seriously ill, but the student chose not to return home (in another

country) because she felt it would jeopardize her medical school standing.

Student disenchantment can extend to patients, as well. Substance abusing patients were often disliked, but the students reserved most of their complaints for “noncompliant” patients who disregarded physicians’ recommendations for what they perceived to be frivolous reasons. For example, one story targeted an adolescent insulin-dependent diabetic who refused to inject insulin into her thigh because she developed unsightly dimples at the injection site. In another story, a patient refused to quit smoking despite severe chronic obstructive pulmonary disease because he “liked” cigarettes. These stories tended to dismiss such patients, in one student’s words, as “a waste of time.”

Other student stories demonstrated bitterness toward the health care system itself. Examples included observing resistance to admitting patients with no insurance; formulaic use of informed consent procedures; and poor treatment of indigent or non-English-speaking patients. In one typical story, a patient who was not fluent in English was consented without an interpreter to a surgical procedure. When the medical student asked if she understood why she was having the surgery, the patient replied that she just trusted the doctor and would do whatever he wanted. In all these stories, the prevalent tone was one of cynicism, frustration, and even despair.

Stories of Renewal, Support, and Empowerment. The most frequent of the positive stories were those of renewal, support, and empowerment that students experienced as a result of contact with patients, peers, residents and faculty. These are perhaps similar to Frank’s restitution stories, in which things of great value that were taken away are restored; and to Hawkins’ myths of rebirth and cure, in that students seem “cured” of their original disillusionment and helplessness. As an example, one story recounted how an inexperienced student was having difficulty placing an intravenous line in a patient’s arm. Instead of protesting, the patient uncomplainingly absorbed the pokes and finally patted the student’s hand, saying, “It’s all right, dear. You’ll get it in a moment.” The student, who moments before had felt panicked and miserable, was sufficiently encouraged to successfully complete the procedure. A similar story revolved around an attending physician who rallied to support a resident after a patient’s death in which a misplaced nasogastric tube might have been a contributory factor. In a climax worthy of great narrative, the attending concludes his consolatory speech by saying, “You never want to carry that coffin alone.” The resident realizes that it is possible and necessary to come to terms with even devastating mistakes in medicine.

suffering, but in the end is rewarded by important persons. The general premise of these stories was to present evidence of and professional growth, from being confused, irrelevant, and disconnected from the medical team to beginning to see in themselves the potential of a real doctor. This process often involved reconnecting with the values that had originally led them to the medical profession, freedom, and freedom in their work (Souba, 2002). These stories related instances where students were able to preserve their integrity by speaking out when confronted by unethical or uncaring physicians. They also talked about developing various skills and attitudes that they believed would make them not just competent technicians but practitioners of the art of medicine.

The novel qualities and attributes some students mentioned in their anecdotes included learning to manifest a compassionate attitude toward their patients; learning to find an inner calmness even within stressful or painful situations; shifting focus from self to patient rather than multi-tasking, learning to focus attention on one thing at a time. In other tellings, students portrayed themselves as vulnerable with appropriate personal disclosures as a way to close the distance between themselves and the patient. Some students told stories where they became more at ease witnessing the patient's suffering because they could not fully alleviate it. Other students told stories where they learned the distinction between "helping" or "fixing" by themselves and patients and doctors serving each other in a mutually beneficial relationship. Still other stories made the point that treating patients is sometimes less important than creating relationship. Some stories showed students learning to respond to noncompliant patients with feelings of challenge, compassion, enjoyment, curiosity, and acceptance; others, accepting that patients and physicians have different priorities, or developing capacity to have fun with patients. Students in these stories saw themselves learning to become advocates, becoming more comfortable in talking about difficult topics, like death and dying, or sex, and becoming more confident and less afraid of patients' feelings.

Why Did Students Tell These Stories? "Telling stories was required of all members of the class. However, faculty did encourage students to give examples that embodied their feelings, whether positive or negative. In addition, positive peer feedback appeared to validate the process of student storytelling. One of the purposes of understanding the purpose of shared stories is found in Sunwolf and colleagues, in which stories "... may function as a tool for learning, as a tool to create new healing realities, ... as a way to envision future healing possibilities, and as a bridge to connect

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Of course, other explanations are also possible, for instance the possibility that students repressed negative storytelling as it became more important to them to identify with the medical profession. There appeared to be an ongoing tension between stories that were *agonistic*, resisting, contesting, and negotiating values and meanings, and those that were *collectivist*, affirming the cultural norms and values of the professional medical community (Gale, 2005). This tension may also be understood as a “therapeutic holding space” (Ryden, 2005, p. 56), in which students struggled to develop a self-identity that successfully balanced tendencies toward resistance and toward accommodation.

Further, it is significant that both the negative and the positive stories of medical students reflected many of the attributes and characteristics of stories told by patients (Hawkins, 1993; Frank, 1995). Medical students often identify with patients, and this may be because in fact they have more in common with this group in terms of low status and limited power than they do with the residents and physicians whom they aspire to become. Both students and patients are in the process of adapting to loss of control and finding themselves in an unfamiliar and often threatening environment. From this perspective, it is not surprising that both groups gravitate toward stories of adaptation.

Conclusion. In attempting to draw any conclusions from these stories, we must not forget that stories bear only an imperfect relationship to actions and events in real-time. We cannot assume that these stories were entirely authentic. There is always a gap between the story and the actual experience (Garro & Mattingly, 2000). Further, stories emerge out of discourse communities that necessarily limit and shape them. Within this class, norms of self-disclosure and transparency intermingled with values of altruism and compassion. This context, and the need to meet the perceived expectations of their audience of both faculty and peers, undoubtedly shaped to some extent the kinds of stories that were heard (Atkinson, 1997).

Like stories told by patients and others (Anderson & MacCurdy, 2000), it was apparent that out of this process of medical student storytelling a kind of healing emerged. This healing seemed related to both the interpersonal connections gained from the dialogic aspect of storytelling and from the distance from experience that shaping and recounting the story necessarily created (Ryden, 2005). Students frequently commented that they felt less isolated, clearer about their reasons for being in medicine, and closer to and more trusting of their classmates after exchanging these informal stories. Perhaps most importantly, through story-telling students began the long process of reconciling their disillusionment with hope in and renewal of their vision of themselves as physicians.

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