Appendix 8: CICMO configurations for each of the identified contextual elements.

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| Only certain knowledge is seen as valuable (C) <> More types of knowledge are seen as valuable (C’) | | | |
| 1.1. | In an inner context where is there is now a broader idea of what is legitimate knowledge (C), an intervention where facilitators are supporters(I), participants broaden their perspective, develop their professional identity, and build narratives (M), which affects their attitudes with respect to patient-centredness, such as the biopsychosocial perspective and emotional support (O) | | Residents said often palliative care was consulted too late because internal medicine attendings modeled they should be able to ‘‘do everything’’ and that consulting palliative care means relinquishing control and was only to be done at ‘‘the end’, when medicine ‘‘gives up’’. One said: *‘‘there seems to be this cultural idea that the palliative care unit means that’s it, you’re going to die within a couple of days and it’s to be a last minute or last case scenario, otherwise you desperately do everything else.’*’ [R11] [AA] - negative example  All the while, the line of questioning is guided by a ‘‘grid of medical knowledge’’ which *‘‘leads the patient to reinterpret his or her experiences and life within a medical framework”. [*AA]  Incongruity between the biomedical orientation of medical education and the high proportion of patients with psychosocial problems. An experienced, supportive trainer. CRT participants appreciated the presence of an experienced trainer offering support and reassurance: ‘‘. . .that’s why there was such a great need to have someone there who was more knowledgeable. It really helped having someone there who wasn’t just a colleague, but who could also bring in expert knowledge of a more psychological nature.’’ [U]  Most students were embarrassed when confronted with patients who expressed themselves emotionally. They appeared to need reassurance that their reluctance to explore concerns and feelings was normal, and that the acquisition of an insight into a patient’s concerns was a legitimate field of inquiry and essential for a therapeutic doctor-patient relationship. (C) |
| 1.2. | In an inner context where is there is now a broader idea of what is legitimate knowledge (C), and good role models are available [C}, an intervention where learners have a role as a chronicler (I)**,** participants broaden their perspective, develop their professional identity, and narratives (M), which affects their attitudes with respect to patient-centredness (O) | | Wow! He’s completely different from what we hear in medical school cause … we hear about potential clogging of arteries or we’re concerned about the eye, or about the kidney. He doesn’t really care about that. He wants to be able to just run around and be normal. So, mom versus son versus medical school are … vastly different [T]  Residents learned not to ask questions that were too intimate because the ‘‘rules’’ of medicine preclude getting too close; professionalism might be called into question if one gets to know a patient too much, and this might be a ‘‘slippery slope’’. One resident expressed: *Because of the doctor-patient rules I have gone into sessions with her that are purely medical where I ask about her arm, but then I go back in the afternoon if I’ve got a few minutes and just have a wee chat with her…I’ve always had professionalism in the back of my mind…that you can’t befriend patients or treat them special*. [R2] [AA]  By pairing students with patient mentors and by getting to know the patients’ story about their illness and its impact, students share remembrance and rededication. [V]  Many felt their attending modelled the notion that there is  no need to see palliative patients once there is ‘‘nothing to do’’. One resident recalled: *‘‘they would say ‘you don’t need to spend too long, they are palliative…you know, we’re not doing any blood work or anything.’ Kind of dismissing the importance of seeing them.’’ [R5]* [AA] |
| 1.3. | In an inner context where is there is a broader idea of what is legitimate knowledge (C), an intervention with real patients who have a more or less autonomous role (I), participants broaden their perspective, develop their professional identity, and build narratives (M), which affects their attitudes with respect to the patient-centredness dimensions such as the bio-psycho-social perspective, and essential characteristics of the clinician (O) | | A prominent theme arising from the students’ responses was that the stories challenged the students’ assumptions of having diabetes or working with individuals with diabetes. The dissonance between pre-existing assumptions and beliefs, as well as the biomedical knowledge about the pathophysiology and treatment of diabetes, on the one hand and the students’ and volunteers’ exploration of the personal and psychosocial dimensions of living with diabetes on the other, stimulated self reﬂection and a new and broader understanding of diabetes and its management. [T]  The students’ constructions about what it means to be a doctor are exposed with comments about perceived authenticity of patients and the students’ views on what impedes their development. The notion of a ‘presenting complaint’ and how that is understood by students and the meaning they attribute to it appears contentious. This view in turn casts an impression on the value of particular encounters with patients. Presenting complaints appear to be something that one experiences when a patient arrives in the emergency department or in General Practice with a speciﬁc query and not in the setting of a chronic illness narrative. It was perceived by students that in P3 patients do not arrive with a presenting complaint and therefore it is ‘pretending’ or an artiﬁcial situation and construe this as providing ‘low impact’ learning, seen clearly in these quotes, ‘‘It obviously is slightly artiﬁcial in terms of you know they don’t actually come in with a complaint’’ (Int3) and ‘‘Sometimes difﬁcult to take histories from patients without a ‘presenting complaint’’’(Quest. extended response) and ‘‘…you sort of sit there and think I’m not learning anything, I wish I was on the ward’’ (Int 4). In the same vein this comment proposes that P3 patients are for basic learning only, ‘‘So it is an artiﬁcial situation in a sense, but I suppose for the level that we’re at it is important that we get the basics ﬁrst, dealing with patients who you know don’t have any real communication difﬁculties’’ (F.G 1).  Constructing the patient as a vehicle for learning is consistent with the students’ construction of the patient–doctor relationship and their subsequent response to regular patient learning encounters. ‘*‘I think that the patients place more emphasis on the relationship than the doctors do but then again it, well I think it’s important to have a good relationship with your patients because they are more likely to do what you say’’ (F.G1)* There was continued evidence of some difﬁculty on the intern’s part regarding constructing an explanation about engagement or relationship with patients, *‘‘I think it’s been, I think it’s been ﬁne I guess but after a while you sort of, I don’t know, you sort of think it’s, damn I can’t think of the word, you sort of forget about what’s been going on, like each patients just a patient sort of thing, I guess after, I don’t know it’s only been my intern year’’ (Int.1).* Such lack of assurance about interacting with patients and reliance on their junior position as a way of explanation might suggest these doctors consider patients mean more to their doctoring identity as they gain more experience. This is an important realisation and contributes strongly to their development of professional identity. [B] |
| 1.4. | In an inner context where is there is a broader idea of what is legitimate knowledge (C), an intervention with real patients who are more authentic than during customary medical encounters, and learners have a role as learner (I), participants broaden their perspective, develop their professional identity, contextualise disease, become emotionally involved, and build narratives (M), which affects their attitudes with respect to patient-centredness such as patient empowerment, patient-as-a-unique-person (O) | | The assumption that doctors (and students) have correct objective knowledge that is superior to patients’ subjective and experimental knowledge, dominated perceptions of the clinical environment. In this environment students wanted to appear professional. In the PI sessions, however, the patients were considered experts on their own diseases and students saw themselves in the role of the learner rather than professional. However, scepticism about the credibility of PIs’ knowledge became particularly noticeable when the PIs addressed general aspects of biomedical knowledge rather than personal experience.  In a clinical environment with real patients, it is stressful. *I have to be professional, ask the right questions, give the right answers – be competent! I am much more relaxed with patient instructors where I can ask any stupid question – be the student that I am.* Wearing the white coat in the clinic signals that I have a huge amount of knowledge about this matter. Patients wearing a patient’s shirt signal that they have a problem that we doctors are going to solve. In the PI session, we all wear our plain clothes. We are young people meeting experienced senior citizens with a huge knowledge about their disease. This switches the roles of who has got the knowledge. Sometimes they [PIs] were a bit quick to say, ‘Never do it like this, it is never like this, it is always like this.’ Then I just had to think, ‘Well, I’m not sure you are right about that.’ learning from patient instructors in the context of coupled faculty-led and patient-led teaching session. And I must admit that I do remember much more from the responses of the patient instructor than the systematic presentation from the ﬁrst session. [Q] |
| 1.5. | In an inner context where is there is a broader idea of what is legitimate knowledge (C), an intervention with real patients who are more authentic than during customary medical encounters (I), participants compare and contrast (M), which affects their attitudes with respect to patient-centredness such as the biopsychosocial perspective and essential characteristics of the clinician (O) | | The dissonance between pre-existing assumptions and beliefs, as well as the biomedical knowledge about the pathophysiology and treatment of diabetes, on the one hand and the students’ and volunteers’ exploration of the personal and psychosocial dimensions of living with diabetes on the other stimulated self reﬂection and a new and broader understanding of diabetes and its management. This observation suggests that the type of learning occurring in this setting is linked with important developmental stages. Evidence from developmental psychology suggests that signiﬁcant learning occurs in the setting of what Piaget has termed ‘‘cognitive disequilibrium,’’ i.e., when encountering new or unfamiliar ideas, beliefs or experiences, an individual is forced to ‘‘step outside’’ of him or herself and critically reﬂect on his or her personal thoughts, feelings, attitudes, and experiences (Kohlberg 1981; Piaget 1985). The self reﬂection which accompanies this activity often results in an incorporation of the new experiences or perspectives into a more open, complex, and dynamic view of oneself and others in the world and may foster personal growth and development. In the words of one student: *‘‘My view [of diabetes] became so much more complex … It’s not as simple as family and friends who check their blood sugar every so often and then stay away from the desserts at dinner but otherwise lead pretty normal lives.’’*[T] |
| 1.6. | In an inner context where power relations and hierarchy are less important (C), an intervention with real patients who have an autonomous role (I), participants will contextualise disease, imagine a patient’s life more completely, and no longer feel pressure to live up to expectations (M), which affects their attitudes with respect to the patient-centredness dimensions such as essential characteristics of the clinician and patient as a unique person (O) | | In a previous study we identiﬁed a unique and balanced power relationship between students and rheumatologic patient teachers, in that context called patient instructors (PIs). This approach was patient-led in terms of both the planning and the performance of the teaching encounters, and therefore differs from traditional, highly standardized teaching. The balanced power relationship legitimised the students’ taking on the role of learners and daring to ask questions they perceived to be inappropriate to the clinical environment. In that environment, students wanted to appear as responsible and competent professionals. Essential elements of content and format contributed to the balanced power relationship. In a clinical environment with real patients, it is stressful. *I have to be professional, ask the right questions, give the right answers – be competent! I am much more relaxed with patient instructors where I can ask any stupid question – be the student that I am*. [Q]  The conceptual basis for these approaches is the recognition of the patient as an individual with his or her own unique perspectives, values, preferences, and life goals (Duggan et al. 2006). It is in this context that the relationship between physician and patient shifts from a ‘‘top-down,’’ expert/novice paradigm towards interactions involving acknowledgment of patient autonomy, collaboration, and shared decision-making. Implicit in this overall perspective is an awareness of the dichotomy between disease and illness, i.e., the difference between the biomedical construct of the pathophysiological processes underlying a medical condition and the subjective experience of an individual who lives with it. [T] |
| 1.7. | In an inner context where power relations and hierarchy are less important (C), an intervention where teachers/supervisors make sure that learners are taken care for (I), which helps them to feel welcome, feel significant and take responsibility (M), resulting in a more patient-centred understanding of patient care (O) such as appreciation of teamwork and team building (O) | | One student described how her greeting on the ward had helped to create a sense of signiﬁcance and set the tone for the placement:  *When I walked on the ward and said I was the new student they said, ‘Rene [Sister] is expecting you’. She showed me all round herself and she introduced me to Fran and said, ‘this is going to be your mentor’, and it was really sort of a positive introduction. You know she was like saying this is my colleague and I trust her; it made me feel important I suppose. Student, placement C.* [E] |
| Patient are seen as objects () <> Patient are seen as subjects (C’) | | | |
| 2.1. | In an inner context where the patient is no longer seen as an object instead of human (C), an intervention with real patients who have an autonomous role (I), participants will take time, develop narratives, broader their perspectives, socialise, and become motivated, which affects their attitudes with respect to the patient-centredness dimensions patient-as-a-unique-person, bio-psycho-social perspective and essential characteristics of the clinician such as self-awareness (O) | | *This interview felt like what you think you will be asking of patients before you go to medical school. But that’s not really our day to day job as a physician. The things you thought you would be doing are taken care of by allied health members, the shoulder to cry on roles…whereas all you have time for in clerkship is learning the empirical and knowledge-based aspects, and this becomes the culture*. [R7]  Medicine was described as objectifying patients with its focus on the technical and empirical, rewarding those with technical prowess with more ‘‘prestige’’: *They are seen as a medical thing and not a human, not a person…the message is: we want to ﬁx your heart failure. They want you to know differential diagnoses because it is measurable and they can make you feel bad when you are wrong*. [AA]  The stories allowed an opportunity to adopt the perspective of someone with diabetes. Numerous students expressed how the volunteers’ stories allowed them to see the world, relationships, school and work through the eyes of someone with diabetes. This type of perspective-taking was frequently associated with the students’ self reﬂection and comparison with the volunteer: *‘‘I was trying to picture myself in his shoes and I would have gone nuts.’’ [*T]  Learning of this kind is not vague. It is not just the experience of talking to old people. It also fosters the ability to make more explicit what is carried over into practice, e.g. the dimensions on which to judge appropriate treatments, or aspects of the decision making process itself. Doctors gained not so much better information as a better orientation; they became aware that their usual stance was to interact with very sick patients in the hospital. What is not usually taught is how elders actually function in their world, what they can do and still want to do for themselves. This resident describes her experience of the kind of preparation needed to have a dialogue among people from very diverse `worlds' the cultures of old people, young doctors and senior faculty. She articulates the complexity of navigating these multiple discourses and what matters to each, which creates a different sense of herself a need to shift back and forth. [M – broadening perspectives] [R]  The stories students tell of their experiences with patients can be seen as their projections of self for the listener; it is how they seek to ‘‘be and be seen to be’’ in the eyes of the listener. As ‘‘experience-near’’ (Mattingly 2000, p. 188) retellings of signiﬁcant experiences during their clerkships, the stories represent developing identities for students as physicians. We have examined these ‘‘identity performances’’ with a speciﬁc interest in how the students are learning to care. The excerpts presented above from the students’ conversations with the researcher highlight their receptivity and responsibility. They get to know their patients beyond their symptoms and diseases. This background knowledge assists students to see that there is more to caring than making the diagnosis and developing a treatment plan. They are learning that there are many ‘‘small things’’ and that it is only through meaningful, therapeutic relationships that these become evident. [S] |
| 2.2. | In an inner context where the patient is no longer seen as an object instead of human (C), an intervention with real patients who are more authentic than during customary medical encounters (I), participants will be emotionally involved, reflect on what they have encountered, listen more actively, become more focussed on their own emotions, and imagine a patient’s life more completely which affects their attitudes with respect to patient-centredness, such as the dimension doctor-as-a-person (O) | | *I think that in lecture we concentrate on the patient as a representation of everyone at the same time. They’re not talking about anybody in particular. The emphasis is on disease, the process, what can happen. It’s all statistics, and it’s a lot different when you actually see a patient, the statistics don’t matter. It’s easy to say ‘‘Oh, you give them insulin like six times a day,’’ and it doesn’t seem like a big deal, but to actually see how this is played out and see a young child and the family deal with this situation is so different. People’s lives are so chaotic [C] I think that you can read about the disease and understand the cause of the disease, but you don’t really get the full effect about just ﬁnding out about [it] from the beginning when you go to the hospital and ﬁgure out why you’re felling the way you are and the shock of what to expect. You don’t really get that from books at all. At home when they talked about when she ﬁrst found out she had diabetes and how she sat in bed and cried … you can’t get that from a book. You can’t get the full effect of what it’s like* [M – patients life more complete], Several third-year students described how their experiences with their volunteers inﬂuenced their approach to patients with diabetes whom they encountered during their clinical clerkships. One M3 student stated that after listening to his volunteer, *I make sure every time that, to discuss with them what our goals are and why we care about those things. For example, why we care about their renal function, why we care about their glucose levels, and often times no one has ever explained to them the correlation between the two*. [M active listening], [T]  For these students, diabetes was contextualized in individual volunteers’ unique lives and perspectives: the stories ‘‘put a human face’’ on diabetes and its management, and lent poignancy and emotional force to their understanding. […] The students’ comments also elucidate two other important and related psychological mechanisms through which they learned about the human dimensions of chronic illness: perspective-taking and self reﬂection. Comments, such as ‘‘I was trying to picture myself in his shoes and I would have gone nuts’’ illustrate an essential characteristic of perspective-taking: an identiﬁcation of the self with the other while simultaneously recognizing the other as a separate individual with his/her own values, perspectives, and life context (Hoffman 2000). This affective identiﬁcation with the struggles or suffering of another while simultaneously recognizing the other’s difference and autonomy is at the core of the more mature forms of empathy (Hoffman 2000) and has been recognized, for example, in medical student narratives through ‘‘critical incident reports’’ during their clinical experiences (Branch et al. 1998). As suggested by some of the students’ comments, this affective link with someone with chronic illness is particularly important in light of a lack of personal experience on the part of some students due to their relative youth and good health. [T] |
| 2.3. | In an inner context where the patient is no longer seen as an object instead of human (C), a real-patient intervention where teachers/supervisors make sure that students are taken care for, makes learners feel welcome and secure (M), so that they can move beyond self as a focus and broaden their perspectives (M), imagine a patient’s life more completely (M), and develop patient-centred attitudes (O) such as seeing the patient as a unique person (O). | | During the early part of their training students usually have an idealised image of what being a nurse means. This idealised vision of nursing is often severely challenged when students are exposed to less than perfect care and the differences between their initial image and reality are brought into stark contrast. Sensitive support at such times is helpful in assisting students to come to terms with their dissonance. [E]  The enriched environments helped students to gain an appreciation of the patient as focus by explicitly incorporating this within placement objectives: *With patient and students I’m the same. I look at the person as a whole from birth, I like to ﬁnd out, you know, what kind of person they are, what relationships they have had, where they have been in their life y and I encourage the students to do that too. Mentor, placement D*. The impact this has on students was all too apparent, not only professionally, but also personally: I have learned so much here, assessment is not just about measuring things or being judgmental but it’s about getting to know the whole person, all the inﬂuences on them. *You have to try to view their lives from their standpoint as well as the professional standpoint. Since I have been on this placement it has really changed my attitude and perception towards them [older people]. I do now realise that they are human beings and their lives have been so full of experiences, y I have learnt a lot about older people. I realised that people at 65 and 70 still fall in love and they still get depressed and worry about the bills, they worry about their kids. Not all old people are settled and ﬁnancially secure y I think that I am learning as much about myself as I am about older people, it’s been interesting*. [E]  When the pathologist called back and reported evidence of invasive adenocarcinoma, my heart felt like it slid down into my abdominal cavity. One of the surgeon’s subsequent comments (followed by uproarious laughter) that *“You better get yourself some new longitudinal patients, because this guy isn’t going to be longitudinal too much longer”* *turned my feelings of intense sadness into anger. “How can they laugh?” I thought, my entire body heating up with fury. My friend is dying and they’re laughing*. [W] Negative example |
| 2.4. | In an inner context where the patient is no longer seen as an object instead of human (C), a real-patient intervention where teachers/supervisors make sure that students are taken care for, makes learners feel welcome and secure (M), imagine a patient’s life more completely (M), experience common ground (M), understand themselves better (M), and develop patient-centred attitudes such as seeing the patient as a unique person (O) ,and develop essential caregiver characteristics (the doctor-as-person) (O). | | Being able to relate the experiences of older people to their own lives was the key to some students viewing older patients as people. Students who experienced an enriched environment found that they were not simply learning about technical care and skills but also about themselves as practitioners and people. They tended to view older people in a markedly different way following their placement; as one put it ‘It was like seeing them [older people] for the ﬁrst time’. [E] |
| 2.5. | In an inner context where the patient is no longer seen as an object instead of human (C), a real-patient intervention where learners have a role as a chronicler (I), participants will take time, develop narratives, broaden their perspectives, socialise, and become motivated, which affects their attitudes with respect to patient-centredness, such as the patient-as-a-unique person, emotional support and essential characteristics of the clinician (doctor-as-person) (O) | | Residents said they learned about the importance of actively, ‘‘really’’ listening: *You always have a few minutes to talk to somebody like a human being… if your attitude is to get in and get out so you can get onto the next patient, it should change to ‘I want to treat the person I’m about to see the way that I’d like to be treated if I were stuck in here’…that would go a long way* [AA]  Students perceptions of their learning included the following themes: 1) patients are more than their disease, 2) be open to opportunities to slow down and listen, 3) stories give new insights into patients, 4) stories can affect patient care, and 5) patients as individuals (Table 1). Student–Patient Dynamic. The interaction between patient and student was often a shared, reciprocal experience that enriched the relationship. *“As I listened to his story, I myself started to get outraged with the story. I was getting upset for him. I was like ‘this is ridiculous!’…And I think we kind of shared the emotions that were captured in the story” (FG1)*. [F]  Medicine was described as objectifying patients with its focus on the technical and empirical, rewarding those with technical prowess with more ‘‘prestige’’:  *They are seen as a medical thing and not a human, not a person…the message is: we want to ﬁx your heart failure. They want you to know differential diagnoses because it is measurable and they can make you feel bad when you are wrong. [R6]* Residents said they had learned that the main priority in medicine is to cure and save, and discharge home: *I think coming from an internal medicine background our main role was to diagnose then discharge, diagnose then discharge…or in surgery it was to operate and get the patient better; don’t think about the patient as a whole, particularly about the operations. This is appendicitis causing the problem or this is colon cancer that needs a hemicolectomy. [R2]* [AA]  the dignity interview’s ﬁrst function is to facilitate the telling of a patient’s life story, where the role of the interviewer is as audience- a role which is critical for the production of narratives. In our study, the residents switched hats, from being an interrogative gatherer of information about a patient’s illness to being the audience of a person’s life story. This may parallel what we think is part of the therapeutic value for patients, a shift back from an objectiﬁed patient to a person. Residents experienced this interview as more ‘‘authentic’’, and less ‘‘hypothetical’’, ‘‘simulated’’, or ‘‘algorithmic’’ than other learning experiences focused on communication with suffering patients. [AA]  Unlike a history, witnessing a patient’s narrative or story moves beyond the facts of their illness to imagining how they were uniquely experienced by that particular patient, or more appropriately- person. This also requires us to tolerate, sit with, and acknowledge the emotions that go with this, and process the emotions it brings up in us. [AA]  Such an experience of increased intimacy with patients maybe especially critical for students face the many potentially dehumanizing influences of their clinical training.12,13 [K]  One student noted that his/her patient *“seemed to feel like someone was taking the time to listen to his side and actually hear what he was saying.”* Other students emphasized their own experience: It allowed me to connect with the patient in a different format. I felt more focused on emotions and feelings. I enjoyed understanding the patient’s perspective. [K] |
| 2.6. | In an inner context where the patient is no longer seen as an object (C)/ with a more complete understanding of legitimate knowledge (C)/ and less emphasis on hierarchy led by power and status (C), a real-patient intervention where teachers/supervisors support learners (I), participants broaden their perspective, develop their professional identity (M), which affects their attitudes with respect to patient-centred care (O) | | Patient as focus. Students hold a largely bio-medical, hi-tech vision of nursing, reinforced by what is seen as being ‘high status’ in clinical areas. Understanding signs, symptoms and syndromes become the main focus for students’ sense of purpose, achievement and signiﬁcance. If reinforced this remains the dominant value that students hold as they qualify. Person as focus. In ‘enriched’ environments, where high quality ‘person-centred’ care is provided, students begin to appreciate the value of seemingly small and inconsequential actions that can really ‘make a difference’. If these are reinforced by staff then they become incorporated into the students maturing vision of what nursing is about [E]  Students were quick to pick up on negative views of older patients in areas where these had become internalised as part of the ward culture… [E] |
| Good role models are not available (C) <> Good role models are available (C’) | | | |
| 3.1. | In an inner context with patient-centred role models (C), a real-patient intervention where teachers/supervisors make sure that learners are taken care for, makes learners feel welcome and secure (M), makes learners feel significant and valued (M), so that they can move beyond self as a focus and broaden their perspectives (M), contrast and connect different perspectives (M), articulate their thoughts and reflections in interaction with others (M) and develop patient-centred attitudes (‘notions of care’) (O), and essential characteristics of the caregiver (O). | | However, in ‘enriched’ environments staff made deliberate and carefully planned efforts to ensure that students settled quickly and had their learning needs assessed, so that they could beneﬁt from a far broader learning experience [E]  As placements become more frequent and longer, students compare their initial vision of ‘good care’ with that experienced on placements. Their notions of care evolve and students begin to challenge poor care, particularly in ‘enriched’ environments where they feel ‘safe’ to do so. [E]  As students experienced more clinical placements they naturally started to reﬁne their initial views on nursing and to make comparisons between the ways in which various nurses worked and interacted with patients and family carers. In this way a personal philosophy of nursing began to evolve, and students increasingly questioned and challenged what they perceived to be poor care. The more enriched practise environments recognised that encouraging students to question and to challenge practise was an important part of their professional learning and this was promoted from the outset. This made students feel signiﬁcant and valued, as one student recalled [E]  I would suggest that most people have a preconceived idea (of care of older people) anyway, but it’s amazing that when they are here and when they go their attitudes have changedbecause they realise just how committed we all are to it and they didn’t realise what it was about. Mentor 1, placement A. [E] |
| 3.2. | In an inner context with patient-centred role models (C), a real-patient intervention where teachers/supervisors support learners in critical thinking (I), induces learners to feel significant and valued, reflect more on the differences they encounter, adopt a broader perspective (M) resulting in a more patient-centred vision on patient care (O) | | If students were enabled to move swiftly through self and course as focus and spend some time exploring their vision of professional nursing in a supportive environment that encouraged them to question and challenge, they were more likely to appreciate the needs of patients. [E]  In ‘enriched’ environments, where high quality ‘person-centred’ care is provided, students begin to appreciate the value of seemingly small and inconsequential actions that can really ‘make a difference’. If these are reinforced by staff then they become incorporated into the students maturing vision of what nursing is about. [E]  The more enriched practise environments recognised that encouraging students to question and to challenge practise was an important part of their professional learning and this was promoted from the outset. This made students feel signiﬁcant and valued, … Staff understood the value of acknowledging the contribution students could make, and recognised the impact this could have on the development of self-esteem and a sense of signiﬁcance… Unsurprisingly, in enriched environments, there was little need to question overtly bad practise. However, even here students might see instances when, for example, the latest research was not being applied and providing that they felt relatively safe they would voice their opinions without fear of censure: Well, I listen [to what the nurse says], and if it makes sense then I do it. But it wasn’t [sense] and I felt that I needed to challenge it. The cuff on the machine was the wrong size too, and I said ‘no, I refuse to do it’. And she was sort of getting really frustrated because she was being put under pressure by her manager to do something and I was following the guidelines, not doing like she wanted y it’s like the pressure that people are under that I’ve found on some wards has been unbelievable. [E] |
| 3.3. | In an inner context with patient-centred role models (C), a real-patient intervention where teachers/supervisors support learners (I), induces learners to reflect more on the differences they encounter, adopt a broader perspective (M), feel part of a health care team (M), socialize through a patient-centred health care environment (M), resulting in a more patient-centred understanding of patient care (O) such as appreciation of teamwork and team building (O) | | The RPAP community-based experience gives the students the opportunity to experience effective teamwork and to understand their professional role in a team. The modelling by an array of ‘teachers’ constitutes the most powerful influence on students’ understanding of professionalism in medicine (Inui 2003). As students observe physicians interact with staff and patients, they have the opportunity to see how this behaviour is received over time, the impact of caring professional interactions and the repercussions of disrespectful exchanges. Students have the opportunity to process these observations within the community, with their preceptor or clinic/hospital staff or outside the community with RPAP colleagues and faculty. As one student said, *‘staff helped him understand what makes a good team member’*. Multiple role models and varied opportunities for feedback may engender self-reflection and evaluation. [FF] |
| See part of the illness trajectory of real people (C) <> See the whole illness trajectory of real people (C’) | | | |
| 4.1. | In an inner context where insight in the whole illness trajectory is provided (C), as a result of an intervention where learners meet with real, autonomous and authentic patients more often and for a longer period (longitudinally) (I),  participants will become emotionally involved, curious about the patient, motivated, and develop a broader perspective (M), which affects their attitudes with respect to the patient-centredness dimensions bio-psycho-social perspective, patient-as-a-unique-person, essential characteristics of the clinician, and experience emotional support (O) | | One student explained, ‘Patients taught me the most valuable lessons’. The continuity and the small town setting allow students to follow patients through their lives, not just the illness process. One student said: ‘I came to understand the disease and healing process very thoroughly. I saw the effect of disease up close as I followed my grandmother through spinal stenosis and eventual laminectomy, attending doctor visits with her and my grandfather.’ [FF]  Another reportedly important feature of the CRT was the investigation of a current real problem from clinical practice. Dealing with a real problem helped engage the students emotionally and was needed to get them to experience the impact of reﬂective practice on the clinical problem. ‘‘I think that it was really about us and our problems. Since it directly involved all of us, we could actually put everything directly to use.’’ [U]  *I think that in lecture we concentrate on the patient as a representation of everyone at the same time. They’re not talking about anybody in particular. The emphasis is on disease, the process, what can happen. It’s all statistics, and it’s a lot different when you actually see a patient, the statistics don’t matter. It’s easy to say ‘‘Oh, you give them insulin like six times a day,’’ and it doesn’t seem like a big deal, but to actually see how this is played out and see a young child and the family deal with this situation is so different. People’s lives are so chaotic.*  *I think that you can read about the disease and understand the cause of the disease but you don’t really get the full effect about just ﬁnding out about [it] from the beginning when you go to the hospital and ﬁgure out why you’re felling the way you are and the shock of what to expect. You don’t really get that from books at all. At home when they talked about when she ﬁrst found out she had diabetes and how she sat in bed and cried … you can’t get that from a book. You can’t get the full effect of what it’s like*  This sense of surprise was pervasive among the student comments and often led to a ‘‘change in perspective’’ regarding living with diabetes. One student described her experience by stating that her conversations with her volunteer ‘‘impacted me to see [diabetes] in a different light.’’ [T] |
| 4.2. | In an inner context where insight in the whole illness trajectory is provided (C), an intervention where learners have a role as a medical professional (I), participants will become emotionally involved and build relationships (M), which affects their attitudes with respect to the patient-centredness dimensions (O), clinician-patient relationship, involvement of family and friends, patient-as-a-unique-person, bio-psycho-social perspective and emotional support. | | The CIC is structured around students’ longitudinal relationships with patients and their family members, with faculty mentors and their practice environments, with student peers, and with the local community. This ‘educational continuity’ allows for and upholds a relationship-centred curriculum, an educational structure intentionally designed to motivate students’ patient-centredness and to create patient-centred roles for students as a way to foster the learning and retention of science and clinical medicine. [L]  *[I]t was a memorable experience because it’s just seeing the whole changes in emotion and in a way I felt like I was kind of connected to the family because I was there, for the birth of their baby and then watched their baby overnight and then watched the baby get sent away [by air ambulance to a tertiary care hospital].*  This story made explicit the perspectives and experience of the family of the patient and, thus, contributed to the student’s compassion towards the new-born and his/her parents. It also demonstrated that through the integrated nature of the clerkship (obstetrics and paediatrics rolled into one experience) and the continuity of patient care that this student was involved in the entirety of the family’s birth experience, following and taking some responsibility for the mother, the baby and the family. [S]  Students also come to know the family of the patient and how illness affects different members. A student explained, ‘I learned not only how to take care of a patient medically but I also learned how to take care of the family’. [FF]  Students described feeling deeply connected to “their” patients, which transformed their roles and inspired their reflections. [W] |
| No time to connect with patients (C) <> time to connect with patients (C’) | | | |
| 5.1. | | In an inner context where workload or work pressure are no longer experienced (C), a real-patient intervention where learners have a role as a chronicler (I), participants will broaden their perspectives and become motivated (M), which affects their attitudes with respect to patient-centredness, and clinician-patient communication (O) | Many spoke of there being ‘‘no time to talk’’ to patients in an ‘‘authoritarian’’ curriculum which says that medicine is something different than having a relationship with a patient. This ‘‘lack of time’’ narrative prevents one from knowing patients; a couple of residents said attendings ‘‘hide’ behind time constraints and medical terminology: On a very busy service like oncology or surgery, they come in and quick, quick, quick, ‘have you had a bowel movement, are you having pain, okay, bye.’ Whereas in palliative care I have way more time to spend with the patient, so I will ask how she and her family are. [AA]  Several students noted the contrast between the exercise and other transactions, as from one student: On morning rounds, we often don’t really have time to listen to what a patient has to say. It was most helpful just listening to what he had to say, without trying to impose too much. [K]  All students expressed disappointment that their ﬁrst three years of medical education offered few opportunities to “reﬂect” on the personal and professional tensions that emerged during those years of medical education. [V] |
| 5.2. | | In an inner context where workload or work pressure are no longer experienced (C), a real-patient intervention where teachers make sure that students are taken care for (I), participants will broaden their perspectives and become motivated (M), which affects their attitudes with respect to patient-centredness (O) | Students identiﬁed four features of the CRT as facilitating their learning experience (see Fig. 1). The ﬁrst of these was the calm, secure space outside the ward, which made it possible for students to shift their focus from the external demands on the ward to their own personal state. *‘‘. . .somehow, the everyday was switched off there, . . . And, there was just this exhaling and calm. More than anything, there was a space where you could discuss difﬁcult things that you don’t otherwise manage to get to during your everyday routine.’’* [U]  Beforehand, I instructed students to observe communications between residents and patients, to observe their facial expressions during verbal exchanges while estimating patients’ understanding, and to observe handwashing practices of staff members. Students who spent continuous hours at the bedsides of laboring women made similar remarks to me about the demands on residents in labor and delivery, *‘‘It looks like residents are called in and out of labor rooms so often, from crisis to crisis. I’m glad I got a chance to remain with ‘my’ mother and see the whole process!’’* [G] |
| 5.3. | | In an inner context where you are no longer expected to be non-emotional (C), an intervention with real patients where teachers make sure that students are taken care for (I), learners feel valued, show affective identification (engagement with patients), broaden their perspectives (more aware of emotions & reflecting) and develop a professional identity…(M) which affects their attitudes with respect to the patient-centredness dimensions emotional support, teamwork and teambuilding, and essential characteristics of the physician (self care, self-awareness)….. (O) | Students learned how to grieve and to be compassionate. One student described the support she received from the Emergency Department physician after telling a family about the death of a loved one. ‘After telling the family ... my first thought was to ask Dr X how he was doing, but he beat me to it. He put his arm around my shoulder and asked if I was okay. One tear, then two. I remember feeling so appreciative that it was okay to cry. This was my first experience with death in my new capacity. I’ll never forget that night, the safe place I had to experience grief as a healthcare provider, a gift I believe is unique to RPAP.’ As a result of such experiences, students learned that they could be ‘compassionate and caring physicians and keep their emotional sanity’. The structure of RPAP allows debriefs with fellow students and RPAP faculty and every 6 week evaluations by preceptors facilitates this self evaluation and reflection. A student said:  *‘It was also enjoyable to see fellow RPAP classmates throughout the year to share experiences and exchange stories. It was helpful and informational to have another perspective on my approach to certain patients during the communication sessions [with RPAP faculty]. Likewise, I found the periodic evaluations from my preceptors guided me in improving my patient care.’* [FF]  Negative example:  Residents felt vulnerable and did not feel comfortable discussing emotional reactions to caring for dying patients with their supervisors. They felt very responsible for the task of breaking bad news, and, having had emotional reactions dismissed, learned to distance themselves. *How many times have I been in a room where bad news was delivered…I understand it's not the professional thing to do to get teary but I think I’m early enough on, and it’s a natural response; certainly not in front of patients but when I leave the room. No one every asks ‘are you ok’…I’ve gotten better at being more pulled back from patients…if you don’t have the space to bring it up and you feel you do it badly, you are just going to repeat the same approach over and over again. [R8]* This strongly articulated message that an experienced physician shouldn’t or doesn’t have time to show emotion was further reﬂected when residents described moderating their responses to patients according to the presence of a supervisor. One explained: *‘‘I would not feel comfortable opening up knowing my supervisor is sitting there watching me.’’* [R5] Interestingly, they anticipated being ‘‘different’’ when ‘‘actually’’ in practice. [AA] |
| 5.4. | | In an inner context where you are no longer expected to be non-emotional (C), and the patient is no longer seen as an object (C), an intervention with real patients where teachers/supervisors make sure that learners are taken care for (I), participants are more aware of their own emotions (broadening perspective) (M), integrate different perspectives (M), and develop essential caregiver characteristics such as respect for others (O). | At all visits RPAP faculty seek to assess the student’s well-being as well as their intellectual progress as a medical student. This models Parker Palmer’s (2007) ‘undivided life’, paying attention to emotions as well as skills and knowledge and helping students see how emotional intelligence informs the intellect. Teaching students how to employ both feelings about a patient as well as objective data about a patient or a situation are important tools for good patient care. These are important components for humanizing medical education as well as growing medical professionals who respect patients, staff and are leaders in their communities. This is labour intensive teaching, but analysis of these essays demonstrates fruitful results. [FF]  All this was done in an atmosphere characterized by respect for the worth of these different interviewing techniques, critical reflection on various approaches, and student empowerment to look for solutions and choose for themselves the balance among the different interviewing styles [C]  Residents felt vulnerable and did not feel comfortable discussing emotional reactions to caring for dying patients with their supervisors. They felt very responsible for the task of breaking bad news, and, having had emotional reactions dismissed, learned to distance themselves. *How many times have I been in a room where bad news was delivered…I understand its not the professional thing to do to get teary but I think I’m early enough on, and it’s a natural response; certainly not in front of patients but when I leave the room. No one every asks ‘are you ok’…I’ve gotten better at being more pulled back from patients…if you don’t have the space to bring it up and you feel you do it badly, you are just going to repeat the same approach over and over again. [R8*] This strongly articulated message that an experienced physician shouldn’t or doesn’t have time to show emotion was further reﬂected when residents described moderating their responses to patients according to the presence of a supervisor. One explained: *‘‘I would not feel comfortable opening up knowing my supervisor is sitting there watching me.’’* [R5] Interestingly, they anticipated being ‘‘different’’ when ‘‘actually’’ in practice. [AA] – negative example  Most students were embarrassed when confronted with patients who expressed themselves emotionally. They appeared to need reassurance that their reluctance to explore concerns and feelings was normal, and that the acquisition of an insight into a patient’s concerns was a legitimate field of inquiry and essential for a therapeutic doctor-patient relationship. [C] |