Learning through narrative writing: Medical students talk to patients in a hospice

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Abstract

Aim: This study examined how medical students use narrative writing as a pedagogical tool to process the experience of talking with patients at end-of-life and express what they have learnt.

Background: There are a variety of ways that medical students are taught about communicating with patients at end-of-life, including talking directly with patients.

Method: Eighty-nine students opted to have their narrative essays retained for research after the academic year was completed. Thirty essays were chosen as representative for the dataset. Charmaz's constructivist grounded theory methodology was adopted, with theoretical sensitivity used to test categories and theoretical concepts of emerging theory.

Results: Narrative writing articulates a learning moment co-created by the medical student, teacher and dying patient. A theory of "learning through narrative" is put forward, with the categories of tension, challenge and growth being identifiable in the students' essays.

Conclusion: In this context, narrative writing, as a pedagogical tool, assists students to understand both the patient and themselves. For most students, this is a challenging experience. They integrate past experience and articulate transformational learning to teachers who in turn are able to monitor the safety of learning. Narrative writing enables students to resolve initial tension, gain insights, describe new skills as well as grow personally and professionally.

Keywords: education, narrative, medical students, palliative medicine.

Background

"The best learning grows out of direct experiences with patients and families" (Billings & Block, 1997, p. 7). In teaching about end-of-life care, establishing opportunities for contact between medical students and patients requires commitment from clinicians

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and educators. It is essential to prepare and guide students and, furthermore, to assess whether learning outcomes have been achieved.

In the context of palliative medicine, effective methods to assess student experiential learning are known to be lacking (Mann, Gordon, & MacLeod, 2009). Typical assessment methods, such as short answer, multi-choice questions or objective structured clinical assessment (OSCEs), do not allow evaluation of personally and professionally challenging topics (Ilic, 2009).

By the time medical students enter clinical medical training, many have experienced the death of a family member or friend (Whyte, Quince, Benson, Wood, & Barclay, 2013). However, this experience is generally not well integrated into their cognitive frame (Druce & Johnson, 1994; Firth, 1986; McKinlay & McBain, 2010).

In an end-of-life context, narrative technique requires students to articulate in writing their perceptions of a patient, the encounter and their response to the patient situation. It is thought to be an ideal tool when a clinical encounter is particularly challenging, outside the student's usual realm of experience or ethically or socially complex (Fins et al., 2003; Novack, Epstein, & Paulsen, 1999; Wear, 2002). Such situations cannot be understood through evidence-based medicine but rather through understanding oneself better (Charon, Wyer, & Group, 2008). This can occur by synthesising experience and ideas (Bleakley, 2005) and linking the cognitive and affective domains of thinking (Bleakley, 2005; Kumagai, 2008).

Mary Potter Hospice, New Zealand, has a long-established and annually-revised palliative medicine teaching program in the fourth (first clinical) year within a strand of palliative medicine teaching woven across the six-year course (MacLeod, Parkin, Pullon, & Robertson, 2003).

The students attend two workshops on the general principles of palliative medicine, local services and communication with those at end-of-life. Following the workshops, patient visits are undertaken in pairs at a hospice (with questions supplied to guide their interview). Immediately following the visit, students complete a structured reflective template and then write a narrative essay about the visit. Finally, students attend a debriefing discussion session. Patients are recruited by hospice staff supported by a written information sheet about the teaching program. The information sheet is entitled "Patients-as-Teachers" and encourages patients to discuss with students parts or all of their end-of-life experience. Patients are informed that while the details of the conversation are confidential, the students will attend a summary class discussion and write about their experience. The following clause is included: *The teaching & student learning outcomes may be published to assist other medical educators*.

Students were given the following instructions for their essay: *Use the visit to the person/family at the hospice as a basis for this essay … in addition [to] the content of the structured reflection you undertook after the visit. Please reflect on the process of your conversation and the communication skills you are developing and use this as an opportunity to think*

about those [skills] you wish to develop further. The instructions were accompanied by additional prompts encouraging students to consider previous experiences of death or loss, feelings and thoughts while undertaking the visit, more or less effective interview questions and the range of patient responses.

Overall, the essays were of a high quality. While some students focused heavily on description, others concentrated more on reflective and interpretative commentary, which more fully describes personal learning.

This study sought to examine how the 2010 cohort group of fourth-year students uses narrative to process their experience of visiting a patient at end-of-life and express what they have learnt.

Methods

Eighty-nine students agreed to offer their essays for qualitative analysis when asked by the course convenor (not a palliative medicine teacher). These essays formed the initial data set.

University ethical approval was granted for data collection involving human subjects. Charmaz's constructivist grounded theory was chosen as an appropriate research methodology to guide the study because it acknowledges that researchers have knowledge of the study context (Charmaz, 2004, 2006).

On completion of the academic year, two members of the academic teaching team, an academic nurse and palliative medicine physician, undertook data analysis. To create a smaller but representative set of essays for in-depth analysis and theoretical sampling, thirty essays were selected that best met the original academic requirements.

Analysis

The researchers independently reviewed each essay identifying topics of interest, which were coded accordingly. By reviewing the coded information, broad categories were identified (Dew, 2007; Kelly, 2010). Each researcher individually refined the categories then together discussed, compared, further tested the evolving theoretical concepts and agreed the central theory (Chen & Boore, 2009; Dew, 2007; Graneheim & Lundman, 2004), which they titled *Learning through Narrative*.

Results

Tension, challenge and growth (Figure 1) describe a sequence of experiences or steps represented within the theory of *Learning through Narrative.* Each of these experiences interface with the next and also potentiate the learning that occurs. Initial anxiety at the impending task resolves as each experience or step is processed.

Within the essays, students describe a sense of tension prior to and when they begin the task of a patient visit. Despite this tension, initial learning occurs, continues and accelerates throughout the ongoing challenge of the visit, as latent skills emerge and

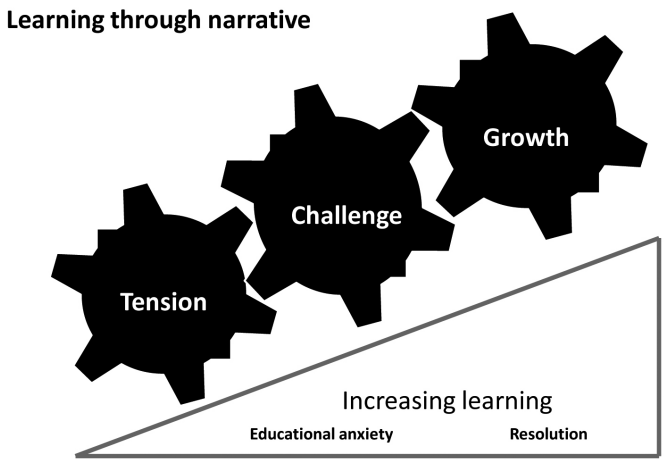

Figure 1. Learning through narrative.

unexpected experiences are encountered and overcome. Growth is articulated by the students within the essay reflections, and these reflections are available for assessment by the teacher.

A number of subcategories were identifiable in students' narrative work and help to further elaborate the theory (Table 1).

Table 1
Categories and Subcategories

Tension	Challenge	Growth
Expectation Anxiety	Interaction Emotion Surprise	Resolution Learning Change

Tension

The first category, tension, arises from the subcategories of expectation and anxiety.

Expectation

The students' expectations of the visit were shaped by preconception, anticipation, past experience and curiosity. In the students' eyes, the hospice was going to be "extremely morbid" (Student 30), "depressing, sad and lonely … where people were left to die" (Student 19). Many expressed "a state of extreme nervousness" (Student 14) or "dreading the hospice visit" (Student 19):

> *Talking to someone about their impending death did not seem like a particularly enjoyable experience. And forcing someone to consider their own mortality for the sake of my own learning seemed just downright cruel.* (Student 29)

Students recalled personal experiences of death and grief:

> *Most people would not be able to recall what they were doing on the day of March 27, 2001. Parents were taking children to school, luncheon sandwiches were being shelved in bakeries and old ladies were complaining about the weather. However, for a father that has suffered … cancer, that day was the last. His shrivelled body was lying still over the sterile-looking sheet covered by the blue jumper that hugged his child good-night numerous times. I am standing in the middle of a hospital corridor. There is a young, tall doctor talking to me. Words are coming out of his mouth like typing on the computer screen. I hear them one by one but I do not know what he is saying. I do not understand and I run away.* (Student 1)

For students without this experience, not only was the hospice a fearful place, but meeting a patient who was dying made them "scared" (Student 27) and "tales and images of death" (Student 24) frightened them:

> *I wish I had had experience with someone who knew that they were at the end-of-life, but truthfully I haven't had any experience at all. I felt unprepared. … I just cannot imagine the feeling of knowing that I was going to die very soon, let alone cope with it.* (Student 21)

Other students were curious about what this experience might hold:

> *As I arrived at the hospice, I had mixed feelings of impending sadness and, strangely, curiosity about the human condition as it faced death.* (Student 12)

Anxiety

Students' anxiety centred on their thoughts about death, preparation for the visit, worry about performance and how they would manage their own and the patient's emotions. Anticipating the visit, some students tried "not to feel anything" (Student 22), and others felt overwhelmed by powerlessness. All expressed universal human existential concerns about death and the meaning of life:

> *I also have a deep-seated fear of myself dying; sometimes it can keep me awake for hours.* (Student 18)

> *Death. The word brings about a myriad of emotions and mental pictures; rainy day, cold breeze, black clouds, leafless trees, grey headstones. … Death. There's no turning back if we have missed an exit, and there's certainly no co-drivers who could read the map for us while we're driving. Death. It scares me a little.* (Student 6)

It is clear that students planned for the upcoming visit, expressing considerable anxiety that they might make a mistake:

> *I started to think, how sick is this person going to be? What do I say so that I won't offend anyone? What if I screwed up, and they report back to the school that I'm useless? Can I still be a good doctor like I always want to?* (Student 9)

In their preparation, students anticipated and feared crying or not being able to cope in the face of sadness:

> *I was scared that I might cry.* (Student 15)
>
> *How would I react if the patient broke down into tears; what if they got angry at me; what if their story was tragically unfair, and their loved ones were also suffering? Would I be able to cope?* (Student 12)

Challenge

The three subcategories of interaction, emotion and surprise are encompassed within the broader category of challenge.

Interaction

Interaction challenges included entering the hospice, meeting the patient, asking suitable questions, eliciting the patient's story, listening to the unedited account, talking about dying:

> *My partner and I sat down next to her bed, and in our nervousness launched straight into the kaupapa* [Māori word for purpose] *of the interview without bothering to do any whakawhanaungatanga* [Māori word for forming a relationship]. … *She interrupted me and scolded us to introduce ourselves personally to her.* (Student 22)
>
> *We left after thanking Ms J.; one thing that struck me as strange about saying goodbye to a dying person is that some of the normal sayings that are used such as "I hope you feel better" and "good luck" become redundant.* (Student 3)

Students were grateful that patients had the energy to give time and were prepared to answer challenging questions. They recorded the words and actions of the patient as they collaboratively explored the issues of prognosis and dying:

> *I felt rude asking about the future from a man who was obviously going to die soon. Fortunately my partner was brave enough to ask him. I almost cringed when he said it so bluntly, but again, after seeing Mr J smile and talk about his goals, I am pleased the question was asked.* (Student 5)
>
> *I plucked up the courage and cautiously asked, "What did the doctor tell you about the prognosis?" His facial expression changed. There was a short silence. "I cannot be cured" … I continued by asking, "How do you feel about it?" This time, I could see remarkable inner strength in the patient's eyes. "Every day I open the curtain; it's nice to be alive".* (Student 17)

Emotion

Before the visit, students considered how they and the patients would feel. This was echoed after the visit when students considered their own and the patients' array of feelings.

Some felt sad or tearful:

> *Although he seemed like he had had good experiences, I still felt "down" during the interview, perhaps because I was dealing with the idea that something similar could happen to me and wondering how I would deal with it.* (Student 26)

Two students referred to their lack of emotional response:

> *She said, "I don't like to dwell on it; it's not a big thing for me." Personally, I think dying is quite a big thing, but I am not in her shoes. … I was also expecting more of an emotional reaction from myself, but there was very little.* (Student 29)

> *I felt rather uncomfortable during the interview; the conversation did not flow very freely. I felt sad that he appeared to me to be hiding his distress about his situation. … I have struggled somewhat with being very emotionally involved with my patients and [feeling] absolutely emotionally and subsequently physically drained at times.* (Student 25)

Others described a "rollercoaster of emotions" (Student 5), feelings of appreciation, awe, shock, hopelessness, fear and struggle:

> *She began to cry, and we waited in silence while she regained her composure. She eventually managed to reply and said that "I cope by just getting on with it." I felt very anxious that we had upset her with this question, but at the same time, I was also in awe of her reply.* (Student 7)

> *My lack of faith means that death is the end. Absolute nothingness follows. This unimaginable future is one that scares the crap out of me. Mr X on the other hand is the complete opposite to me; he is accepting. … "I've lived a good life".* (Student 18)

Surprise

Astonishment, for diverse reasons, was frequently mentioned by students. Some students described the "look" of the patients:

> *Finally being introduced to the patient, I was shocked. I was expecting a much older person who would be frail and weak. Instead Mr X didn't look much older than my own dad.* (Student 2)

> *She had thin short grey hair, appeared overweight, and was lying almost flat in her bed. Her thin smile conveyed survival rather than happiness. She appeared younger than I had expected.* (Student 23)

Others commented on the unexpected actions of staff:

> *I was greeted by Dr […], who was holding a light bulb. He was about to change the fused out bulb of a patient's bedside lamp. … Dr […] has succeeded in inspiring me, just by holding a light bulb.* (Student 6)

Humour sometimes caught students by surprise:

> *We quizzed her on her home life and her interests. Talking about home renovations and her pets seemed to lift her spirits. She laughed while telling us a story about her small white dog.* (Student 19)

> *There is positivity around this man. "Oh, two females," he says, "I am surrounded by them all the time. Am I the last male species on this planet?" We laugh away. This is definitely an ice breaker, and I freely dive into the conversation.* (Student 11)

The raw reality of a patient's human struggles challenged the students:

> *Then Mrs M said, "I have tried to kill myself before." I tried not to look it, but I was screaming inside, thinking, "How could this lovely, warm, kind woman, with her husband and children get to the point where she would even think about taking her own life?"* (Student 14)

> *After a while, Mrs S shared with us her frustration at how others could be free to do as they wished whilst her body did not let her do the things she wanted to … she was exhausted and was sick of her "lazy bones". She looked at the both of us; two medical students who she thought could provide an answer to her frustration but who instead met her gaze with nothing.* (Student 13)

Yet overall, students felt admiration and gratitude for lessons learnt:

> *One thing I really enjoyed during my hospice visit was the patient telling us about some of the "positives" of knowing you only have a short time to live. She told us about how she had never got on with her mother … Once she had this news, she felt compelled to patch up this relationship.* (Student 30)

> *I walked to the staff room and started doing the reflective exercise with too many thoughts for words, but what surprised me the most was something very simple. It was the fact the patient was willing to speak to us medical students at the end of his life. Shouldn't he be a bit more depressed, a bit more unstable in emotion and a bit less willing to talk to strangers?* (Student 9)

Growth

Growth was evident in the way students summed up the outcomes of the visit. Resolution, learning and change were identified as subcategories of this personal and professional growth.

Resolution

A sense of tension existed prior to the visit and the visit itself was a challenge. Tension and challenge appeared to dissipate and to resolve through written reflection on the visit. Students who initially wrote of challenging or difficult interactions during the visit went on to describe ways they resolved this discomfort, often through emotional reconciliation or skill development:

> *My feelings had changed while walking home. I no longer felt sad or anxious, rather a feeling of ease. … Seeing that he was well looked after, comfortable, and achieving the things he held important made me aware that palliative care can make a difference.* (Student 12)

> *From this patient I learned not to assume anything about a person. I also learned that even if you have the best intentions, you could still come across as callous and uncaring if you are not careful. … When I am trying to act like a doctor, I find it hard to let my natural character shine through in such an unfamiliar social territory.* (Student 22)

Learning

Students described what they had learnt that would benefit them in their future professional role. Some students expressed feeling challenged by the limitations of curative medicine:

> *I am unsure if any amount of training or practice could truly equip me to deal with the sorrow of a dying man.* (Student 27)

> *This made me reconsider my feelings of unease about medicine's powerlessness. Since all lives inevitably come to an end, death is permanent, and it is practically impossible to predict when someone might die … These realisations made me appreciate that focusing on living was more important than focusing on the prospect of death*. (Student 8)

Students also gave more attention, than they previously had, to dying and death:

> *This visit made me think about death and dying. As with many other young people, this hasn't really been something I have given much thought in the past.* (Student 24)

The importance of listening, as a skill, was validated:

> *You will often have to read between the lines when listening to people. You will not understand every person because we are all so different. … Just listening will often be enough*. (Student 16)

Students recognised patients as expert teachers:

> *Seeing someone facing death with that courage, I become somewhat bold enough to think, "what if" I was in his shoes. This made me understand why the patient was willing to share with us medical students.* (Student 9)

> *I had also mistakenly assumed that this patient coming from a hospice would teach us about dying. … Contrary to what I expected, this patient, in a way, mostly talked about life and "living".* (Student 21)

Most importantly, students learned about themselves as people:

> *She seemed to have come to turns [sic] with her mortality and was not particularly fazed by the prospect of death. … She mentioned "life flew by me somehow." I think too often we cannot wait for the future and the things that await us. Maybe we should be content with the present.* (Student 4)

> *I have a newfound respect for people at end-of-life. So much courage is needed to carry on living; to think that death is not a destination, but a stopover. I realized that four years of medical education has not prepared me to accept the fact that not everything needs cure.* (Student 6)

Change

Students described a number of changes that occurred as a result of the visit. Some students planned ways to develop particular skills such as being comfortable with silence:

> *There are three aspects of my visit that I would change if I was given the opportunity again. Firstly I would not be afraid to ask the hard questions but make sure they were worded well. Secondly I would not be uncomfortable about silence and thirdly I feel I would be better equipped to deal with an upset crying patient.* (Student 5)

Others described personal change gained through insights and "pearls of wisdom" (Student 10):

> *By continually shying away from discussing death, I was condemning those struggling to come to terms with their mortality (be they in an end-of-life situation or not) to loneliness. I thus resolved to be more open and willing to discuss death whenever the opportunity rose.* (Student 8)

> *I feel light as I close the hospice door even if I am carrying a messy bag of new knowledge. I go home and take it out one by one. I thought death was hopeless, but I learn that while you cannot give false hope to patients, you should never stop hoping. I thought death was painful and ugly, but I learn that it's all a matter of attitude. I am reminded of the healing power of love and kindness.* (Student 1)

Discussion

This grounded theory study aimed to investigate medical students' use of narrative writing about visiting a patient at end-of-life and examine what they learned through this process. Our theory of *Learning through Narrative* builds on the 2003 work, also undertaken in Wellington, New Zealand, by MacLeod et al. (2003). Since 2003, the end-of-life program has expanded to include a reflective tool and narrative essay (McKinlay, McBain, Stanley, Taylor Johnson, & Robertson, 2014). This study demonstrates the use of the pedagogical tool of narrative essay and how it fosters transformational learning.

Transformative education practice, first described by educational theorists Mezirow (1990) and Friere (1974), enables students to make meaning from past experience, which aids future understanding (Taylor, 2008) and, consequently, the development of leadership and change agent skills (Mezirow, 1990). Learning is optimised by establishing particular conditions for the learning moment to take place; for example, in this program, both the patient and student are prepared for their conversation. This preparation supports the student's freedom to learn, aligning with Freire's belief that the act of teaching is a practice of freedom (Freire, 1974).

In addition, transformative education practice also supports the goal of humanistic medicine "to 'rehumanise' the relationships between doctors and patients, students, and teachers such that the value of human beings is realized, not as a means to an end but as an end in itself" (Kumagai, 2008, p. 657) Thus, narrative technique is embedded in humanity and relationships (Friedlander et al., 2011; Schein, 1993). Humanity is expressed in the student essays through a freely expressed range of feelings. Dirkx (2008)

believes that this expression of emotion and anxiety within an educational context is a necessary and positive force resulting in emotional intelligence, with feelings being "managed and used in our encounters with the outer world" (p. 14).

Narrative technique and the encouragement of student reflection on action and experience also echoes the whare wananga, a Māori philosophy of education. "In this tradition … the entire natural world 'speaks into' the consciousness of the individual" and encourages students to engage the world with a sense of depth and reflection, allowing it to "speak directly into one's experience" (Royal, 2007, p. 19). Such deep and full engagement supports students to consider future action; in this instance, subsequent interactions with other patients at end-of-life.

Ensuring an appropriate patient-visit experience is critical to writing the narrative essay, and guidance is necessary for students to achieve this. This visit differs from clinical history taking in both the pace and sequence of information gathered, with students asked to particularly focus on the patient and their experience (Charon, 2000, 2005). In the narrative essay, students consider both the information collected and also the act of interviewing the patient. "Extended interview is employed regularly in generating narrative data but the interview itself is rarely considered critically where researchers fail to comment on how the interview was planned and conducted or on the qualities needed for effective interviewing" (Bleakley, 2005, p. 537).

Furthermore, the narrative writing technique itself is different from the clinical or case report or reflective template (Head et al., 2012). The form of the narrative essay requires the student to engage with a topic for a sustained length of time. Students draw upon past experience as well as the more recent thoughts noted down in a reflection immediately after the visit. The depth of engagement attained through the narrative essay also contrasts with a verbal debrief or a summary reflection, suggesting a reflexivity not gained through other pedagogical techniques (Bolton, 2006).

Each essay shows a sense of movement or change as students progress from initial anxiety and apprehension to wisdom, with a deepening of self-awareness and growth as individuals. In this progression, they are urged to better understand suffering, acceptance, powerlessness, humanity, death and life. The act of writing helps students resolve issues. They express satisfaction in what they have achieved coupled with a greater awareness of their developing skills, such as empathy and listening (Kumagai, 2008).

The narrative essay is also a safety net for teachers. Students come with a range of past experiences, and in itself, the requirement to visit a patient at end-of-life creates unease. The writing creates a lens through which teaching staff can assess individual student vulnerability and offer support if necessary.

The fact that this study was set in one geographical location and focused on medical students from one university visiting patients at end-of-life within one hospice is a limitation; however, a number of factors offset this limitation. The initial dataset was large and inclusion criteria was specified for further detailed analysis. This resulted in a smaller selection of essays for thorough examination, and rigor was maintained by

two researchers, firstly, undertaking the analysis independently, and secondly, working collaboratively to resolve differences and agree on the theoretical model.

Several areas require further research. The study did not examine how the patients perceived the visit or attempt to follow-up students to assess on-going learning; ideally, the latter would be reviewed some months after the event and after students had further opportunities to meet patients at end-of-life. Offering the option for students to use other creative modalities instead of the essay format is another area worth consideration and may enable some students who have an affinity for these modes to more effectively process the experience. A final area of interest arises from the student's demonstrated ability to witness the mystery and paradox of life. Students were capable of being with and engaging in depth with patients (Lim, Moriarty, & Huthwaite, 2011). They demonstrated empathy, compassionate listening and an ability to meet the patient as a person, not primarily seeing them as "the sick one" (Tavakol, Dennick, & Tavakol, 2012). This inner resource is fundamental to the practice of medicine (Burks & Kobus, 2012). In the future, we wish to explore how teachers can monitor, enhance and sustain this inner resource in our students.

We believe that narrative writing assists medical students to learn about people who are dying. This process enables students to further develop their understanding of the practice of medicine (Kumagai, 2008) and their role as a healer (Charon, 2000; Mount & Kearney, 2003). In particular, they learn that meeting a patient who is dying is a challenge not to be avoided. Patients teach them many aspects of facing death: the acceptance, the uncertainty, the humour, the strength, the struggle. Finally, students learn how to look at themselves and reflect on their own vulnerability and mortality.

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