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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.

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

for 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 clerkship 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 feeling 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 talked 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; staff 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 fell 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.

Students also told stories about cultivating personal skills to regenerate and restore themselves. These included meditation, prayer, reading, relaxation, practicing thankfulness, and identifying positive role models who took time to do extra teaching and mentoring and/or who were committed to delivering health care to indigent people. For instance, one student was inspired by the example of a physician who spent summers working in Vietnam. Other stories recounted how, with experience, students learned to deal more effectively with both supervisors and patients. In terms of residents and attendings, students told stories about how they developed skills in giving constructive negative feedback to and negotiating with superiors, as well as expressing their needs without being offensive. Student empowerment stories regarding working with difficult patients emphasized developing a kind of caring persistence—not giving up when the patient didn't respond immediately; getting on the same side as the patient, being empathic, and looking for areas of compromise.

Heroic Stories. In other stories, the students portrayed themselves in a heroic light. These stories sometimes had the quality of testimonials as described by Hawkins, in the sense of being shared to inspire and guide other students. In these stories, the medical student's intervention, however small, made a significant difference to the patient. One illustrative story involved a patient with AIDS who was anxious and resistant about undergoing a painful procedure to be performed by a resident. The student did not know what to do or say, but after a few moments simply took the patient's hand, at which point the patient relaxed, and the resident was able to proceed without further difficulty. Other stories were variations on the theme of advocating for a patient under difficult circumstances. For example, one student confronted the department of radiology about denying a diagnostic procedure because the patient was not properly insured. Another student talked about providing his team with psychosocial details about patients' lives that residents and attendings initially mocked, but which later proved relevant in the management of the cases. All of these stories gave the impression that the students who recounted them were intent on finding a meaningful, laudable, and even courageous role for themselves within the medical hierarchy.

Stories of Transformation. Finally, though with relative infrequency, students told stories of personal transformation, and the number of these stories increased as the year progressed. As has been observed, myths of quest, rebirth, and transformation are pervasive throughout history (Hawkins, 1993). Both Hawkins and Frank describe this category as an extreme event that is experienced as a quest, includes hardship and

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

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

Why Did Students Tell These Stories? "Telling stories" was not a required part 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 encourage and validate the process of student storytelling. One framework for understanding the purpose of shared stories is found in the work of Sunwolf and colleagues, in which stories ". . . may function to seed learning, as a tool to create new healing realities, . . . as a foreflash to vision future healing possibilities, and as a bridge to connect people. . . ."

(Sunwolf, 2005). In this classroom, medical students appeared to tell stories as an act of reflective "seeding," to find the moral or lesson in their experience that would make them better physicians. Students chose as narrative events incidents about which they needed to create significance and phenomenological weight. For example, they sometimes prefaced stories with a statement similar to the following: "Something happened in the OR yesterday that I don't understand, but I think has something to teach me about myself and about this profession." Students also seemed to tell stories as a plea for connection and a kind of "bridge-building" with each other. Often students would ask their peers something to the effect of "What's your opinion of this? Do you have any ideas about how I might have handled this situation differently?" The stories appeared to mitigate the sense of isolation from which students suffered. They both sought and found confirmation of their experience. A typical concluding comment might be, "I didn't realize other people felt this way" or "I'm glad you've had similar experiences." A final reason for the storytelling appeared to be narration as an act of activism, similar on one level to Sunwolf's "foreflash" into the future, intended to mobilize both themselves and peers toward positive change. In these instances, stories might lead to a specific plan for intervention, as an individual or as a group, either in terms of medical education or clinical practice.

What Do The Stories Mean? One way of interpreting these stories is to understand them as narrations of students' struggles with *adaptation to physicianhood*. In reflecting on the various themes that emerged as a whole, students often seemed to be trying to reconcile who they were and who they wanted to be with the requirements and expectations of the physician role. Students are often disillusioned and disappointed during their clinical years of training (Woloschuk, Harasym, & Temple, 2004). Although this disillusionment has many sources, in the stories told in these classes it was especially profound with regard to physician role models. Their stories also reflected deep concerns that the students themselves were changing, often in negative ways, as a result of their education. In these stories, they worried that core parts of who they were had begun to disappear. They hoped that their idealism, their commitment, their caring could be restored by their teachers, but this often proved to be a disappointed hope. Yet there were simultaneously more sanguine stories that counterbalanced these negative perceptions as the year progressed. This shift may be explained as an effort on the part of students to resolve their problematic feelings about their clinical experiences; to take a more active role in how they connected with patients; and to make a place for themselves on the medical team.

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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