Feelings related to first patient experiences in medical school
A qualitative study on students’ personal portfolios

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Abstract

Feelings and thoughts of medical students related to first patient experiences during the first clinical year were examined. Twenty-two volunteer third and fourth year medical students (15 women and 7 men) of the University of Helsinki participated in a portfolio course for 1 year. Their reflective learning diaries and writings on specific themes were analyzed by qualitative content analysis. First patient encounters were strong emotional experiences for medical students. The first patient examination was often described as an anxiety-provoking and confusing incident. Other emotionally significant encounters included helplessness when faced with serious illness and death, and role confusion when examining patients of one’s own age but opposite sex. Students felt guilty for using patients for their own learning purposes. Portfolios as learning tools may help in recognizing key experiences and support professional development of medical students.

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1. Introduction

What is the emotional journey like on the road to becoming a doctor? What kind of feelings do students have related to first patient experiences? Profound changes are known to take place in medical students as they progress through medical school [1–6]. Medical education is a stressful and anxiety-provoking experience [1,3,4,7–9]. Depressive and somatic symptoms are common among medical students [9,10]. To adjust to the medical culture, students must suppress the inner feelings [4,11] and objectify patients [3,4]. While still quite young students are faced with cadavers, human suffering and death [4,5]. Medical school focuses on teaching facts but does not support students’ reflective thinking in the developmental process [4,5,12].

Discussions about a “hidden curriculum” have been active for the past decades [3,4,6]. The introductory clinical year is considered to be especially important in the process of becoming a doctor [4,7,13]. Performing the first physical examination and finding one’s role in the clinical culture are key experiences in this process [1,3,4,6]. Several well-known studies on medical school have observed that first patient contacts, particularly first physical examinations, produce anxiety in medical students [1,3]. In addition, young patients of the opposite sex and dealing with issues of sexuality provoke role confusion and embarrassment [1,3].

To our knowledge, besides these incidental findings, few studies have dealt with inner experiences of ordinary medical students and how students reflect on them. Rather, it has been suggested that students are unable to introspect about their feelings of insecurity and anxiety [6]. In addition, previous studies have mainly been participant observation studies by sociologists [1–4,6], and findings on medical students’ experiences have been drawn from the behavior of students. These studies have also been criticized for the researchers being outsiders of medical culture [4]. Thus, very few documents exist of “first-hand” experiences and personal feelings of medical students on their emotional journey through medical school [4].

Thus, the aim of our study was to investigate (1) the kind of feelings first patient experiences evoke in medical students and (2) how students reflect on their feelings.
2. Methods

An optional 1-year portfolio course was arranged for medical students during their first clinical year. At Helsinki university students start their first clinical year on spring term during their third year in the medical school and finish their first clinical year in fall term during their fourth year in the medical school. Two different student cohorts took part in the course: (1) those attending their first clinical year in 1997 and (2) those attending their first clinical year in 1998. The course was arranged as a pilot course for a small group of students in order to gain experience on its attractiveness to medical students and on its applicability during the first clinical year.

The aims of the course for the students were (1) to enhance reflective thinking and analyze one’s own learning needs in becoming a doctor; (2) to analyze one’s own level of development when adopting a physician’s role; and (3) to become aware of one’s own strengths and developmental areas as a medical student. At the same time, students started their first clinical year, examined their first patients and became acquainted with hospital culture. One of the authors (KHP) served as a tutor both in an internal medicine course and in a portfolio course for the entire year. The portfolio course included preparation of personal portfolios, which consisted of personal learning diaries (about 1–4 pp., four to five times during the first half of the course), writing on specific themes (1–4 pp., four to five times during the second half of the course), logbooks, self-evaluations, and personal feedback from teachers. Table 1 presents the instructions given to students on writing their learning diaries. Table 2 presents the instructions and specific theme suggestions provided to students. In addition, students participated in focus group discussions three times during the year, discussing themes that had arisen in their diaries. Students spent approximately 20 h on preparing their portfolios during the course. In addition, they had a 2-h discussion group on three occasions during the course.

Table 1

<table>
<thead>
<tr>
<th>Instructions for writing learning diaries</th>
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<tbody>
<tr>
<td>Write your diary preferably immediately after the incident you intend to write about. Besides a description of the actual event, also try to reflect your thoughts and feelings from, for example, the following points of view.</td>
</tr>
<tr>
<td>What did you learn or experience?</td>
</tr>
<tr>
<td>What has been difficult or dubious in this learning situation or experience?</td>
</tr>
<tr>
<td>What problems did you encounter in learning sessions with personnel, teachers, or your group?</td>
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<tr>
<td>What has been especially inspiring?</td>
</tr>
<tr>
<td>What has been especially troublesome?</td>
</tr>
<tr>
<td>Where have you succeeded?</td>
</tr>
<tr>
<td>What kind of difficulties have you encountered and how have you coped with them?</td>
</tr>
<tr>
<td>You may write briefly and often, or longer in one session. Please write at least 1–2 pp. every 3–4 weeks. You may write by hand, typewriter or computer. Return the sheets by the given dates to KHP.</td>
</tr>
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</table>

Table 2

<table>
<thead>
<tr>
<th>Specific theme suggestions for student writings during the second half of the course</th>
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<tbody>
<tr>
<td>1. What do you think about the responsibility of being a doctor?</td>
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<tr>
<td>2. What qualities do you appreciate in a physician? Please reflect on your own qualities as they relate to being a good doctor.</td>
</tr>
<tr>
<td>3. How have experienced hospital and clinical culture? How do you think physicians tolerate failures in their work? Are physicians allowed to make mistakes?</td>
</tr>
<tr>
<td>4. Describe your experience and feelings when you have failed or made mistakes in medical school or at hospital. How well do you think physicians tolerate failures in their work? Are physicians allowed to make mistakes?</td>
</tr>
<tr>
<td>5. What values do you hold important in life? How do you think these will impact on your work as a doctor when your patient has different values from your own? Have your values ever been in conflict with what you have seen in hospital culture?</td>
</tr>
<tr>
<td>6. How do you imagine your patient feels about his illness? How much do you actually know about the thoughts and feelings of your patient? How do you feel when your patient talks about his feelings to you?</td>
</tr>
<tr>
<td>7. Intimacy in the physician-patient relationship: what do you feel when you have to discuss delicate matters with your patient?</td>
</tr>
<tr>
<td>8. Analyze a situation where you have had difficulties interacting with a patient.</td>
</tr>
<tr>
<td>9. Describe a patient contact that has moved you. Why was it touching and what did it teach you?</td>
</tr>
<tr>
<td>10. What kind of physicians are produced by this medical school? Do you get adequate support for your professional development?</td>
</tr>
</tbody>
</table>

2.1. Participants

Altogether 22 students participated in the course, 10 in 1997 and 12 in 1998. Of these, 15 were women and 7 men. The age ranged from 20 to 24 years. Four students participated in their first half of the course alone, thus only writing learning diaries. Another four participated in only the second half of the course. Students represent 69% of those (22/32) to whom the course was offered (KHPs tutor groups in internal medicine; these 32 students were randomly assigned to KHP). The total number of students in the 1997 student cohort was 86 and in the 1998 cohort 78.

2.2. Analysis

The entire data set consists of students’ personal portfolios, semistructured questionnaires and audiotaped and transcribed focus group discussions. In this study we have only used the students’ personal portfolios (learning diaries and writings on specific themes) to identify their inner experiences and reflections on these.

Analysis of writings was performed using qualitative content analysis [14]. All learning diaries and writings were systematically examined several times to identify emergent themes. Data were organized into codes and further into broader categories encompassing the initial codes. Each item
was compared with the rest of the data to establish analytical categories (constant comparison) [14,15]. Portfolios were reviewed and coded independently by both authors to ensure reliability. In a few cases, the authors had discussions to reach a consensus on differing concepts. This procedure was refined following a review of transcripts for non-conforming cases. Tabulations were also used to determine frequencies and distribution of differing concepts [15]. The written material is abundant. Therefore, we limited the range of themes and report only concepts related to feelings and reflections of patient encounters. By feelings we mean expressions of emotions in contrast to expressions of thoughts or pure descriptions of different situations.

All participants gave their written informed consent. The study protocol was approved by the local ethics committee.

3. Results

Students described their feelings abundantly and openly. The first year was full of important experiences with various emotions. We have classified these findings from diaries into feelings related to own competence with medical knowledge and skills, emotions emerging from patient interaction and feelings related to own role as “student–physician” (Table 3).

3.1. Feelings related to own competence with medical knowledge and skills

3.1.1. Anxiety and tension with the first patient

Encountering and examining the patient for the first time was a key experience for medical students. A great deal of tension, anxiety and insecurity were related to the encounter, and students reported that the experience had been confusing.

My pulse is high, stomach is upside down, how can I manage all this? I know nothing and I am so mixed as there are so many things to remember (no. 14).

I don’t remember that I had been so tense and anxious before as I was when I had to go to the ward for the first time to meet my first patient. I felt myself faint-hearted, weak and doomed to fail (no. 1).

3.1.2. Insufficiency in knowledge and skills

Anxiety emerged from the fact that students felt that they were not ready for the encounter. They felt they had to meet and examine their patient with inadequate knowledge and skills.

Fine lectures about molecular genetics and Latin is stuffed wherever possible, but how about the basic skills? I feel I’ve been taught to navigate in the ocean and then thrown into the water considering it self-evident that I can swim (no. 17).

Students were inexperienced, and the physical examination was difficult to conduct smoothly and logically. Students simultaneously felt, that the encounter took too much time, yet they still forgot things.

The examination proceeded very illogically. I had made a check list, but still I forgot many things … (no. 2).

I should have planned the physical more carefully beforehand … so that I would not have to trouble the patient to take off his clothes several times (no. 3).

3.1.3. Emotional and ambivalent encounter

During the 1–2-h encounter students felt both joy and uncomfortable feelings. Most of the students felt that after the encounter they were much more experienced, and they reassured themselves that at least next time it would be easier.

My feelings waved from side to side: “You don’t have to know everything at the first encounter” to “Will I ever be a doctor as my heart beats so that I cannot differ my own heart from the patient’s” (no. 10).

When walking out of the ward I felt even if I was a quite a different girl from the one who had gone in there some hours ago. Joy, success, failure and insufficiency were the feelings alternating inside myself. But whatever there was in my mind, I did not feel disappointment (no. 7).

3.1.4. Joy for learning new things

Most of the experiences of joy and success during the first clinical year were related to learning minor skills, or to medical procedures and operations that the students had observed.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Feelings emerging from first patient contacts</th>
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<tbody>
<tr>
<td>Feelings related to own competence with medical knowledge and skills</td>
<td>Anxiety and tension with the first patient encounter</td>
</tr>
<tr>
<td>Insecurity in knowledge and skills</td>
<td>Ambivalence related to own competence</td>
</tr>
<tr>
<td>Joy for learning new things</td>
<td></td>
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<tr>
<td>Patient interaction</td>
<td>Uncomfortable feelings related to corporeality</td>
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<tr>
<td>Feeling helpless in front of death</td>
<td>Shame related to intimacy</td>
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<tr>
<td>Sympathy for patients feelings</td>
<td>Joy for closeness with patients</td>
</tr>
<tr>
<td>Role as “student–physician”</td>
<td>Inferiority in front of patients</td>
</tr>
<tr>
<td>Confusion in front of a patient of own age and the opposite sex</td>
<td>Guilt for using patients “selfishly” for own learning purposes</td>
</tr>
<tr>
<td>Worry for lacking professional attitude</td>
<td></td>
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</tbody>
</table>
We managed to have a look at a bypass surgery. I have never seen anything like this before! It is incredible what a human being is able to do . . . it is not only the technical procedure but also the coolheadedness and the capability to work so intensively. It is really great that human beings may be helped by radical procedures like this (no. 13).

3.2. Emotions emerging from patient interaction

3.2.1. Uncomfortable feelings related to corporeality
Corporeality appeared in only two diaries, although this must have been a theme that most students encountered, consciously or unconsciously. Uncomfortable feelings, even guilt, appear to be related to this event.

Yesterday I felt I failed totally with my patient. I was really disappointed and ashamed of myself. A sweet, older lady, but she stank so badly I could not concentrate at all. How childish! I felt strangling in my throat, and I thought I cannot touch her (no. 9).

3.2.2. Feeling helpless with dying patients
Fifteen students wrote about meeting a patient with a serious illness and described their feelings and thoughts about the approaching death. Facing serious illness and death was upsetting and students felt insufficient and incapable with these patients.

I met a patient with a lung cancer . . . at the end, she and her husband started to cry. I was wordless. I put my hand on her shoulder and wished her the best. Is this all I can do to comfort? I felt myself so uncertain (no. 12).

We met two patients with pancreas cancer . . . . I was very touched by these encounters . . . . Maybe it is the loneliness. The patient has to stay the rest of his life at the hospital. It is so hard to accept. And another thing, I would not have anything to say to these patients . . . (no. 13).

3.2.3. Access to intimate areas of life
Overcoming the intimacy barrier was difficult both in the physical examination and in asking delicate things in history taking. Students commented on the development they saw in themselves in handling these situations more naturally.

I did not dare to examine the patient’s breasts neither to propose a rectal examination. I’m ashamed how bashful I am. In vain. Next time I have to think over these matters and gather all my courage (no. 10).

When examining the first patient I felt that I don’t dare to ask for intimate things in the history taking. It was enough that I dared to ask somatic symptoms, fever, etc. Somewhere between the history of smoking and alcohol use was the border that seemed unachievable (no. 8).

3.2.4. Feeling sympathy for patient’s feelings
Many students reported identifying with patients’ feelings in different situations.

It is difficult to go to the patient with a big group of six people. And those injections—I feel disgusted to cause pain to another person. I feel so insecure (no. 13).

When I was watching a gastroscopy, I was strongly affected by the patient’s nausea. I did not understand it at the moment but next night I had a nightmare. I was performing a gastroscopy to my patient, and while feeding the tube to the patient I started to puke up at the same tempo as my patient (no. 4).

3.2.5. Touching, rewarding contacts with patients
Six students also reported touching encounters with patients.

Meeting own patients has continuously been something that bring me joy, upsets me . . . (no. 7).

My patient burst into tears several times during our conversation and I—surprisingly—did not get upset. I was content that the patient had the courage to tell me so openly about her illness. I got closer to her (no. 13).

3.3. Feelings related to own role as “student–physician”

3.3.1. Feelings of inferiority: receiving support from patient
Many students expressed the view that their patients were experts in their illnesses and more experienced in the hospital culture than they themselves. Students had feelings of inferiority and interpreted patients as giving them their support.

The patient noticed my insecurity, but she was very understanding (no. 2).

Some students viewed themselves through the eyes of their patient, presenting themselves with self-irony.

My patient even tried to calm me down when I mentioned that this is my first time with a real patient. I laughed by myself and thought that isn’t this a peculiar doctor–patient relationship (no. 1).

At times my patient seemed to be really amused what I was doing (no. 5).

3.3.2. Role confusion
Four students had had a confusing experience when they had examined a patient of their own age and of the opposite sex. It relieved to them that their identity as doctors was still quite weak.

For the first time I collided into an identity problem when I had to examine quite young man. The situation was really upside down. Me—a 20-year-old girl—was trying to handle the batons and control the course of the encounter
staff and teachers. Students have been claimed to put great effort into impression management in front of their teachers in an attempt to show their competence [1–3]. Our students felt great anxiety and insufficiency related to their competence but rather than showing off they revealed honestly and openly their insecurity and experienced deficiency. This is somewhat surprising given that the researchers who the students were writing for were faculty members and one of them not familiar to students.

Our students presented many uncomfortable feelings related to patient encounters. Some confusing experiences with patients have been reported in previous studies, dealing with intimate issues, for example, is embarrassing and is an acquired skill [1,18], and meeting a young patient of the opposite sex interferes the role of the student–doctor [1,3,4]. In addition, experiencing death and the process of dying is traumatic and medical students have few means to prepare themselves for these events [18,19]. However, oncology is one of the few specialties that has taken actions to support students’ reflective emotional learning [20].

In first patient encounters, our students regarded their patients as experts of their illnesses and as active supporters. In a recent qualitative study, patients’ active role as teachers has been studied from patients’ point of view [21]. Patients also see themselves as experts in their condition and as facilitators of students’ attitudes and professional skills. This finding could have implications for medical training. Patients’ active role in students’ learning could be enhanced, strengthening the partnership and the supporter’s role.

To our knowledge, guilt related to patient examinations was a new finding. This probably reflects the lack of clear definition of the student’s position in the hospital; students perceive themselves to be outsiders. Cynicism, suppression of feelings and objectification of patients which are often referred to in the literature [3,4,22,23], were not observed in the writings of our students, although some self-irony was obviously present in reflections. Patient encounters were instead experienced as touching incidents, and students’ feelings were reflected upon intricately. However, there seems to be some difference between the genders in how they report various feelings in their writings. We tabulated the number of male and female students reporting their feelings related to patient experiences (Table 4). It seems that female students report more often in particular the feelings of insufficiency of their own knowledge and skills, ambivalence related to their own competence, helplessness in front of death, and inferiority in front of patients but also feeling of joy for closeness with patients. These differences may be related to general gender differences: either females reflect on their feelings more openly, or the male students have better self-esteem and feel less vulnerable about their own competence. Thus, it is difficult to interpret whether some writings represent denial and suppression of feelings or truly non-existing emotions. However, even if not all of them did so, most males were also able to reflect their feelings openly and deeply. Two students did not reflect on uncomfortable feelings at all. It has been pointed
out that some students (“scant and avoidant writers”) focus on objective events rather than exploring their own feelings in their learning diaries [24].

One of our important findings was, in fact, that students were surprisingly thorough and humble in their description of uncomfortable feelings. This is in contrast to previous literature, which has suggested that students are unable to introspect on their anxiety and insecurity [6]. Our study does, however, support the view that medical education should focus more on students’ reflective thinking and personal development in their emotional journey through medical school [5,23,25].

4.1. Limitations

The validity of the diaries and medical students’ experiences described there in may be questioned. Qualitative research does not aim to produce findings that are representative of larger populations [14]. Therefore, the findings of our study are not necessarily generalizable. The students are a self-selected group as they are volunteers in this portfolio course. They are probably more used to self-reflection and more capable in writing than other medical students. However, these students represent 69% of those (22/32) to whom the course was offered. In addition, the writings may be interpreted as honest and highly valid in the context in which they have been produced.

Several limitations in validity are apparent. While these writings are supposed to be self-reflections and internal discussions, they have been produced in a situation where students are aware that their tutor (KHP) will be reading them. Thus, conscious and unconscious presumptions and the desire to please may guide theme choices. Moreover, the themes offered during second half of the course may have had an impact on students’ elaboration of matters. However, these limitations also apply to studies in this field that use interviews or surveys. We believe that while inner experiences can be approached from different perspectives, the whole truth will always be elusive.

4.2. Conclusion

First patient encounters are strong emotional experiences that medical students openly and humbly describe. The medical students’ emotional development takes place especially in the areas related to own competence, patient interaction and role as student-physician. Feelings of guilt, helplessness, anxiety and insecurity, for example, should be recognized and medical students should be supported in their professional development. There could be several ways of doing this. For decades, Balint groups, for example, have supported professional development [26], and portfolio writing with supportive groups is known to facilitate reflective thinking and “deep” learning [27,28]. In addition, creative writing is a promising tool for capturing and elaborating uncomfortable feelings and imaginings [29].

4.3. Practice implications

Writing as learning tool may help in recognizing key experiences and support professional development of medical students. The writing process itself may have had an impact on how students elaborate on their feelings [30]. Writing is a powerful tool, forcing the writer to stop and think, to structure thoughts and to give words to uncomfortable feelings [30,31]. Whether these writings reveal ordinary reflections of medical students or whether they reflect the process of reasoning caused by writing remains to be seen.

Acknowledgements

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References


