UNIVERSITY OF Southampton

The Higher Education Academy

Appendix 4b Southampton Medicine Qualitative Data (Staff and Students)

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Background to the Medicine Qualitative Data Report

Acknowledgements

This report draws on seventeen individual interviews and two focus groups with third year medical students regarding their experiences of early clinical placements. The section also reports on interviews with six clinical teachers.

The individual medical student interviews, preliminary analysis and analysis report were undertaken by Regina Karousou. The focus groups were conducted by Stuart Ekberg and Anja Timm. Further analysis and development of themes was undertaken by Faith Hill, Regina Karousou and Anja Timm. The final report presented here was written by Faith Hill.

The clinical staff interviews were conducted by Regina Karousou and analysed by Sarah Bignold, Faith Hill, Regina Karousou, Selma Omer and Anja Timm. The preliminary report and final report presented here were written by Faith Hill.

Methodology

All of the interviews were conducted with volunteer students who had responded to an open invitation to take part. All volunteers were interviewed where possible. At the time of interview, all of the students were on placement within their first clinical rotation. The interviews were semi-structured and followed protocols developed by the project team. They were fully transcribed and entered into NVivo. Analysis included in-depth coding of the interview data using framework analysis and further development of themes using the coded data.

Context

The BM programmes at Southampton are currently under review and major changes are planned from the start of the 2013-14 academic year. At the time of interview, however, for the majority of medical students the first two years are based in the University. Learning takes place primarily in lectures, small groups and practical classes. They also have some early patient contact: Year 1 has 11 GP sessions; and Year 2 has nine GP sessions and seven hospital sessions.

In the third year students have four days in a hospital or community setting and one day at the University each week. They rotate round three broad clinical placements: medicine, surgery and community. Students spend 12 weeks on each placement. However, as each placement is sub-divided they may spend as little as one week within a particular clinical discipline / sub-speciality. For example, within the medicine placement students are attached to general medicine, elderly medicine and palliative care.

At the start of the third year, students have an induction week organised by the Faculty of Medicine. During the week students receive lecture-based presentations from clinical teachers about the placements. They also have practise-based sessions regarding clinical aspects of the placements such as history taking, examining patients and other clinical skills.

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Findings from medical students

Preparing for clinical placement

Most interviewees reported looking forward to their first clinical placement and were keen to get first-hand experience of their future roles as doctors. However, some reported finding the idea of starting placements overwhelming, and at the beginning some felt lost and unsure of themselves. In the interviews students discussed the week-long introduction that takes place at the beginning of the year. Some reported returning to University after a long break without really thinking about clinical placements and struggling to engage with the task in hand. They also identified a mismatch between the support they expected from the introductory week and the support provided. They looked for more reassurance:

> *It [induction lectures] was a bit like "Well you turn up at eight o'clock and do ward rounds, and the more you do the more you'll get out of it". And you go, "Well great, but what am I actually expecting?"* (Sarah)

> *I know the university likes the whole thing about…just throwing you in the deep end and seeing if you can swim, which is fine, and it doesn't help a lot of people, like you just feel you're lost in some places.* (Adil)

> *And they [induction clinical tutors] kind of were a bit like, "Everyone loves surgery" but still in my head I was thinking, "It's going to be awful, it's going to be awful." 'Cos I think it's that kind of thing where, whatever you're on anyway, you kind of, because you haven't done it before, you just feel like, "Oh I'm just gonna look like a moron…" (*Camilla)

> *I wouldn't say it really did prepare us for third year because um it was – it was pretty heavy, the week. And there was a lot of information in there…* (Abigail)

In addition to the University introduction, students reported seeking advice from more senior students. Although many of the suggestions were similar, some participants appeared more willing to listen and pay attention to senior students than to the University introduction. Most sought suggestions a few days before the year started but some received information earlier from fellow housemates and friends:

> *From the older years, like they just told us what to expect and which doctors to avoid and which doctors to go with, yeah.* (Anna)

> *They said it was really good, but that you had to sort of put yourself out there and try and get the teaching and the learning that you want. Like people aren't going to come and find you to teach you, you need to go and be available, and be in the right place at the right time…* (Natalie)

> *…they [senior friends] said it was a lot of standing around, a lot of not, you know, getting involved, a lot of the time you're gonna be in the way. Whereas I would think that um we would be helping out more, doing more things that they would have planned for us.* (Adil)

Central to the advice students were given by senior students was that learning on placement had to be self-directed. They were advised that they had to be vocal and assertive if they were to get the most from their placements.

Starting placement

Students reported very different experiences concerning the start of their placements. Some did not go straight onto the wards, but attended a number of placement-scheduled sessions dealing with theoretical and practical aspects of the placement:

> *…you're always told, "This is the start of your placement, so you'll be out there" and then you've got a week of lectures before you start really going out there which at the start it's like you think, "Oh God, still we're in lectures… ".* (Lionel)

Despite his initial surprise, this student later reflected on how valuable these lectures were in prompting him to revisit knowledge gained earlier and preparing him for the placement.

Students who received less extensive preparation often reported feeling lonely and lacking direction. They appreciated that clinical tutors were busy; that some of the smaller hospitals were understaffed; and/or that there were the quite large number of medical students around. However, many felt that they needed more help when they first arrived:

> *I found that I spent an awful lot of time hanging around waiting for something to happen and for someone to tell me what to do.…* (Sarah)

> *Where do you start? You don't know. You need someone to tell you.* (Lionel)

> *When we went on the ward in the afternoon there was no one there, no consultant. And we just arrived, and the junior doctor was really busy… and he was, like, 'Oh go sit in that room.' So we literally sat in the room for … four hours and did like nothing***.** (Carole)

Although these were common complaints, some students found a way to hit the ground running:

> *…on the first day I got to write in the notes. And this guy, who was one of the registrars, he just gave me these notes and was like, "Write this, write this," and started like teaching me how to kind of – because in certain specialties there's different short-hands that you use for different things. … So on the first day I'd kind of written in about four patients' notes.* (Camilla)

It is possible that getting started was easier and quicker for students in smaller hospitals where there seemed to be more clinical tutors and fewer students. It may also relate to the particular discipline and the amount of structure provided, as will be discussed below.

Taking responsibility for learning

In their initial placements, students often found it difficult to rely on their own abilities and take active responsibility for their learning. They were looking for guidance, feedback and general reassurance about their knowledge and abilities. When the interviewees were asked directly who was responsible for the provision of learning opportunities, there seems to be a mixed response:

> *…I'd say maybe it's 50/50, that 50% of it is um them giving you the opportunity, and the other half you have to make that opportunity.* (Adil)

> *I know I said that thing about making your own opportunities, but I think you can make your own opportunities if people are welcoming. If people don't want you there, you're in the way and they're not interested in you, you can't really make your own opportunities, it's much more difficult.* (Camilla)

Students reported that, by the time of interview, they were beginning to realise they did not gain much by sitting around and waiting for something to happen or someone to tell them what to do. They recognised the need to take charge:

> *…if it's not a busy day in that department [phlebotomy] or they normally have bloods and cannulas to do but not at the moment, don't just stick around and hope for something, do something else and come back another day.* (Lionel)

I would say make your own opportunities, don't just wait for them to be handed to you, because they might be or they might not be. If you're not doing anything, don't just slope off to the library, try and find something clinical to do, because you learn so much more. (Camilla).

…sometimes you're on the ward and there's no one to sort of guide you, no one to assist you, and so then you could go and speak to the patients and take histories and just talk to them... (Luella)

On some occasions, students felt a personal conflict between their learning needs and how busy the doctors were. Some students concluded that to make the most of placements they had to put their own needs first and not worry that their learning was putting pressure on clinicians:

…I felt like I was um bugging the doctors and bugging everyone. But I felt like I had to do it, maybe, to get any learning out of it. (Luella)

Where the participants found there was very little to do or when they did not seem to learn anything more by following clinical tutors, two alternatives seemed to be quite popular: working through the sign-off sheets of basic competencies or going to the library.

…we had a sheet we had to get signed off, and by the last week there were quite – like a few things left that we all had to do, so we were like just trying to get all these things signed off really in the last week. (Carole)

...when there's no one there to help you then I just found it was better to be at home revising or be in the library revising, than to just stand on the ward and do nothing. (Luella)

A core part of their thinking was the importance of keeping themselves busy by doing something relevant. For example, the need to make the most of the learning opportunities in surgery encouraged many students to prepare by brushing up on their knowledge prior to attending the procedures. Some did this just before the procedure, while others said they needed considerable time in order to feel secure in their knowledge.

So if I'm gonna go watch a surgery I make sure that I've done some amount of work, some type of preparation, just in case the surgeon, while he's doing it, is asking a question about the procedure… (Adil)

Spending like five minutes before you go into an operation just quickly reading about it, or five minutes before you have a tutorial, doesn't take you very long, but it gives you a big leg up. (Carole)

The participants reported keeping notes of particular types of things – usually medical conditions – that they had learnt or practiced while on placement. Making notes allowed them to enhance their learning at home by doing additional work and keeping up-to-date. However, balancing learning while at placement and doing additional studying at home was not easy:

And the first four weeks of surgery you're trying to get to grips with it, and to try and cover two specialities, upper and lower GI, you're still trying to get used to how the theatre system works, where your consultant is, and read up on some of the stuff you've seen, trying to cover upper and lower GI in the four weeks, I don't know, I haven't really…felt I coped with that all that well. (Lionel)

The degree of responsibility the student had for their learning was seen to be linked to the amount of 'structure' on a particular placement. Structure refers to the amount of learning organised by the placement. Many students appeared to welcome a structure to their day, reporting that this left them to concentrate on their learning. Students described differing amounts of structure depending on the placement they had experienced:

> *It [psychiatry placement] was all very structured, everything was very timetabled, even for like work that we had to do in our own time, there was a group project that we had to do, even that had a space timetabled in saying, "You can do it at this time on this day."* (Natalie)

> *...paeds is really good, because it's all timetabled, we had quite a lot of specific lectures and twice a week, for instance, we had like a rotation thing.* (Abigail)

> *I think rather than being just thrown in [medicine placement] and just told to get on with whatever it is you want to do, having that structure with a timetable and sign in sheets was really, really helpful.* (Aina)

> *… I do also like, at the very beginning, bit of structure, bit of guidance from someone from a top…person that knows what they…should be expected of as at third year, they've got some idea. "Right, what do you want from us?" "We want this. We want you to practice this, this and this at this stage. Go."* (Rose)

Some students preferred less structure, especially as they began to realise the opportunities available. One participant described in positive terms the lack of structure she experienced in surgery:

> *We haven't had that [structure] in surgery ... you are very charged in self-directed learning, which I'm a fan of anyway.* (Rose)

Earlier, this student had described how her surgery attachment had little structure and she was left to read the learning outcomes and identify for herself what was expected. She reported that, over time, she had come to realise how constructive this was for her learning as it encouraged an independent approach. She also knew that the clinical team would be there to support her with any questions she had. She reflected that in order for her to become more independent, she had needed initial reassurance from the consultant. Many students are keen to make the transition to self-directed learning but look for support to be available in the background:

> *I think we should be left alone so that we can figure things out for ourselves, but have that back up support there.* (Luella)

Overall, therefore, most students are looking for support and direction at the beginning of placements but also appreciate staff allowing them increasing autonomy as they progress.

When describing how they were adjusting to particular placements, participants sometimes spoke of a sudden moment of realisation when things just seemed to fall into place. Others describe a more gradual process. Some felt that it had taken them longer than others to gain confidence because of the way teaching was distributed between students. This student gives us an example:

> *But the other part of it [paediatrics placement] was we were just given a ward allocation for a week and they'd be like, "There you go, go and do it." And I really struggled, I don't think I got to grips with it until the last two days. Um and then I was like, "Oh can i do it all again now? Because I know what I've gotta do." … So some people had bedside teaching first, which meant that they were with a doctor like in their first week, and they got to see how to do an examination and things like that. I didn't have that until my last week.* (Abigail)

Because the student did not have the opportunity to shadow a clinical tutor until very late on her placement, she felt she had been disadvantaged. She also reported that because of her fear of what might happen, she did not volunteer in doing more than the minimum of patient examinations and histories. Some students seem unable to set aside their negative perceptions of what will happen on placement until they are able to observe for a while. This may reflect the difference in learning styles that would be expected across any cohort of students but would seem to have considerable impact in clinical learning situations.

Students also discussed the importance of making mistakes now, rather than later when they would be responsible for patient care:

> *But now, if there's any opportunity to do something, I'll put my hand up and say I wanna do it, just because that's the only way to do it. And I'd rather screw up when someone's watching me, like the doctors are watching me, or like even if other students are there watching, it doesn't really matter, as opposed to when it actually matters when I need to be doing it.* (Adil)

Becoming part of the team – fitting into the clinical environment

Students discussed the importance of becoming part of the clinical environment and feeling as if they were part of a team. They felt it was important to have some role within the hospital.

> *Yeah it's great when, like, the consultant turns around to you on your, you know, your first day and he'll be, like, "So you guys are my students for the next four weeks, well just so you know, I consider you guys part of the team." (Focus group 1)*

> *…you wanna be seen by your team to be keen, and that sort of leads to more opportunities, 'cos if they know you they're more likely to – if they've seen you around and seen that you're keen they're more likely to give you a better experience of your placement…* (Lionel)

Some students reported taking an active role almost immediately; for others this was a more gradual process; and a few of the participants reported not feeling part of a team until the last week of their placement.

Students learnt much more from the team than just being able to take a history and present it to the consultant. Feeling part of the team allowed students the opportunity to engage in a range of clinical and non-clinical tasks in order to learn more about the medical profession. Having an opportunity to contribute to the workload of the team made the experience stand out for them.

Students talked about a hidden contract between students and clinical tutors. Students are aware that there are a range of learning opportunities that they can access on their clinical placements. In order to make the most of these opportunities, they highlighted the importance of being proactive and having done work in advance, showing up and appearing enthusiastic and eager to learn. They added that through asking questions and finding out how they can contribute to the workload of the team, they can gain more teaching in return:

> *There were four beds and one SHO, and they had to kind of organise the bloods, organise the scans, do the x-rays… So by you taking like a half an hour really detailed history and then presenting it to them, they could just go and check it in five minutes, rather than having to spend their own time doing it. So you did actually feel like valued and part of the system…* (Camilla)

Building rapport and trust with the clinical team required time for students to form relationships and get to know people. However, the amount of time students spend within each clinical placement is limited, so establishing such relationships can be difficult to achieve. In addition some students said that becoming part of the team was difficult due to the busyness of the hospital environment and the time constraints on the staff.

The interviews suggest that students identified a hierarchical clinical structure, with the consultant seen as on top, followed closely by registrars and senior house officers. They perceived the junior doctors and nurses to be at the bottom of the hierarchy. This 'knowledge' seems to guide participants' learning and help them fit into the clinical environment. The consultants are seen by students as all-powerful and there was a sense that some are to be avoided:

> *…I was talking to someone and I'd come out, and they'd [nurses] go, "Are you all right?" I'd just go, "Ooh bad mood." They'd go, "Hmm, hmm didn't you know you have to avoid him [the consultant]?" And you're like, "Yeah I know now." …. And, you know, it's not like you're sharing a private joke, 'cos everyone knows. But, you know, you feel like, yeah, you're a member of the team.* (Sarah)

There seemed to be a widespread agreement amongst the interviewees that there are times when students do not feel a legitimate part of the clinical environment:

> *…there were times where I was just feeling, you know, invisible, and I just felt like a spare part and didn't know if I was learning anything at all.* (Luella)

> *…[people] can have very little time, but still make you feel like it's OK to ask a question. It's when people don't allow – don't make you feel that, make you feel like you're allowed – and make you feel like you are a nuisance being there.* (Abigail)

> *You'll spend a lot of time not knowing what you're doing and being yelled at and getting in the way, and that's gonna happen for quite a few years more.* (Sarah)

Attending team meetings was one way that students felt they could become part of the team as well as gain a better understanding of how the hospital worked:

> *Well what really happens on placement is you do see how teams work and you do see individual characters, so you see doctors as people, and you see the nurses interacting with each other… And you go into multidisciplinary meetings and you see them all talking to each other… And you see them looking at slides from histology that you had learnt in first or second year, and you see them really analysing it and interpreting it, and you see them talking about it in a different way.* (Luella)

Students often reported becoming familiar and comfortable with teams on a particular placement, only to move to another placement where they felt they had to start all over again. They might still have a familiar pattern to the day (such as ward rounds and clinical sessions), but getting to know the new clinical team and the 'rules and regulations' of a new placement can often mean going back to 'square one' - and can take a considerable time.

The very real differences in placements are seen as a source of confusion to many students. They highlighted that adjusting to a new placement meant more than becoming familiar with the physical environment and knowing what the consultant expects of the students. There seemed to be a different ethos and philosophy embedded in each placement which influenced the nature of the student experience. This impacted on the manner in which clinical teachers interacted with patients; the number of patients seen each day; the type of resources and teams that were available to them; and the nature of the physical environment. The difference was often most noticeable between hospital settings and the community.

Learning from clinical teachers

A number of the participants reported that some clinical tutors appeared more enthusiastic and willing to teach them than others. They were also quick to identify characteristics they perceived as 'good' and 'bad' clinical teaching – particularly in consultants. Good attributes include: enthusiasm; setting the scene at the start; and acting as good role models. Bad characteristics include not valuing students' contributions, not directing their learning or failing to acknowledge their presence.

> *Some of them are really just, you know, "Let's get excited." And I love that enthusiasm.* (Aina)

So you have ones who are really keen to teach, there are ones that don't even remember your name after four weeks, and there's ones in the middle that are just, you know, they're indifferent to whether or not you're there. (Adil)

…he personally printed off, and emailed all four of us, what he expects of us, what he would like us to do, what the aim is for the next three weeks, what his timetable was… you've got a set-up, you've organised, you already know what's expected of you from day one. (Rose)

…some of the consultants were really good, but some of the consultants didn't really know how to teach as well, and so would just ignore the medical students and just get on with their job. (Luella)

…what I find difficult is um consultants; they're difficult people – not all of them. ...But in general the difficulties are the consultants who seem to forget that they were once medical students. And that sounds quite stereotypical, but actually it is quite true. Quite a few do just seem to have forgotten. (Abigail)

Students felt they needed to 'adjust' to the approach and style of the consultant in order to get as much as they could from the opportunities they were offered. Different styles of teaching were described, for example:

…he [consultant] was doing keyhole surgery, and he got me to hold the camera, and he was like, "If you hold the camera right I will teach you. If you hold it wrong I'm not speaking to you." (Camilla)

… [some] welcome you with open arms, …instead of, "Right, I've got my ward round to do, you follow, you get involved" and no teaching involved, which is kind of what's happening with me in surgery now. (Rose)

…just different characters, which is the beauty of it, and the beast of it as well. Because obviously some you won't get on with, some just won't get on with you, you know, and their teaching style you won't get on with, so that's difficult. (Rose)

In particular, students discussed teachers who adopted a 'teaching by humiliation' style.

There was a consultant I was with, which I find it quite – quite demoralising every time I see him, because every time I see him then he will ask a question. He will ask a question, and I will answer, and then he will – he will go in deeper, in greater depth. And (the extent that I could answer), he – sometimes he would say, "Oh no, even my 5 year old can answer that." Then the whole group of us would be like, "OK," you know. So sometimes it's just like that, yeah. (Wuji)

…when they [consultants] ask questions and you panic, you don't know the answer, and then you'll probably get it wrong, that makes you feel really uncomfortable because you're like there squirming in front of everyone else and they kind of let you squirm. (Sarah)

You kind of get so caught up at the time over the consequences, but actually if you take a step back there aren't any consequences of us asking the wrong questions. All that's gonna happen is we're not gonna be able to say to the doctor, "I think this is what it is," and the doctor will have to go and do it again. (Abigail)

…like if you get grilled, you get grilled, it's not the end of the world. If you get grilled and screamed at, it doesn't matter, like tomorrow is a new day, and you might have somebody really lovely tomorrow. (Camilla)

Some students reported feeling fearful at presenting in front of the clinical teacher, partly because of the fear they may be humiliated, censored or found wanting. There is a sense of being overwhelmed by the formality of

the experience and by the perception of the consultant as all-powerful, especially when compared with their low status. Fear, particularly fear of humiliation, seemed to be very significant for some students:

> *...you go and see a patient and then you have to come and tell the consultant what you've found out, but there's like a formal structure to it, and you've got to make it as clear and concise as possible, and get all the relevant information across, that's very nerve-wracking every time.* (Natalie)

Students also talked about consultants who favoured a more gentle or friendly approach. They appreciated clinical teachers who found time for them and gave them encouragement and positive feedback:

> *I've been with some friendlier consultants and they were like, 'Yeah, it's a good try,' and stuff like that, so you feel like motivated to go on, move on, and go back and study more, and try to impress them more and more, yeah.* (Wuji)

> *And she [the consultant] was really nice about it [dealing with bad news] and, you know, she just gave me that time off, and it was really good of her, and she just talked me through it, and it was really nice of her. I mean I'm a lot better equipped to deal with it now. (Aina)*

> *…there were four consultants in obs and gynae for me, for my group – I've met three, 'cos one he is like doing IVF, and I wasn't really that interested so I didn't bother to go and find him. I met the other three, one was obstetrician, and the other two was gynae. I didn't really like the obstetric guy. Um the other two gynaes were amazing, so we just pick between one of them, and like we just went with him and like just went for his theatre…* (Anna)

Even though participants recognised the expertise of the consultants, other members of the team were highly valued as teachers:

> *…you don't get the majority of your teaching from the consultant. … the juniors teach you a lot of like clinical skills and kind of cannulating and stuff like that. And the SHOs teach you a lot about history taking and presenting. And then the regs teach you like knowledge and stuff like that.* (Camilla)

> *Junior doctors are lovely, er and more than happy to help you out normally, and actually pitch it at the right level. … If you've you got questions or you want to understand something, you ask them. Because a) haven't done it that long ago b) remember what it's like to be you.* (Abigail)

The majority of the medical students interviewed see junior doctors as younger, more approachable and easier to talk to than registrars and consultants. Junior doctors are also seen as more likely to empathise with the students as it is not that long ago they were in a similar position.

As discussed above, students discussed the importance of 'shadowing' clinicians and learning from them by observation. Some preferred to do this for some time before taking histories or examining patients themselves:

> *If you can, try and um – try and find somebody that you can – even if it's a junior, like find a junior that you can kind of feel comfortable just to say, "Can I follow you around for the day?" And kind of get used to, even if you're not thrown straight in to go and take a history for a patient, just stand there and watch a junior do it, or watch an SHO do it, just ask if you can just shadow them for a bit.* (Camilla)

Students also discussed the importance of feedback from clinical teachers. Taking time to comment on students' performance and give clear evaluations, are seen as helping students enhance their understanding. Even when feedback is negative, students recognise that such interactions can help them learn from mistakes:

If you get it completely wrong, and then they laugh at you and tell you the right answer, you're bound to remember for the rest of ever. So this is probably quite a good time to get it completely wrong, and get completely embarrassed, and never wanna come to the hospital again. (Sarah)

…is having these experiences, these sort of difficult experiences, and realising what you did wrong or why, and going from there and not making the same mistake, or doings something different next time. (Lionel)

I remember standing beside the bed with this child, and having a chat with the mother, and kind of just generally playing with the child, and then coming back to feed back. And she [consultant] was um… "So did you get a respiratory rate?" And it was like, "No it was really difficult, she kept fidgeting." "And did you get a pulse?" "No, well, no, not really." And she was like, "OK well right, this is what you need to be doing." (Abigail)

And we did have some people sat in like observing you take a history, and then afterwards they say, "Well you didn't ask this," or, "You could have asked this better," or, "You could have – you know, that question went a bit waffly, so you could have said that better," and just kind of giving you feedback on what you've just done. (Natalie)

On occasions the students were particularly proactive in seeking feedback:

...I got to my last week in paediatrics and I was like, "I really haven't grasped this," so I emailed her [clinical skills tutor]. And she took me on the ward, and I wouldn't say that I'm massively more confident now, but like she was like, "Well I've got half an hour, I'll take you on the ward and we'll go and do an assessment. And it was just having that someone there who was willing to take me on the ward and examine a child and be like, "You can do it, it's absolutely fine." That's all it took. (Abigail)

Others were very critical of instances when they felt they did not receive enough feedback:

…there wasn't really anyone there to help us or watch us do – taking examinations or histories and things like that. (Carole)

No one ever marks you, no one ever tells you you've done anything well. They'll just tell you to do something, and come back when you've done it, or have not done it. And if you get the questions wrong, they get grumpy. If you get it right they'll just carry on. … There's very little positive feedback. (Sarah)

…sometimes, like on the wards it just is so busy, you either don't have a chance to feed back or it is a, "Oh two minutes, and I'm relying on you to give me the right information. (Abigail)

Not only were students critical of a perceived lack of feedback, some also complained of limited access and availability of clinical teachers generally:

But then when we went on the ward in the afternoon there was no one there, no consultant. And we just arrived, and the junior doctor was really busy ...and he was like, "Oh go sit in that room." So we literally sat in the room for ... four hours and did like nothing. (Carole)

With surgery it's been a bit different because we've only had one consultant each time. And if they're away it's very difficult. I mean thankfully mine haven't been, but I know other students who have had consultants who have been ill or away at a conference…and that's half of your placement… (Lionel)

I was quite lucky that my consultant had a clinic that morning at the hospital, so I did actually meet the person, and so I started quite quickly. Um and that was very lucky, 'cos I've got friends who didn't meet

> *their consultants for weeks, and that was much, much harder I think, 'cos you have to impress your consultant to get him to sign you off.* (Sarah)

It is interesting that students sometimes describe the availability of clinical teaching as 'lucky'. There seems to be a widespread belief amongst the interviewees that ending up in a good hospital, getting a good consultant, and having good learning opportunities, seemed to have a strong element of chance.

> *And I've been very fortunate, I've had really good clinical experiences all the way throughout the year. But it was really structured and it was really good. And we had loads of people watching us take histories and, you know, making sure that we're doing it right, and being told very sternly if we did it wrong. But it's all useful. (*Focus group 1)

Working with and learning from patients

Learning to feel confident and relaxed around patients, especially during examinations, proved a steep learning curve for many students. For some of the participants worrying that they might upset or even cause harm to a patient made them reluctant to approach a patient:

> *…there was a couple of children who weren't very happy about having somebody trying to examine them, you know, they didn't want to be touched. And you think, "Oh I'm just a student, you know, I don't want to upset them."* (Natalie)

> *And you have to be careful and gentle and sort of if – 'cos you've not got to hurt them, but at the same time you have to find out what's wrong. … that's a bit scary when you feel like you're hurting someone for the first time, or the patient you've been following deteriorates…* (Sarah)

> *Sometimes the patient just looks so sick and you just don't want to give them more pain.* (Wuji)

When seeing patients for the first time, students found themselves struggling on the one hand with their own personal insecurities and on the other being able to perform as medical trainees. On the whole, however, students reported enjoying talking to patients, listening to their stories, and understanding their conditions:

> *And if you talk to an interesting patient with an interesting story, it's so much better to learn about a disease by someone saying, "Yeah I've been vomiting up blood, and it looked like coffee," you'll remember it, than if you've read in a book that it looks like coffee when they cough up, because it's just one of a million other words on that page. In fact I'd say, you know, in bed A3 on whatever, there was a person who coughs up coffee because they have endometriosis.* (Sarah)

> *I find it really nice talking to patients and finding out what they like. And also, like, when they have symptoms and signs and they tell you and you sort of figure it out, you know, it's different from the text books. And reading something and then having to investigate something, it's a bit like, you know, a little puzzle putting it all together.* (Aina)

The pressure to perform clinical skills successfully and confidently and to present the patients they clerked to the clinical tutor, often seemed to be at the forefront of students' minds. Students had to become competent in a number of clinical skills and would first have to practise those skills on plastic dummies with a clinical teacher:

> *… they [clinical teachers] like take you through it [taking blood] really slowly, and they teach you again on a plastic arm, and then you go to the patients, you watch them do a few, and they they're like, "OK your turn." And then they help you through it…* (Carole)

When talking about how they accessed patients during their early clinical attachments, students said patients were often identified for them by a member of the clinical team. For instance:

> *...if there was something interesting on the ward round, the consultant would be like, "You go back later and go and feel that abdomen, or go and feel that…." And the next day they would ask you if you'd been to see it ...* (Camilla)

> *...all you need to do is say to one of the nurses, "Can I go and clerk a patient?" and then you can go and do that. We were asked by a registrar, he said, you know, "This patient is interesting, go and examine then, ask one of the F1s to chaperon you." So we went and did that. And if we hadn't have asked them to do it, obviously…they wouldn't have known to come and sort of help us out, in a way.* (Lionel)

However, it also appeared that some students selected patients who they thought would be easiest:

> *…30 to 50 age group is probably the best with respect to like teaching, teaching me and like helping me out and giving me easy answers that I need to know, and definitely making clerking a lot easier… when you get to the older age groups, like 70s and 80s…a lot of people are delirious and it's just very hard to talk to them.* (Adil)

> *They're [older patients] very much like they want you to learn. And the amount of times I've heard from an older lady, "Oh you've got to learn, don't worry, it's fine." Like whereas young boys, like I did this one guy in A&E, he screamed the house down, and he had like thick skin, so it was kind of much harder, it was – it was horrible. But then the SHO [Senior House Officer] couldn't do it [putting a cannula] on him either, because he was really muscly.* (Camilla)

Some students talked about the difficulties of finding patients who have not been seen by other medical students. This can be problematic in particular at smaller hospitals where there did not seem to be enough patients. On occasions the students found that particular patients did not want to see a student:

> *Some of them [patients] are like, "Oh I've already had two medical students today. Not another one. Come back tomorrow" kind of thing.* (Carole)

> *I've only had a few patients that said no. … probably because it involved genitalia or something like that or else they just don't want to be prodded around. They've had enough people doing it to them already.* (Taine)

Alternatively, the students themselves might not feel ready to do a particular examination:

> *…in GP practice um we had to do a breast examination on a er – on a woman who came in. And it was – I wasn't prepared for it.* (Taine)

Working with patients led some interviewees to reflect on their own motivation and approach to medicine:

> *…it [learning] doesn't become about you anymore, it's not "I need to learn this so that I can pass year three", it's, "I need to learn this so that when I graduate I can give the best possible care to my patients".* (Luella)

> *…It's not [being a doctor] just about treating the disease, but rather like forming a connection between the patients, to be able to understand the patient having the disease, rather than the disease on the patient.* (Anna)

> *…you just get so caught up in kind of the medical model and thinking, "Have I thought of all my differentials, am I asking the right questions?..." And you get so caught up in that, that you kind of – you forget to listen and see the patient in front of you.* (Abigail)

Students learning together

Students also reported that they valued learning from other students, especially when they were paired up during history taking. Although this was not regarded as the main route to their learning, they often described feeling relieved to have someone else to practise with:

> *...one person would take like a back seat, the other person would talk to the patient...* (Abigail)

> *Sometimes we like went and did history examination in pairs, which I actually much prefer, I like having someone else there like just to help you. And they can see if you're doing anything wrong and they can tell you.* (Carole)

> *It's good to be able to talk to people about placement, and realise that other people are having similar problems to you or where's a good place to go, or what they've done, what you should think about doing perhaps…* (Lionel)

> *I went to my flatmates' house, the ones they're now in their fourth year, and they were saying that in their third year they did study sessions and they taught each other, and that they found it really helpful.* (Luella)

> *I've got involved and created like an informal sort of support group now for the year, the BM4 second year, with whoever wants to meet me, and I've given my email address, and they can contact me if they've got any questions or anything.* (Rose)

One student described how half way through the year she set up a study group with similarly minded medical students. The group met up fortnightly for a two-hour teaching sessions. Each member of the group, would pick a topic, learn it and then teach it to their fellow group members. The topics were drawn from the list of learning outcomes they had to complete by the end of the third year. Besides using the group for academic purposes, she said that students also talked and shared their experiences of their placements.

Not all students reported finding the advice from other students useful. The following quote illustrates how student advice can be misleading:

> *…my current placement kind of like took - because it's third, the two types of students who had it first and second build me up that it would be really hard, everyone would hate me…when I turned up, I came home and said, "I've had a fantastic day." She goes, "Really?" I said, "Well, it probably wasn't fantastic, but compared to what you told me it was gonna be like, I've had the best time of my life."* (Sarah)

Emotional and personal responses

Many of the interviewees reported feeling very positive about their early clinical placements. Being exposed to a variety of teaching practices and having the opportunity to interact and examine patients, observe the staff in situ and gain hands-on experience were some of the benefits that were identified. Some stated that the active, experiential, 'on-the-job' learning involved is more valuable than any amount of classroom learning. Some discussed the importance of enjoying the whole process:

> *…enjoy everything…I really enjoyed those long hours though, 'cos I was like, "I'm learning so much," and I was full on and, you know, I was so hyperactive. It's just go in with an open mind and just enjoy it.*(Aina)

… have fun, enjoy it. Enjoy being with the patients, enjoy learning about this subject. Because it is so much fun, it is, you do have a lot of fun with it. … But um yeah – no to enjoy it and just have fun and learn whilst you're enjoying it, because this is what you're here for. You've got plenty of time to start mastering things and getting to know to the level that they expect you to be at already, but you've got plenty of time for that, so relax and enjoy it. (Rose)

When the students were asked about the aspects of learning that they enjoyed most, they identified the value of witnessing for themselves what they will be doing in the future, becoming more involved in patient care and feeling part of the team.

You see the job that you're gonna do. You see the type of person that you need to be in order to do certain specialties. … Um you see other doctors working, and you see what the jobs you're gonna have to do as an F1 are from the very beginning. (Lionel)

It prepares you, rather than having one year to prepare and going straight into work, it prepares you a lot earlier on. (Aina)

As described earlier, working closely with clinical staff, feeling part of the team and learning from patients all enabled students to learn and to feel engaged:

And I do really enjoy going and clerking a patient, but negotiating with the consultant that's going to see them and they say, "Right, go and clerk them, go do it in your own time, try and make it about 40 minutes, 45 minutes, write it down, have a think, present it back to me, and then we'll go see them together. Like this is what happened on AMU for me, and I absolutely loved it, and I felt part of the team, I felt competent. I wasn't made to feel – you know, if I didn't get anything right, "No it's fine, it's fine, this is learning, that was brilliant. I got feedback, they said, "You've gone and you've done it, you've clerked a patient properly," it was fantastic. (Rose)

The students also felt a degree of relief that they were allowed to make mistakes. As discussed above, there was consensus among them that making mistakes while they are still students and closely supervised is more acceptable than after they have graduated. Students also valued the opportunity to see that mistakes are made on a daily basis and how these are handled:

In some ways we've probably – you're more comfortable about the fact that doctors do make mistakes and doctors aren't – don't know everything. So you see that on a day to day basis, and that's quite comforting. (Taine)

While there was much that students enjoyed about their placements, there were also emotional challenges for them. One such challenge concerned the need to balance competing demands. This was particularly true for those students who had additional commitments such as childcare. Failing to get the balance right could impact on students' performance and self-perception of their abilities and knowledge.

...it just makes it quite hard when you've already got so much learning, so much reading, you're really out of your depth, you're juggling about 30 different balls in the air, so a lot of the time you are in survival mode, and it's not a good place to be, because you're not performing at your best and that just makes you feel more rubbish. (Rose)

The extent to which students appear and feel confident, seems to impact a good deal on their learning experience.

> *I do think a lot of the time though you have to seek it [learning opportunity] yourself. And that's why I think I feel a lot of students who don't have that gumption, who don't have that confidence, won't. And a lot will just not turn up.* (Rose)

> *…I know there's some people that have now decided that they hate it and they are thinking about dropping out. Some people are finding it really hard to deal with the stress.* (Carole)

> *I basically didn't do an examination, I don't think, my whole time on paeds, um just because I wasn't particularly confident.* (Abigail)

Students also talk about the need to accept both good and bad days, and to be resigned to experiencing bad days on placement.

> *These things are gonna be there, you're gonna meet people that are not – you're not gonna like. You're gonna have teachers that you don't like. You're gonna have situations that are gonna make you feel absolutely crap. And even patients can, they can talk to you – you know, patients can make you feel horrible. So you're gonna get it from all angles.* (Rose)

Bad days included occasions when students encountered particularly emotional issues relating to patients. Feeling sorry for patients or upset by their experiences can prove very distressing for students.

> *I was quite lucky in medicine not to see patients dying in front of me.* (Anna)

> *I'm just – I'm still getting used to the whole concept of death.* (Aina)

> *So if someone's told you, oh yeah, they've been abused and stuff, you – it'd hit you, but you'd be like, "Oh OK." But then I suppose throughout the day you'd keep thinking about it without realising, and it's like it gives you a more pessimistic outlook on life and on humanity, I suppose, and it's like everybody's bad almost. And it – it doesn't feel so good. So that's – emotionally it's quite difficult. Um and especially if children are involved as well, like a lot of things happen with children, that's quite disturbing. (Taine)*

> *I can't let my emotions get – get the better of me. It's not very professional and it just, you know, it just – you need to build up – because I'm going to be seeing so many patients in the future, I just need to learn how to take it. I can't break down and cry every time I have to break bad news to someone*. (Aina)

As well as finding many of the experiences distressing, students also felt a degree of conflict between what they were seeing or hearing from clinical staff and what they had been taught in University. Sometimes they reflected with strong emotions on their attempts to reconcile their experiences with their own views. Other times they appeared to reject what they had witnessed. For example:

> *I think there is a lot of prejudice that shouldn't be there. And there are times when you can't help but be judgmental because it's just an instinctive reaction. But I think if you can kind of try and stop yourself from having that, why would you not? Because why would you want to be in a situation where you think, "I don't wanna treat that person"? It makes things very difficult. And I also think it was very unprofessional of him to pass that opinion on to me…So I think …there's um conflicting views and things like that.* (Camilla)

> *Little things like, yeah, not drawing the curtains round, just little things, you know, not introducing the people that are with, and you've got like six people there, waking a patient up with six of us, and telling us all to come in and draw the curtains round when they're asleep, and this poor woman wakes up to all these heads. And I wanted – I did, I said it under my breath, I said, "I absolutely hate that." I would have hit him (laughs). Well maybe not hit him, but I would have been – I would have been really angry.* (Rose)

*I think under NHS it's not about – I mean you can be a very good doctor, but if you spend long time in a consultation with a patient you're not a good doctor, but if you are just a moderate doctor and you speed things up and complete the numbers of patients within a day, you are a good doctor. I think that's not really the right way, but if that's the system and you are in the system you just have to follow that. (*Adil)

Overall, students enjoyed their placements but realised that learning medicine was never going to be easy. This is nicely illustrated by the following focus group excerpt:

Although being at the bottom of the food chain is crap, I've kind of come to just understanding you will be….. there's definitely times when you're just like, "I wish the ground would swallow me up. …that although we've told you most of the bad points about it – I mean I dunno how you guys feel – I'm so very glad that I'm here.

Yeah, I couldn't think of doing anything else.

And I couldn't think of anything else that I would rather do. Like it's difficult, but then I think you're a fool if you go into medicine thinking it's gonna be easy. I mean the people who are like, "I didn't think it would be this hard," and I go, "What did you think it was going to be?" (Focus Group 1)

Summary of medical student findings

Third year medical students in this study told us that they:

- Appreciate the University induction week but want more opportunities to discuss their concerns and to get emotional support during the week.
- Value introductory information and guidance from more senior students.
- Want more guidance and structure at the start of each placement and some would like this throughout their placements.
- Recognise the importance of taking responsibility for their own learning and appreciate the autonomy they are given once placements are underway.
- Appreciate the opportunity to shadow and observe clinicians at the start of placements and some resent situations where they are expected to make a start without this opportunity.
- Worry about making demands on busy clinicians and sometimes feel in the way.
- Have trouble juggling the competing demands of placements, academic work and home life.
- Welcome opportunities to be part of the clinical team but don't always find it easy to fit in and sometimes feel invisible.
- Consider that helping out clinicians can gain them additional teaching and learning opportunities
- See hospital teams as strict hierarchies.
- Have trouble adjusting from one placement to the next and identify both practical and cultural differences between placements.
- Identify 'good' teaching: including enthusiasm; setting the scene; and acting as good role models.
- Identify 'bad' teaching: including not valuing student contributions; not directing their learning; and failing to acknowledge their presence.
- Dislike 'teaching by humiliation'.
- Like encouraging teachers and those who adopt a 'mentoring' approach.
- Make a conscious effort to adjust to different teaching methods.
- Want and value feedback and are critical if this is not forthcoming.
- Complain of limited availability of clinical teaching.
- Strongly value the opportunity to learn from patients.
- Sometimes become upset by the experiences of patients and do not want to cause them more pain or suffering.
- Like to have patients selected for them but can sometimes choose 'easy' patients for themselves.
- Complain that sometimes there are not enough patients for the number of medical students.
- Find that patients are usually, but not always, willing to be seen by them.
- Enjoy working with other students, sharing tasks and developing support groups.

Duration of project: August 2010 – October 2012

- Find it hard to come to term with issues such as death and dying and other distressing areas of medicine.
- Are surprised and confused by the degree of prejudice, cynicism and poor role modelling that they sometimes believe they observe in clinical staff.
- Have varying degrees of confidence and are aware that lack of confidence can negatively impact on their learning
- Sometimes avoid clinical learning if feeling a lack of confidence or unsure where to start
- Enjoy the opportunity to learn about medicine in an 'on-the-job' way.
- See good and bad days as inevitable and recognise that learning medicine is going to be hard at times.
- Think themselves 'lucky' if they end up in a good hospital, with a good consultant and good learning opportunities.

Findings from medical staff

Introduction

Six clinical teachers of medical students were interviewed for the Beyond Competence Project by the Southampton research team. The teachers were drawn from several NHS trusts and ranged from a relatively new FY2 doctor to a senior consultant with considerable medical education experience. The clinical teachers were asked to describe their roles within medical student teaching; what they felt makes or breaks a clinical placement; and asked a number of subsidiary questions that are shown in the interview protocol (See Appendix 2b). Analysis of the data was undertaken by researchers linked to the project and an independent consultant, using a framework analysis approach.

The main findings are presented here under three heading that emerged through analysis.

What the students bring to the placement

The clinical teachers placed a lot of responsibility for the success or otherwise of early clinical placements on the students themselves. They appeared to conceptualise students as belonging to one or other of two categories: keen, well-motivated students who were prepared for the demands of clinical learning; and those who were less so. They argued that students who are less good at self-directed learning and at seeking out learning opportunities will inevitably struggle in a clinical context.

> *The good students will really grasp the opportunities and get a lot out of them.* (William)

Staff identified issues such as cultural background, forward planning, personal confidence, being proactive and inquisitive, asking for help, and knowing how to relate to senior tutors, as aspects that can impact on how students experience a placement.

The students who learn a lot on placements were also described as willing to do things out of normal hours, when there are fewer students around and things are less pressurised, and they can go round the hospital with an F1. The interviewees reported that there is almost an unwritten contract between student and team – if the student mucks in and can do something useful for the team, the team will repay the student with some 'teaching'.

Graduate entry students were seen as particularly well prepared and motivated to learn in clinical contexts. Students with previous healthcare experience were also singled out as 'good' students. Younger students, with less life-experience and/or healthcare experience are seen as finding the transition to clinical learning more difficult:

> *….I think that transition can be really difficult for some of them. And you see them on the wards, and they just don't know what they're supposed to be doing. They don't really get being on a ward round and what they're supposed – like where they're supposed to stand, they don't really understand when they can speak, they don't really understand how to speak to patients very well. Whereas the ones who maybe have a bit more life experience actually are much better at kind of learning the etiquette, if you like, and maybe they're just much more comfortable talking to nurses, to patients, to everybody.* (Ebony)

Students who lack confidence and who don't ask or respond to questions are seen as less likely to gain from clinical learning:

> *… you always have a few like throughout the year who just they'll turn up for ward round but they're not really there, and they stand in the background, and they are not confident about maybe coming behind the curtain, and they're just a bit awkward. And they don't ask any questions, and if anyone asks them a question they'll*

> *freeze, and they don't know what to do, and they're not comfortable around patients, and they're just not comfortable in the ward environment.* (Ebony)

> *…they turn up for the teaching, but they are not going to the wards, they are not finding the patients, they're not getting the clinical experience they need.* (Elizabeth)

> *…it's very easy to stand in the background like a rabbit in the headlights and not really engage.* (Ebony)

On the other hand, while teachers encourage students to be pro-active, they are not keen on students who they view as too pushy and as asking too many questions. They find such students irritating and "too cocky" (Elizabeth). Mature students in particular are sometimes described as time consuming and demanding.

Clinical teachers are also critical of students who fail to turn up on a regular basis or who don't take advantage of learning opportunities that are made available to them. Some students are seen as too focussed on passing exams or on 'ticking boxes' – rather than from learning in the clinical context.

What the clinical teacher brings to the placement

The clinical teachers in this study emphasised that they did not see themselves as responsible for the students' learning.

> *You can make them aware of their deficiencies. Whether they go and do something about it is up to them. And one thing I don't see myself as is a nursemaid…* (Simon)

Students need to realise that they are responsible for "*managing their own education*" (Simon) which includes asking questions, reflecting on their gaps, and ensuring they make the most of the clinical tutors' time and expertise. The teachers felt that students were often unaware of the need to take responsibility for their learning but reflected that they didn't always see it as the teachers job to explain this to students.

While clearly stating that they are not responsible for the students' learning, teachers do see themselves as contributing to placement learning in a wide range of ways. For example, they say that students need to be given something to do in the wards and have their progress reviewed by clinicians. Similarly, they consider students need, to varying degrees, some sort of structure to guide them through what they are supposed to be doing; and to help them identify what they are expected to achieve and what support there is in helping them with this. The less confident the student, the more they are seen as needing structure.

Structure is seen to be particularly important in early placements when students are still finding their way around. Staff recognised that students faced a major transition from classroom to clinical environments and that it could be very bewildering:

> *…especially at the start of the year…they're just totally out of it.* (Elizabeth)

Numerous examples were given of how clinical teachers can help structure student learning. For example:

> *So I write to my students before they start and I say to them, you know 'This is my timetable, this is when I'm available, these are the sorts of things we will be doing on a ward round, and these are the sorts of things I will be talking to you about'.*(Nicolas)

However, the teachers differed in how much structure they felt students should need. Some expressed concern that over-structuring learning could lead to a 'tick-box' approach - where students would do the very minimum and lose out from experiential learning opportunities on the ward.

Teachers appeared keen to help students learn from unstructured, unplanned activities. For example, this teacher was clearly pleased to have helped a student overcome some of her anxieties:

> *I remember one man who was peri-arrest, and … got one third year student to maintain the airway for me. And, you know, she looked terrified, but afterwards actually she was like, 'That was really cool like, you know, I did something real'*. (Ebony)

And clinical teachers emphasised the opportunistic nature of the learning opportunities:

> *…it does tend to be very ad hoc. It's, you know, "Oh look, there's somebody there, that would be a good thing for you to go and see, why don't you go and do that now?" or "We're doing a lumber puncture in half an hour, do you want to come along and have a look?" So it doesn't lend itself quite so well to a clear structure."* (William)

One of the main ways that teachers perceive themselves as helping students learn is through questions. Most of the interviewees talked about how they would use questions both to prompt student learning and to gauge their understanding. They recognised that students could find questions challenging but were sometimes disappointed by the students' inability to link their earlier learning of basic sciences with questions posed in a clinical context:

> *Some of them struggle because they haven't got the basic scientific knowledge and they can't connect what they're seeing with what they've learnt. Some of them have the basic scientific knowledge but can't integrate it with what they see.* (Simon)

Some of the teachers, however, thought the most important thing was for the students to show they are interested and to try to answer - not necessarily to have the right answer. As one pointed out – if they knew all the answers they would be the consultant not a medical student!

It was reported that junior doctors often have more time and opportunity to help students than the seniors. Following junior doctor around and the juniors pointing out what students might do, were described as good learning opportunities for students. Consultants recognised that they might be less easy to find or that students might be "*reticent to pester*" them (Elizabeth), compared to juniors who are around most of the time. The juniors were seen as providing a good learning experience. In comparison, consultants recognised that they could be quite intimidating:

> *I'm absolutely certain that they find me unbelievably intimidating, even though I try not to be*. (Simon)

The clinical staff argued that one of the main things that they bring to clinical learning is themselves – as role models for the students. They expected students to "*learn by osmosis*" (Simon) the style and etiquette of being a good doctor. It was suggested that learning how to act within a ward and be part of that placement by observing and following senior staff is as important as gaining medical knowledge. Personal relationships were described as the key to good role-modelling:

> *I think relationships with people are really important. The people that I've learnt the most from are the people that were interested in me as a person, and were good role models for me.* (Nicolas)

The clinical environment

Clinical teachers were keen to discuss the ways in which clinical environments are changing and the impact this is having on students. One of the main differences they identified is that the patients who are in hospital now are much sicker than in the past. One clinician illustrated this difference by commenting on how there used to be mobile hairdressers in and around the hospital but these days:

> *...if you're well enough to have your hair cut, you're not going to be in hospital* (William, P19)

Staff believed that learning through working with patients was essential for medical students and were concerned that hospitalised patients being sicker than before is leading to less opportunity for students - particularly third year students. Some of the teachers we interviewed thought this was an insurmountable problem but others thought it could be solved by good management of resources. One said she wouldn't send a third year to see a really sick patient on their own.

All of the clinicians interviewed said that patients are normally happy to see students. When students voiced reluctance to disturb patients or cause them more pain, the staff were keen to reassure them. However, there was a sense that this might be changing:

> *In a university teaching hospital, sometimes patients get fed up with seeing students, so that can be an issue. But patients have probably changed a little bit. .. I think probably 20 years ago no one would have refused to see a medical student. And most people don't now, most people are very kind actually, and very accommodating. But there's maybe a little bit of that as well.* (Ebony)

Another change that the teachers mentioned in interview was the demise of the 'firm' structure within medicine. Doctors were described as working in much more fluid teams, with changing shift patterns and patients spread across a large number of wards. These changing work patterns are seen as making it more difficult to integrate students into teams, especially in larger units. It is harder for students to have a sense of belonging, or knowing who to speak to, or where they should be. For these reasons, clinical teachers emphasised the importance of helping students to integrate into the new-style teams and to have definite points of contact, time-tables and information on availability of staff.

Along with the changes that are taking place, clinical teachers talked about how increasing workloads and sicker patients meant that clinicians sometimes feel under too much clinical pressure to find time for teaching. There was recognition that teaching students was an important part of their professional roles and was an important income stream for some hospitals, but nevertheless when staff are really busy:

> *…the thing that will get squeezed is the medical students, there's no two ways about it.* (William).

There was discussion about clinicians who are keen and committed to teaching versus some who are much less so. The interviewees felt more should be done to build teaching into clinical job plans and to ensure that all teachers were up-to-date in their teaching skills.

Regardless of all the changes that are taking place, our interviewees also pointed to the inevitable uncertainty and anxiety that comes with working in a clinical environment and compared this with the security of the early years of medical training within the University:

> *…life becomes really uncertain. So in years one and two it's very structured, they're in lectures, that's fine, they know what they need to do. And then all of a sudden things become very uncertain and actually…. that's quite real, medicine is incredibly uncertain and anxiety inducing a lot of the time.* (Ebony)

It was also pointed out that clinical environments are not always pleasant for students and they have to come to terms with:

> *…just being around sick people, being around smelly hospital wards, being around distressed patients, being around, you know, lots of doctors and nurses who are, oh, sometimes a bit pressurised, sometimes a bit frustrated because something they wanted to be done with a patient hasn't been done.* (Nicolas)

Summary of main messages from medical staff interviews

- Experiential learning in clinical environments is crucial for medical students.
- The transition from classroom to clinical learning is demanding and inevitably stressful.
- Confident, motivated students who take responsibility for their own learning do well.
- Less motivated, less confident students who wait around for teaching will struggle in clinical learning environments.
- Clinical environments are in themselves places of uncertainty and anxiety and students have to come to terms with this.
- Clinical teachers can support students through the provision of an appropriate degree of structure and providing students with direction and encouragement.
- Too much structure can lead to a 'tick-box' approach, which undermines the essential experiential nature of clinical learning.
- Direct teaching, questioning, feedback and good role-modelling are all important .
- Junior doctors have an important part to play in medical education.
- The clinical environment is changing: e.g. patients are sicker; teams are more fluid; clinical teachers are busier with patients.
- Medical students will lose out if clinicians do not have time formally allocated to teaching.

Duration of project: August 2010 – October 2012

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