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“You’re Not Trying to Save Somebody From Death”: Learning as “Becoming” in Palliative Care

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Abstract

Purpose

Learning can be conceptualized as a process of “becoming,” considering individuals, workplace participation, and professional identity formation. How postgraduate trainees learn palliative care, encompassing technical competence, compassion, and empathy, is not well understood or explained by common conceptualizations of learning as “acquisition” and “participation.” Learning palliative care, a practice that has been described as a cultural shift in medicine challenging the traditional role of curing and healing, provided the context to explore learning as “becoming.”

Method

The authors undertook a qualitative narrative study, interviewing 14

residents from the University of Ottawa Family Medicine Residency Program eliciting narratives of memorable learning (NMLs) for palliative care. Forty-five NMLs were analyzed thematically. To illuminate the interplay among themes, an in-depth analysis of the NMLs was done that considered themes and linguistic and paralinguistic features of the narratives.

Results

Forty-five NMLs were analyzed. The context of NMLs was predominantly a variety of clinical workplaces during postgraduate training. Themes clustered around the concept of palliative care and how it contrasted with other clinical experiences, the

emotional impact on narrators, and how learning happened in the workplace. Participants had expectations about their identities as doctors that were challenged within their NMLs for palliative care.

Conclusions

NMLs for palliative care were a complex entanglement of individual experience and social and workplace cultures highlighting the limitations of the “acquisition” and “participation” metaphors of learning. By conceptualizing learning as “becoming,” what occurs during memorable learning can be made accessible to those supporting learners and their professional identity formation.

Populations in many areas of the world are aging and dying at greater rates than at any time in the past, and family medicine residency programs must train physicians competent to care for people at end of life.^{1–3} Palliative care has been described as a cultural shift in the practice

of medicine: from disease-focused interventions of acute care and chronic disease management toward a holistic and person-centered approach.^{1,2} How medical trainees learn palliative care is not well understood or explained by the common “acquisition” and “participation” models of learning.^{4–11} Hager and Hodkinson^{12,13} propose the metaphor of “becoming” as a more nuanced way to consider learning as both embodied in individuals and occurring through social interactions within workplace cultures.

Postgraduate education is situated in clinical workplaces, and these contexts of learning influence learners’ attitudes, beliefs, and identity in intentional and unintentional ways.^{14–16} Professional identity formation is a key focus of modern medical education, and it is through complex microinteractions in daily practice that learners develop their emerging identities as physicians.^{11,17–19} If the dominant medical culture and way of being a physician is through a curing or healing role, the practice of palliative care may challenge the way learners see themselves and potentially cause discomfort and distress.²⁰

Learners and practicing physicians experience emotional challenges when

working with dying patients.^{21–23} Emotions influence cognition and professional identity formation.^{17,24–26} Helmich and colleagues²⁵ suggested four paradigms for describing the interplay between emotion, meaning making, and identity for medical students: insecurity, complying, developing, and participating. Workplace opportunities for meaningful engagement and exploration of emotions resulted in the paradigms of “developing” and “participating” that supported identity formation, while the paradigms of insecurity and complying did not. This model suggests that, for undergraduate students, awareness and exploration of emotions elicited through participation in clinical encounters created conditions wherein identity could be explored and enacted. This is consistent with Hager and Hodkinson’s¹² “horizons of learning,” referring to how the individual, the culture of the workplace, and social interactions support learning and the process of identity formation.

Medical education includes many discourses, two of which have been described as biomedical competence and humanistic caring.^{27,28} Biomedical competence has been argued to be the dominant discourse.²⁸ Palliative care

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requires both technical competence and caring, can be emotionally evocative, and challenges the role of physician as healer. Thus, palliative care practice provides a rich context for exploration of learning and professional identity formation. Personal incident narratives have been used to explore an individual's reality, actions, consequences, and emotions.^{21,29} Using the lens of learning as "becoming," this study focused on family medicine residents' personal incident narratives of memorable learning (NMLs), to ask the following questions: What are family medicine residents' memorable learning experiences in palliative care? And how does memorable learning contribute to professional identity formation for palliative care practice?

Method

We undertook a qualitative narrative study of memorable learning in palliative care recounted by family medicine residents from three urban training sites affiliated with one Canadian family medicine residency program.²⁶

Conceptual framework

We drew on multiple theoretical perspectives to understand memorable learning. As this study considered the lived experience of individuals, each participant's interpretation of his or her experience was unique. The underlying ontology is interpretivism, which considers reality as subjective and changing.³⁰ The epistemology is constructivism: Knowledge is subjective, and meaning is constructed.^{30,31} We used the theoretical perspective of learning as "becoming" through interplay between the individual and the learning milieu that is inclusive of the notion of professional identity formation.¹² To research identity, we adopted Jenkins's¹⁹ conception of identity as a process embodied within an individual and socially constructed through interactions with others. Individuals narrate stories that reveal how they see themselves and how they think they are perceived by others.^{19,26,32} One important purpose of narrative is in recounting identity: the stories we tell ourselves and others of who we are.^{26,32}

Participants, recruitment, and sampling

We recruited participants through a purposive sampling strategy.³³ An e-mail invitation was sent from the postgraduate program director, Department of Family Medicine,

University of Ottawa, to all 62 family medicine residents in their final six months of training at the program's three urban sites who were preparing for certification exams in the spring of 2014. The invitation originated from the program director as the lead author (F.K.) was in a position of power and authority with respect to the potential participants.

Data collection

We asked all volunteers responding to the e-mail invitation to participate in one semistructured interview, providing an opportunity for exploration of their perspectives and learning experiences about palliative care. Interviews were chosen because we wanted to hear each participant's unique voice about potentially emotionally evocative stories. An interview guide, presented in Box 1, was developed by the research team following the structure of the personal incident narrative.^{21,29,34} Interviews were held in person or over the phone, during the participants' residency training, in May and June 2014, audio-recorded and transcribed verbatim by a professional transcriptionist. All interviews were conducted by one interviewer (D.A.), known to participants but not in a position of power or authority. Following the initial 11 interviews and after preliminary analysis of the data, 3 further interviews were conducted, in October 2014, to increase participation from one site underrepresented in the initial group of volunteers. As thematic areas developed were sufficient in answering the research questions, we ceased data collection.³⁵

Data analysis

We began data analysis by listening to interview recordings and executing multiple close readings of each transcript. Three initial transcripts, representing one participant from each site, were reviewed, discrete NMLs were identified, and each NML was analyzed independently by two investigators (F.K., R.A.) to inductively develop themes and subthemes for a coding framework.^{26,36,37} The framework was discussed and reviewed by all coinvestigators to reach consensus. F.K. subsequently undertook coding of all data using NVivo qualitative data analysis software version 10 (QSR International Pty Ltd., 2014). F.K. and D.A. had an insider's view of the residency program as a clinician teacher and an education researcher, respectively. R.A. had an outsider's view as an education researcher from another institution; hence, the team brought different perspectives to bear when analyzing the data.

R.A. and F.K. reviewed the coding at regular intervals to explore developing interpretations of the data. Disagreements about coding were resolved through discussion about theme and subtheme definitions and the understanding of the contested quotation's meaning from both insider (F.K.) and outsider (R.A.) perspectives. While the thematic analysis identified "what" was said, the in-depth narrative analysis explored "how" it was said by focusing on linguistic (emotional words, metaphors, pronouns) and paralinguistic (tone, laughter, repetition, hesitation) features of each NML.²⁶ To deepen the understanding of individual

Box 1

Memorable Learning Experiences Interview Guide—From a Qualitative Study About Memorable Learning in Palliative Care and Professional Identity Formation, University of Ottawa, Department of Family Medicine, 2014

Can you reflect back on some memorable learning experiences you have had in palliative or end-of-life care, at any time either during or prior to your medical training?

Part A:
 What happened?
 Where was it?
 Who were you working with? Who else was there?
 What did you do?
 How did you feel?

Part B:
 What did you learn?
 How did you learn?
 What did you enjoy?
 What was difficult or challenging?
 What interfered with your learning?

Can you think of any other memorable experiences? Repeat part A and B until there are no further memorable learning experiences to recount.

NMLs and illuminate the interplay between the developing themes, an in-depth narrative analysis of the NML was undertaken considering themes, language, and structure of the narrative: what was said and how it was said.^{21,26,29,34} This holistic interpretive act was undertaken by R.A. and F.K., who interrogated and discussed each NML. Through close attention to how participants structured their stories, the interplay between how the narrators presented themselves, their emotions, their social interactions, and their ability to act was illuminated.

The research ethics boards at the Ottawa Health Sciences Network (protocol no. 20140045-01H) and Bruyère Continuing Care (protocol no. M16-14-008) approved this study.

Results

Interviews were conducted with 14 family medicine residents based at three different urban teaching sites within one program (4 site A; 6 site B; 4 site C). Interview length varied from 18 to 59 minutes with an average of 29 minutes. Participants recounted between 2 and 5 discrete NMLs per interview, resulting in a total of 45 NMLs for analysis. Three NMLs described memorable learning outside of formal medical education while participants accompanied family members at the end of life. The remaining 42 NMLs occurred in the context of medical education, with 3 from undergraduate years and 39 from clinical workplace experiences during residency in a variety of settings: family medicine outpatient, hospital, and hospice settings; palliative care and internal medicine specialist inpatient wards; and the intensive care and emergency units. We begin with presenting themes: how palliative care contrasts with other areas of clinical practice; emotions present in the NMLs; and how learning happened in the workplace. Then, three deidentified NML excerpts are presented with a closer narrative analysis that considers how the participants recounted their stories: the interplay between themes and how the NML was constructed, allowing an appreciation of how professional identity is presented by the narrators.

The concept of clinical palliative care

Participants conceptualized palliative care in a variety of ways. Very few

considered it as an integral part of their practice in all domains, while the majority described palliative care as something that contrasted with their usual clinical role (Table 1). This was expressed in terms of what they did: defining and focusing on the goals of care and not on disease-specific interventions; taking more time with patients and families; underlining the importance of communication; and finding out about the patient's life story. The difference was also expressed in how they felt: an embodied sense that what they were doing when participating in palliative care was different from their usual clinical practice.

Emotions in memorable learning for palliative care

NMLs for these participants were infused with emotion, both their own and those observed in others (see Supplemental Digital Appendix 1 at <http://links.lww.com/ACADMED/A498>). These emotions were positive and negative, and at times both valences were represented within a single NML. Personal emotions were expressed about doing the work: feeling unprepared, overwhelmed, frazzled, humbled, supported, comfortable. Emotions that related to death and dying were similarly rich and often contradictory: sad, happy, positive, difficult, distressed, conflicted. Coping with and managing emotions were part of the NMLs: through creative outlets such as writing poetry; celebrating the life of a patient; discussing feelings with supportive family members, colleagues, or preceptors. Some NMLs explored the discomfort the narrator felt in the role of palliative care provider—for example, witnessing decline and managing symptoms without intervening in the underlying disease. Some participants, in spite of discomfort, described trying new ways of interacting with patients

Table 1

How Family Medicine Residents Contrast Palliative Care With Other Clinical Care, From a Qualitative Study About Memorable Learning in Palliative Care and Professional Identity Formation, University of Ottawa, Department of Family Medicine, 2014

Area of contrast	Illustrative example
Focus on the goals of care	"I ... explained to them what palliative care was and that it wasn't that you're ... accepting death.... Our goal is to make him comfortable and if he ends up passing away while he's comfortable then that's not a bad thing." P11
Not disease-specific interventions	"It was a bit refreshing ... to think in a very different way ... in all the other aspects of medicine ... you're supposed to save them and nobody really tells you what you're supposed to do afterwards.... You really feel as though you're cherishing and you're helping ... dying which is part of living." P13
Patient and family centered	"I didn't feel like we had a central role but I felt like that we were an important piece ... we were there to make sure that he had everything that he could possibly need ... as he passed away and made sure the family had all their questions answered.... We were doing an important thing but it wasn't all about us." P5
Importance of communication	"They came in and he had already passed ... but we had a really good conversation with them [the family] afterwards ... and I think so much of what they'll remember about the night that he passed away ... is going to be the conversation that they had with me and the nurse ... those things are what stay in people's minds." P7
Finding out the patient's story	"He told me a lot about the way that he was seeing the dying and his life right now and his fear.... I think that I learned from him to be more comfortable and to talk about all of those things." P9
Mental shift	"I liked ... the shift in mentality from going from a clinic base where ... you're treating illnesses ... trying to ... heal people and kind of 'fix people.'... You go to palliative care where it's all about ... quality ... and your goals are different." P11
Physical shift	"The [hospice] ... I love the facility.... I feel like things really slowed down while we were there." P5

Abbreviation: P indicates participant number.

and families or feeling empowered to participate in and make clinical decisions in novel ways.

Learning in the clinical workplace

How learning occurred in the NMLs was a large thematic area. The context of most NMLs (41 of 45) was the clinical workplace. Within these NMLs, elements of the formal curriculum (books, lectures, modules) were mentioned as supports to the learning that happened in the workplace. The majority of NMLs involved participating in the care of patients and families within interprofessional health care teams. Workplace learning included the subthemes of learning: through supervised clinical care; from interprofessional colleagues; by doing; and from patients and families (see Supplemental Digital Appendix 2 at <http://links.lww.com/ACADMED/A498>). The NMLs encompassed different levels of participation in the clinical workplace, from observation to providing care under the guidance of supervisors or interprofessional colleagues.

Learning as becoming: Professional identity formation

Analysis of the NMLs suggests that professional identity is constructed by participants in complex and individualized ways that are evident through what is recounted and how the narrative is conveyed. For example, narrators presented emotion through language and paralanguage. Emotions can influence the narrator's actions or their inability to act. We present a deeper narrative analysis of three NML excerpts to illustrate this process. Attention to how the narrator told the story and its content provides an opportunity to consider the process of professional identity formation.^{19,26} Three NMLs were chosen to highlight different paradigms of identity formation described by Helmich and colleagues²³: complying, developing, and participating (respectively).

Excerpt 1: Complying

One participant (P10) described working in a community hospice caring for a man with rapidly advancing cancer and her sadness and frustration with not being supported to provide the care she felt was required (Box 2). P10 emphasized how memorable the experience was by stating she would always remember it and connecting this with negative feelings about the interaction. She

Box 2

Excerpt From Participant 10 NML: Complying—From a Qualitative Study About Memorable Learning in Palliative Care and Professional Identity Formation, University of Ottawa, Department of Family Medicine, 2014

There was one patient ... he was one of the ... the [Community] doctor's patients. So we would check in on him every once in a while ... um (.) he was quite healthy up until a few months and then he developed pancreatic cancer so it was a very acute sort of onset so (.) he was very ah (.) he was very depressed and I always sort of remember him because I don't feel (.) I don't feel that I um (.) I adequately dealt with it.... I definitely saw aspects of [depression] but (.) and I mentioned it to the doctor but it was kind of (.) um (.) I guess brushed off. So (.) but it was something that I never kind of sat well with me but I didn't want to step on anyone's toes.... I guess that's sort ... that maybe is a bit of a limitation being a resident ... sometimes you see things that you can't (.) you want to act on but you can't necessarily act on because you are a resident. It may not be the same approach ... that a supervising physician or another physician might not think is that important or might not see it in your way so you kind of have to take a step back.... I always kind of remembered him and I always felt like there was (.) a lot of um (.) I mean you know we were always taught this idea of total pain and I just didn't feel like ... his total pain was being addressed.... So he was just somebody that I remember and that I didn't really feel good about. [laughter] ... that's a part of palliative care that we didn't get a lot of experience on.... I found pharmacotherapy and learning how to manage physical symptoms was quite well done but certain other aspects in regards to total pain, like the depression (.) the ah (.) the spiritual aspect (.) it wasn't necessarily that it wasn't um, addressed it's just that sometimes I just um (.) I guess we just didn't have the opportunity to work with patients enough to really sort of have that discussion and work through it.

Abbreviation: NML indicates narrative of memorable learning.

(.) denotes pause in speech.

... denotes edited text for brevity.

identified herself as a member of the health care team by using first-person pronouns when indicating her active role in caring for this man. With multiple pauses and hesitation, she used different expressions to describe her discomfort in not being proactive with her desired approach and how she felt her views were dismissed or "brushed off." Her distress was further underlined by laughter for coping, after the third reiteration of how memorable and uncomfortable the event was. The NML described her lack of power: to be heard, to question, or to explore alternatives. Her learning entailed being compliant with an approach that was not consistent with how she sees herself as a physician, within a learning culture that was not supportive of her. She went on to underline how, in her experience, teaching and learning palliative care biomedical competencies was well done and contrasted with the holistic caring approach that requires supported clinical opportunities. The narrator did not feel empowered to express her position or seek help in exploring other ways of being and becoming.

Excerpt 2: Developing

Memorable learning in this narrative revolved around how participation in the provision of palliative care challenged one participant's (P1's) notion of herself as a physician and what constitutes active care (Box 3). P1 recounted a novel

clinical experience caring for a man in a community hospice who was initially well but died soon thereafter. She situated herself as part of the interprofessional team using the pronouns "I" and "we" when referring to the action in the story. She distanced herself from the dying patient by describing him as a "case" and using formal medical jargon such as "decline," suggesting her discomfort. There was tension arising from what she knew and did, and how she felt about this, suggested by multiple repetitions about how she wanted to undertake interventions aimed at the disease despite knowing that the focus was patient comfort. She alternated between the use of "I" and "we," creating distance, when describing what she wanted to do and what the rest of the team was doing. Her distress was further suggested by repetition, frequent pauses, and laughter for coping. She initially described palliative care in terms of "just focusing on goals of care" but then altered this conceptualization as "not just" goals of care, suggesting something larger as she made sense of and reflected on her experience. Her narrative was rich with emotion and challenged how she sees herself as a physician. She had been empowered to try out new ways of being a physician and had reflected and received feedback from team and family members. P1 was able to consider her emotions

Box 3

Excerpt From Participant 1 NML: Developing—From a Qualitative Study About Memorable Learning in Palliative Care and Professional Identity Formation, University of Ottawa, Department of Family Medicine, 2014

One of the patients there that was interesting was a gentleman perhaps in his 70s ... um, was really actually pretty well on admission to the hospice ... so what was interesting about that case was because, umm, over the next few days he really declined and ... and then passed away while we were on hospice. So for me it was a good, umm, it was a good experience because I saw the decline so I hadn't seen that before ... usually in the hospital you just see someone who's not doing well and is palliative but it was somebody who was doing well, we thought would go home and then declined and then passed away and I think in the decline it taught, what I reflected on was that I still wanted to do active care like I still wasn't used to just focusing on goals of care.... I still was, what can I do, what am I missing, what can we do, what can you know we order but just in terms of like talking to the team this was a normal progression and we had done everything we had to do but it was really reflecting on, like (.) my I really wanted to do more than (.) was really necessary.... We were at the hospice when he passed away and a part of me felt like did I not do enough like did I not intervene enough but you know with the staff is like, this is how it happens and the family was so (.) grateful like they didn't feel like anything was missing in the care.... Like they felt like after it was such a good experience and it was ... they felt (.) relieved but also felt like the care was well done but I still felt sometimes, like eventually in the end I felt like okay that was the right thing to do ... so feeling like I really should intervene but learning that that was what palliative care is ... it's just goals of care, not just (.) but it is goals of care and if the patient is comfortable and the family is comfortable then you should be comfortable as well.... But the family did say like "Oh," like he did decline faster than we thought ... so they were ready for it ... more ready than me maybe [laughter].... I think it made me more comfortable with (.) hmm with that feeling of going through recognizing that I wanted to do more active care but recognizing that there are goals and if you reach those goals and as long as you make sure the patient is comfortable then, I think going through that exercise, that mental exercise was helpful.

Abbreviation: NML indicates narrative of memorable learning.
(.) denotes pause in speech.
... denotes edited text for brevity.

and actions and what this meant to her identity as a physician. In the end, the resolution was uncertain as she described the experience as a "mental exercise" and used the ambiguous term "okay" as a summation of her complex feelings.

Excerpt 3: Participating

One participant (P12) narrated an emotion-filled story about participating in the care of a young woman who died at home (Box 4). He actively assumed a central and supported role in her care despite his discomfort and difficult emotions, and came to resolution about the meaning of palliative care and how he incorporated this into his emerging identity as a physician. Using the pronoun "I," P10 situated himself as the focus of the narrative of his first experience of palliative care in the home. He actively took a central role in the action of the story, using the first person when relating to his feeling of duty toward this patient and family and his sense of autonomy. He assumed this role even though it was difficult and evoked emotion that "was a tough one to go to bed with that night." His speech reflected this emotional depth as he paused frequently, hesitated, and

repeated words. He described how he managed his emotions and the support he received from interprofessional colleagues. He clearly articulated how this care was different from what he had experienced elsewhere: contrasting it with providing care in an emergency room and outpatient setting, and what palliative care entails in terms of a willingness to develop relationships in the intimacy of a home environment, and attending to the wishes and dignity of those involved. He further contrasted acute and palliative care by initially describing the difficult and mature decision "not to treat somebody," referring to treatment as intervention in the underlying disease. He acknowledged the supports around him and suggested that his autonomy and independence in participating in this care as well as his emotional struggles were important aspects of memorable learning. He described active participation in providing care and in shaping his learning opportunities.

Discussion

Learning palliative care happened in a variety of clinical settings and

was influenced by participants' past clinical and life experiences. NMLs were predominantly about clinical experiences: what learners did, how they felt about the experience, how it contrasted with clinical care in other domains, and how it challenged the way they saw themselves as physicians. Participants had expectations about their role and identity as doctors that were contested in their NMLs. Challenging but supported experiences enabled participants to explore and reflect on strong emotions, what that meant to how they saw themselves as physicians, and to embody and explore different ways of being and becoming. By broadening the way that we conceptualize learning, as a process of "becoming," this study deepens the understanding of learning in general and of palliative care learning in particular.

A striking characteristic of most NMLs was the rich description and expression of emotion. Strong emotions are often what make experience memorable, and recounting them helps to deepen understanding and create personal meaning.^{24,26,29} Emotionally rich experiences in clinical settings have been described as powerful triggers for identity formation, and the process of identity formation can be emotionally disruptive.^{23,25} Our findings suggest that the paradigms of lived experience identified by Helmich and colleagues may have a broader application in thinking about professional identity formation beyond those entering medical practice for the first time.

Many ways of teaching the knowledge, skills, and attitudes for palliative care practice have been incorporated within formal curricula in undergraduate and postgraduate medical education.⁶⁻⁸ These activities were most notable in this study by their absence in the NMLs. Elements of the formal curriculum were mentioned infrequently and only as tools that supported memorable learning experiences. This suggests that conceptualizing palliative care learning as "acquisition" of knowledge, skills, and attitudes is not sufficient to understand how learning happens. "Acquisition" may explain how best to equip learners to participate in the clinical workplaces where most memorable learning happens.

Box 4

Excerpt From Participant 12 NML: Participating—From a Qualitative Study About Memorable Learning in Palliative Care and Professional Identity Formation, University of Ottawa, Department of Family Medicine, 2014

The first girl I palliated was actually a home visit for my preceptor ... he happened to be away ... essentially it was the first time I had to make the decision moving forward about what we were or weren't going to do for this person.... And being a part of that inside somebody's kitchen and realizing ah (.) um (.) the depth of (.) of being involved with that, I mean medicine goes way beyond being in an [emergency] department and treating coughs and colds and ... treating hypertension ... you end up being involved in these people's lives in some a (.) at (.) some (.) very personal moments.... It's, it's coming to the table being open to developing a very deep relationship very quickly with people who are (.) who are losing a loved one and ... being involved in their decision-making process and, and helping them realize the wishes of the person who's ah (.) who's dying and honoring those in a (.) in a respectful way.... So the decision, from my perspective, was one of the more mature med decisions I've ever had to make (.) by myself. Because the first time I walked in the door (.) it was ah (.) well that (.) that my preceptor was (.) away and somebody else was covering it was kind of (.) my responsibility because I was the person who knew the family and knew the patient best.... And yet (.) yeah (.) it was a (.) it was a tough one to go to bed with that night. I talked it over with my wife and (.) you know, it was (.) it was (.) the first time in medicine that I've ever made a decision essentially (.) not to treat somebody.... I know it was the right decision, looking back (.) it was (.) it was (.) she was suffering enormously ... but um (.) it was a tough decision to make with the mother (.) ... I contacted the ah (.) the supervisor that I had at that time.... And so I very quickly learned about which pharmacies are open when in town and how to write things in a way that get these ah (.) um doses of ah things ... in the house so that they can be used in catastrophic events um ... you know coordinate with [home care] ... just all kinds of little intricacies to palliating somebody outside of an environment that's formal.... And so I learned a lot ... this was experiential and um (.) and less formal but (.) very formative and personal for me.... We also have a really good nurse in our clinic ... and so some of it (.) in my (.) from my perspective some of it was just um (.) organizing the right people to help.... I ended ah (.) I ended up having s-some good supports coming around me to help me.

Abbreviation: NML indicates narrative of memorable learning.
(.) denotes pause in speech.
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In the NMLs, the practice of palliative care provided the participants ways of engaging in clinical practice that contrasted to what they had experienced elsewhere. These differences were about putting the patient and family at the center of the interaction, attending to emotions and other issues that were not biomedical, and not intervening in underlying life-limiting disease processes. Participants articulated and struggled with their personal beliefs and socialization into the dominant healing doctor narrative that was contested in the NMLs in palliative care.^{20,28,38} When using the lens of learning as “becoming,” the consequences of these experiences and how participants acted and felt differently were a fundamental part of learning.¹² If “acquisition” is the only way learning is understood, then what happens in memorable learning and its potential for profound effects on the learner will remain invisible. The entanglement of unique personal experience with workplace social interaction in the NMLs highlights the limitations of the “participation” metaphor. By reconceptualizing learning as “becoming,”

what is actually occurring in workplace learning can be appreciated and accessible to those who support learners and plan and design curricula.

Participating in palliative care in the variety of settings described by the participants was often a novel and different way of practicing medicine for them. Several authors have underlined the dominance of biomedical competence over caring in medical education despite institutional support for reform that seeks to redress this imbalance.^{3,20,28,38–40} The findings of this study demonstrate a gap between such espoused institutional values supporting a patient-centered focus and the lived experience of participants: Not focusing on disease interventions was memorable and challenging. There is an inherent danger in considering places where palliative care happens as different from other domains of care in that they can become marginalized as clinical subcultures, wherein caring is a competency that is expected, valued, and expressed. We suggest that a dichotomous view—*care OR care, biomedical OR psycho-social-spiritual competence*—is unhelpful.

Findings from this study demonstrate that learning palliative care happens in a variety of generalist and specialist clinical environments. There is potential to learn palliative care and different ways of “being” a physician in many and diverse clinical settings. The competency of caring should be embedded, enabled, and valued in all these environments.

Evidence from this study underlines the importance of clinical learning environments as places where identity is constructed and reconstructed through both challenging clinical opportunities and supported reflective space for exploration. Within this reflective space, attention to language (the words) and paralanguage (the emotional tone, hesitations, repetitions) used by learners during debriefing sessions can further illuminate the complexity of the struggles and challenges inherent in participating in clinical practice. When learning is conceptualized as “becoming,” attention to the individual with their unique personal experiences and the social interaction within the workplace culture can create clear “horizons of learning.”^{5,12,13}

Limitations

This study was limited by having participants from only urban practices within one residency training program and the cross-sectional perspective taken. The participant group is further limited to those who volunteered to share their experience and thus includes the voices of those available, interested, and willing to give of their time. The voices of those who are not interested, who may have had negative or traumatic experiences, or who simply do not identify with this area of practice may not be heard, and their absence may have skewed the findings toward a positive predisposition to the concepts and practices of palliative care.

Implications and future research

This study underlines the importance of reconceptualizing learning in postgraduate medical education as a process of becoming. In moving beyond an “acquisition” model of learning, important elements of learning are rendered visible, and thus accessible to exploration and development. If learning is the entanglement of both the individual and her or his participation in the learning environment, then attention

to what happens in those environments and the consequences on the emerging professional identity of learners is critical. An essential part of this process is the ability of educators and learners to engage in exploration of the emotional consequences of their work. In this clinical domain, if the desired learning outcome is family physicians who are competent and embrace the practice of palliative care as part of their professional identity, then what are the elements in clinical workplaces that support or hinder this? How are clinical workplace conditions that support professional identity formation created and supported? How does this conceptualization of learning affect the role of faculty and their professional identity as teachers and educators?

Conclusions

This study demonstrated that memorable learning in palliative care is a complex interplay of individual and workplace experience that is not adequately explained by a conceptualization of learning as “acquisition” or “participation.” Learning as a process of “becoming” that considers and supports individuals, their entanglement in clinical workplaces, and the development of professional identity is a more apt description to appreciate palliative care learning. The practice of palliative care presented postgraduate learners in this study with novel ways of being a physician and engaging with patients, families, and interprofessional teams. Evidence from this study supports the creation of meaningful clinical experiences and reflective spaces for dialogue to support professional identity formation.

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Teaching and Learning Moments

Hair Loss: It's Not Just a Cosmetic Concern



During my third year of medical school, I rotated with a dermatologist who specialized in hair loss. She often mentioned to me that hair loss was more than just a cosmetic concern. I didn't realize the true meaning of her words until I saw her patients myself.

On the first day of my dermatology rotation, I met Cindy, a woman in her 50s. After exchanging pleasantries, Cindy started crying, completely catching me off guard. I asked her what was wrong and handed her a tissue, hoping I was not the cause of her distress. Wiping away clumps of mascara soaked in her tears, she said: "I am so sorry for reacting like this. It's just . . . I am losing my hair and it's really affecting me." Sensing her pain, I sat down and asked her to tell me more. Cindy told me that she had been facing this problem for almost a year, and it was becoming very bothersome. She saw the reflection of a man when she looked in the mirror, and her friends had stopped using her college moniker "Cindy with the nice hair." She then reached into her purse and pulled out a plastic Ziploc bag that was teeming with hair. "See, I haven't been making this up!" she exclaimed as if the bag were evidence in a court of law.

Realizing she was deeply affected by her hair loss, I locked eyes with her and explained that I believed her and wanted to do whatever I could to help. After conducting a hair exam, the diagnosis was apparent—female androgenetic alopecia. However, it seemed like so much more than just a medical condition to

Cindy. It was like she was slowly losing a part of herself.

The very next day, I met Adam, a 16-year-old male patient. As soon as I walked into the room, I immediately noticed his receding hair line, which was about two inches shorter in the front than it was on the sides. I also saw that he was slouched in his chair and kept looking at the ground. Surprised to see such a young patient in the outpatient clinic, I asked what brought him in that day. "Well . . . I'm here because I think I may have a hair issue. Recently, my classmates have started calling me 'baldy.' At first, I thought it was a joke, but I am starting to wonder if there is any truth to it. I really want to know if I am going bald."

As I analyzed his hair growth pattern and distribution more thoroughly, there was no denying it. He had early onset male pattern baldness. After discussing it with my attending, we carefully delivered the news to him and explained that he was likely to have to use Rogaine for the rest of his life (or undergo a potentially costly hair transplant). Although a little disappointed by our inability to offer more, he was at least happy to have a treatment plan.

My experiences with Cindy and Adam reinforced the damaging psychosocial effects that hair loss can have. Why is hair so important? As I reflected, I began to understand that the answer has to do with identity. Our hair is a significant source of our identity. It is often present from birth to death and becomes an

integral component of who we are. Similar to how Alzheimer disease takes away our memories or how vitiligo can completely change our skin color, the hair loss process is like completing a puzzle in reverse, with parts disappearing until the overall picture becomes unrecognizable. Hair loss also can affect our cultural identity. For example, from wearing a turban, Sikhs can experience traction alopecia, a common form of hair loss in a religion in which long hair is highly valued. African American women can lose the hair in the center of their head, called central centrifugal cicatricial alopecia, and then can have to avoid wearing natural hair styles.

We need to do more for these patients. We can start by listening to and taking their concerns seriously. We can acknowledge their hair loss as a true medical concern and explain to them that it can lead to emotional and psychological distress in many patients, which may help them feel less isolated. Most important, we can support our patients and help them feel that positive change can and will come; there is hope.

Author's Note: The names and identifying information in this essay have been changed to protect the identity of the individuals described.

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