Sense made common: how to add value to early experience

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SUMMARY

Background: Authentic early experiences (AEEs) have become commonplace in medical curricula. There is a wealth of evidence that students enjoy these experiences, despite significant diversity in context, content and intended purpose between different medical schools. Positive evaluations have rarely explained how or why particular outcomes are achieved, or if unpredicted consequences occurred. AEE is a form of experiential learning, but experience alone is not sufficient for useful learning. Students need support to maximise the potential learning from AEE and minimise undesirable consequences.

Context: This article makes practical suggestions for clinical teachers to add value to AEE. It is based on research that used multiple qualitative methods to further understand AEE. The research sought to address two questions: (1) how and why do students construct useful knowledge and meaning-making from AEE; and (2) how and why do students make AEE work for them? The author draws on her perspective and experience as a practising clinician and clinical teacher to interpret and practically apply research findings.

Innovation: Clinical teachers can add value to AEE through both actions in the workplace and interactions with their local medical school(s). Suggestions are made to: actively manage expectations; deliberately create legitimacy; proactively manage risk; constructively discuss differences; model connectedness; and develop a consensus understanding of what is ‘allowed’.

Implications: All of these suggestions are about ‘making sense common’. Clinical teachers are encouraged to use questions accompanying the main text to make a self-assessment of their current practice and consider potential changes to provide additional value for students during AEE.
AEE should provide a foundation that students can build on

INTRODUCTION

Medical students are increasingly engaged in authentic early experience (AEE) of workplace practices. AEE describes new medical students undertaking ‘human contact in a social or clinical context that enhances learning of health, illness or disease, and the role of the health professional’. In this setting ‘authenticity’ refers to real patients, and real professional and real workplace contexts. Although diverse in context, content and purpose, there are common characteristics that define AEE. Students are at the start of their training (i.e. the first 2 years of undergraduate degrees in the UK, or the international equivalent). AEE offers a mechanism to undertake their first workplace-based experiential learning with ‘real’ people – patients, professionals or the public, with their new medical identity. AEE is intended to create a stimulus to refine, reinforce or change existing knowledge (through assimilation or accommodation); however, conflict between new experiences and prior knowledge can lead to the inappropriate rejection of new or existing knowledge if learners are not adequately supported. Experience alone is necessary but not sufficient for useful learning. It is important, therefore, that clinical teachers interact with students during AEE in ways that add value by generating desirable learning. AEE should provide a foundation that students can build on as they progress through medical school and beyond.

APPLICATION OF RESEARCH TO PRACTICE

In this article the author offers an interpretation and suggestions for the practical application of findings from her recent research using multiple qualitative methods to further understand AEE. The research was designed to integrate sociocultural theories with empirical data in order to further understand about how students make meaning and construct knowledge from AEE. Sociocultural theories of learning recognise the influences of interactions between people within workplaces on learning. Interested readers can find further discussion about sociocultural theories of experiential learning (of which AEE is a form), and details of the methodology and findings of the research, in the section on suggestions for further reading. In summary, the key findings included: the identification of a lack of shared understanding between students, medical school faculty members, and workplace teachers of the possible value and potential challenges of AEE, and clarification of the importance of social processes for knowledge construction and meaning-making, including mapping variables affecting learning. In this article the focus is on answering the ‘so what?’ question that arises following research. This is achieved by considering research findings through the author’s additional perspective and experience as a practising clinician and clinical teacher delivering workplace-based learning across the continuum of medical education.

SUGGESTIONS FOR CLINICAL TEACHERS TO ADD VALUE TO AEE

Although it is accepted that medical schools have responsibilities to ensure they support clinical teachers through communicating and discussing the curriculum, this article focuses on practical suggestions for clinical teachers to add value to AEE. The suggestions fall broadly into two categories: adding value through actions in workplaces and adding value through interactions with medical schools. Questions for clinical teachers to use these suggestions in the self-assessment of their own practice are provided in Boxes 1 and 2.

ADDING VALUE: ACTIONS IN WORKPLACES

Actively manage expectations

Students base their expectations of AEE on their perceptions of what medical school faculty members and clinical teachers believe AEE can or cannot achieve. Clinical teachers and medical school faculty members have been found to ‘under-expect’ the content of learning derived from AEE, and to ‘over-expect’ student abilities to independently manage transitions into different workplaces. Students make judgments about the relevance, importance and usefulness of AEE according to their interpretations of the demands (including formal assessments) placed on them by others. AEE cannot be considered as purely a means to the end of preparing students for later clerkships. There is a continuum from expectations through to the processes of interacting in workplaces and resulting in the consequential sense-making from AEE (Figure 1). Sense-making from AEE will prime students with respect to their personal ability to see different sorts of learning potential or knowledge creation in the future.
Box 1. Adding value: actions in workplaces

**Suggestion: actively manage expectations**
When you are supervising authentic early experiences (AEEs) in your workplace are you having explicit discussions with students about their understanding of: (a) what the medical school expects of them; (b) what you expect of them; and (c) addressing any potential discrepancies?

**Suggestion: deliberately create legitimacy**
Do you deliberately orientate students to specific practices of your workplace? For example, in surgical specialties, this might include where to find scrubs and theatre shoes to change into. Do you ensure that key professionals within the workplace know who the students are and why they are there? Do you facilitate appropriate interactions between students and patients by discussing the student’s learning needs with your patients and ensuring that they are willing to assist?

**Suggestion: proactively manage risk**
Do you ask your students what they think the potential risks are of any given task? Do you discuss with them how these can be minimised or avoided? Do you provide support to help them understand that being competent to carry out any interaction (e.g. basic history-taking) or procedure (e.g. taking blood pressure) is not the same as being confident or comfortable doing it? The latter feelings can be developed through practice. Do you discuss how some conversations will never be easy (e.g. listening to patients about the impact of progressive disease), and provide examples of how you manage this in your own practice?

**Suggestion: constructively discuss differences**
Do you seek to engage students in meaningful debriefing at the end of AEEs? Do you ensure that they know that you expect them to see differences between workplace practices and prior learning within the medical school? Do you discuss possible explanations of these differences with them? Do you spend time encouraging and supporting students to work out what they have learned that is potentially transferable?

Box 2. Adding value: interactions with the medical school

**Suggestion: model connectedness**
Do you know what students are doing when not on authentic early experiences (AEEs) with you? Are there ways you can seek to link their AEEs to this? Could you work with the medical school to improve AEE objectives (and assessment) from a clinical perspective (e.g. identifying medical content learning that aligns with the overall curriculum or identifying learning you see arising from AEEs that the medical school faculty might not be aware of)? Are there opportunities for you to teach jointly with non-clinical colleagues or to invite them to see how your workplace practice functions?

**Suggestion: develop a consensus understanding of what is ‘allowed’**
Are there opportunities for you to discuss with your local medical school(s) what is or is not allowed, or when their students might be expected to have gained specific competencies (or ready to gain these with support and supervision in workplaces)? Are you confident in assessing and supervising AEEs, including making judgments about what is appropriate for students to actively participate in during an AEE? If not, then who could you approach at your local medical school(s) to change this?

Deliberately create legitimacy
The necessity of being competent to identify, understand and interact with different workplace cultures (‘the way we do things around here’) has previously been underestimated with respect to AEE. Medical school faculty members and clinical teachers often assume students either already have or can independently gain access to and integration into different workplaces. Such assumptions are based on premised ‘common sense’ (which new medical students do not necessarily have). Nor is ‘legitimacy’ in workplaces automatically conferred with designation as a medical student. So-called ‘common sense’ simply is not common to newcomers to a workplace, unless someone shares it with them. Students describe how, paradoxically, the label of ‘medical student’ can perpetuate a sense of being on the ‘outside’. This is because of the ill-defined (or absence of a) role that a new medical student has with respect to primary workplace functions, such as the delivery of patient care.

Wherever you work there will be specific actions you can take to ensure students have access to practical workplace knowledge and are made to feel legitimate members of the workplace. Participation requires someone to confer a sense of legitimacy on the students and others: ‘this student is with me’. In addition, patients should be able to par-
The creation of useful learning opportunities requires readiness from workplaces.

Figure 1. The continuum of expectations–processes–consequences

participate in the process. A student needs to receive a mandate from both patients and professionals to act, even if this is at the simplest level of introducing themselves and enquiring about the details of the patient’s health care experiences. Without this mandate, students are not confident to cross normal social boundaries during conversations and interactions. Contrary to the perceptions of many medical educators, students are all too aware of the patient perspective and potential to be intrusive. What they need to know is how to retain this understanding alongside the development of their professional role and identity.

Proactively manage risk
The preparedness of learners may not be the best sole construct for improving experiential learning. This is because the creation of useful learning opportunities requires readiness from workplaces (facilitated in this case through the actions of clinical teachers) to encourage and support learner engagement. The desire of students to integrate into workplaces during AEE should not be underestimated. They are keen to develop bargaining tools to achieve this: a bargaining tool is anything, however simple, that they can contribute to the primary workplace function. However, the vast majority of students take very seriously the exhortations of medical schools not to act beyond their competencies. Paradoxically, this can lead to an overinflated sense of risk, with students feeling less sure, for example, of speaking to patients than they report having felt when in voluntary or paid hospital work prior to entering medical school. Clinical teachers should risk assess specific workplace scenarios and demonstrate to students how to manage, rather than avoid, perceived risk. The management of risk through supervised and graded increases in responsibility is vital learning for doctors.

Constructively discuss differences
It is inevitable that there will be gaps between the aspirational teaching of medical schools that seek to set out best medical practice for students and some of the workplace practices they witness during AEE. Some differences may simply result from professionals not maintaining best practice. Others (one hopes more often) are caused by additional contextual information requiring professionals to make a judgment of best practice when faced with conflicting risks and benefits in any course of action. Students need support to make sense of these differences and learn through comparisons. Without support, the easiest way for them to make sense of difference is to reject either the workplace practice or the teaching of the medical school. For example, if students are told that they must always explicitly discuss confidentiality with patients prior to history-taking, but rarely see practising doctors doing so, then they will need assistance in understanding why. Although doctor and patient may either assume confidentiality to be a given, or have a prior understanding from a previous interaction, left to their own sense-making the new student might equally conclude that confidentiality is not important in ‘real’ practice. Similarly, students need help to create connections and identify elements of learning from specific episodes of AEE that might be transferable to other contexts. It is not easy to achieve transferable learning. Students need to experience multiple examples that provide a spectrum of experience, plus support through the use of guidance to develop analytical strategies for handling new situations.

ADDING VALUE: INTERACTIONS WITH THE MEDICAL SCHOOL

Model connectedness and developing a consensus understanding of what is ‘allowed’
Despite the advent of integrated curricula designs, students are often not exposed to examples of integration in practice amongst clinical teachers and medical school faculty members (including those from basic and social science disciplines). It is not uncommon for students to see their teachers act as sources of discipline specific expertise. If students do not observe interactions between people in different disciplines, or experience teaching designed and delivered through co-operative working across disciplines they can feel that they are the only ones attempting integration and that they have been left to make connections relatively unaided. Clinical teachers can address this problem by modelling connectedness with colleagues within the medical school faculty. Opportunities to input into curricula design and
assessment objectives for AEE can benefit teachers as well as students through raising expectations of learning potential from AEE, and improving alignment with practice and theory. Without a shared clarity of understanding about what medical students can actively and purposefully participate in during AEE there is a risk that myths will be generated about what is (or is not) allowed. Clinical teachers need to work with medical schools and each other to address the challenges of identifying (and trusting in each other’s assessments) the levels of competencies for individual students. There should be consensus and a clear policy on who is mandated to make judgments about levels of participation within workplaces, and guidance for clinical teachers who are on the ground about putting this policy into practice. Once these issues have been addressed, improved ways of integrating experiential learning from AEE into assessment can be sought.

CONCLUSIONS

All these suggestions are about making sense common. Without support, it is easier to contrast experiences by creating dichotomies (such as good/bad or better/worse) rather than compare experiences in a positive manner to potentiate learning. The ideas discussed are suggestions, albeit ones that the author has found personally useful, not ‘one size fits all’ solutions. It is necessary for clinical teachers to reflect on their own practice in order to tailor these ideas to their personal context. Such reflections might usefully begin with considering the questions: are you sharing your practical workplace knowledge with students during their first experiences of health and social care; what might you do differently?

REFERENCES


SUGGESTIONS FOR FURTHER READING

Readers interested in the detailed methodology, research design and findings upon which this article is based are directed to Box 3, which contains suggestions for further reading.

Box 3. Further reading


There should be a clear policy on who is mandated to make judgments about levels of participation.