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"It's Like Starting All Over": 5th-Year Medical Students Approach Psychiatry Clerkships as Absolute Beginners

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Abstract

Objective: Student skills acquisition behavior during medical clerkships is rarely described. Based on the university learning objectives, the students should advance from the novice stage to the competence stage, making them ready for work as medical residents. We aimed to understand how the students' skills acquisition progresses during the psychiatric clerkship, preparing them for resident work in psychiatry. ***Methods***: This qualitative study is primarily based on ethnographic observations of key informants during a three-week clerkship in psychiatry, supplemented with semi-structured interviews. Field notes and the transcribed interviews were merged in a thematic analysis. Batalden's model of skills acquisition was applied in the analysis of the observations and statements. ***Results***: The students felt deeply unfamiliar with the field of psychiatry. They spent considerable time observing, imitating, and strictly following instructions. Gradually familiarizing themselves with the specialty, their work continued to exhibit crucial shortcomings. Applying different skills' acquisition models to the discussion, the authors observed the students' progress from the absolute beginner stage to the advanced beginner stage, with some moving towards the competent stage. ***Conclusions***: The study shows that students are at risk of advancing no further than the advanced beginner stage during the brief psychiatric clerkship. The results indicate a need for better preparation of medical students before they begin psychiatry clerkships.

Keywords

Medical Students, Medical Education, Skills Acquisition, Psychiatric Clerkship, Model

1. Introduction

The clinical clerkship is the backbone of medical education as it supports practice-based learning intended to prepare the students for their future careers in medical practice (Egan & Jaye, 2009; Kvale & Nielsen, 1999). In the clerkships students carry out chores in the clinical field, along with guidance and instruction from doctors who function as role models (Dornan et al., 2014; Monrouxe, 2010). The shortage of psychiatrists in the wards and inpatient bed reductions seriously affect the clerkship in psychiatry (Abdool et al., 2017; Bokken et al., 2008; Peters & ten Cate, 2014; Hall et al., 2004).

In general, the international literature offers several studies of clerkships in relation to the training of clinical diagnostic and treatment planning (Bowen, 2006; Pugsley & McCrorie, 2007). In the context of psychiatry, however, studies have focused on the students' attitudes to the psychiatry specialty, whereas the students' skills acquisition during psychiatry clerkships has so far attracted scant attention (Niedermier, Bornstein, & Brandemihl, 2006). The traditional summative assessment at the completion of the clerkship is seen as being of little educational value (Burgess & Mellis, 2015), providing an insight into students' capability to perform the assessment rather than into their behavior in the clerkship (Dornan et al., 2014). This calls for a new perspective on learning in psychiatry clerkships. While Dreyfus and Dreyfus's five-stage skills acquisition model has previously been used in studies of residents' learning progression in the psychiatric setting (Newman et al., 2016; Falzer & Garman, 2012), it has not been applied to the study of medical students' clerkships. This article describes the progress of medical students' skills acquisition in the psychiatric clerkship and relates it to Batalden's model of medical professional progression based on Dreyfus and Dreyfus's five-stage skills acquisition model (Batalden et al., 2002).

Batalden's Model of Medical Professional Progression

The original Dreyfus and Dreyfus's skills acquisition model describes five stages through which a person progresses to attain expertise in skill performance (Dreyfus, Dreyfus Stuart, & Athanasiou, 1986). Offering a general description of the progression from novice to expert, the model underscores the importance of practical, as opposed to scholastic, training to gain experience as the key to advancement toward expertise (Borgnakke, 2014). Focusing on skills, situated performance, and experiential learning (Benner, 1982), we find the model highly relevant as an analytical perspective where the practical training of clinical skills and skill acquisition is in focus and the model is widely used in medical education. Further the Dreyfus and Dreyfus model has been directly applied in the medical profession as the foundation of a new accreditation model in 2002 (Batalden et al., 2002) see **Table 1**. We refer to this accreditation model as the Batalden model. The model by Batalden et al. connects the different stages in the model by Dreyfus and Dreyfus to the different levels of medical professionals' progression (**Table 1**).

Table 1. Created from descriptions in *Model of Skills Acquisition Applied to Medicine* by Batalden, Leach, Swing, Dreyfus, and Dreyfus (Batalden et al., 2002).

Novice stage: Freshman medical students begin to learn about history taking. This entails memorizing its elements, extracting the main complaint and the course of the present illness, reviewing of organ systems, as well as the family and social history.
Advanced beginner stage: Junior medical students begin to see situations, like admission, rounds and discharge that are similar for all hospitalized patients. The situations are difficult to describe and learning is best achieved by the students being confronted with the specific events. The experiences yield rules later to guide the student.
Competent stage: Resident physicians learn to plan the treatment of individual patients. Supervision is formally organized to avoid unnecessary risks for the patient. Hands on the planning of treatment entail learning from the evident consequences of own decisions.
Proficient stage: Specialist physicians at the early stages of practice need to develop routines that optimize their patient approach. Managing several distractors in a sensible way is challenging, intellectually and emotionally.
Expert stage: Mid-career physicians are able to recognize patterns of subtle clues and to respond smoothly, relying on intuition. They are attuned to pattern irregularities and ready to slow down if unexpected patterns emerge.

2. Materials and Methods

2.1. Programs and Clinical Context

Medical education varies across universities (Hautz et al., 2015). In general, medical education in Europe conforms to the requirements of the Bologna Process, which aims to secure alignment across the EU (Cumming, 2010). This is true also of the program at the University of Copenhagen, Denmark, consisting of a three-year bachelor's program, followed by a three-year clinical master's program. The entire program is based on the learning paradigm posited by Ramsden and, later, by Biggs and Tang (Borgnakke, 2014), offering a combination of academic study and practical learning, the latter mostly during the master's program.

The mandatory psychiatry course takes place during the second year of the clinical master's degree program and consists of four elements: One week of 16 lectures, three weeks of mandatory clerkship with students assigned to ten different psychiatric hospitals, and, at the end of term, 16 plenary lectures. The students are then tested in a long clinical case exam. The clerkship typically involves activities such as bedside teaching during rounds, practice in patient interviewing, and, in general, participation in ward routines and small-group teaching. Students are required to fulfill a faculty-defined list of mandatory clinical tasks in order to pass

the clerkship. Before the psychiatry course, students have completed clerkships in internal medicine and surgery.

This study was conducted at a psychiatric hospital with four inpatient wards and an emergency unit. The number of residents at the wards ranged between one resident and a senior resident to one psychiatrist. To improve the training in psychiatry at the hospital, we had previously implemented a video library for the students to use in their training of Mental State Examination (MSE) skills. The library offered a number of short videos of a resident interviewing different patients, a task of writing an MSE based on the video, and, for comparison, MSEs of the videoed patients, prepared by a professor of psychiatry (Arnfred et al., 2018; Fog-Petersenet al., 2020). Region Zealand's Ethical Committee on Health Research and the Danish Data Protection Agency has approved the study (REG-96-2015).

2.2. Curriculum

The overall goal of the psychiatry course at the University of Copenhagen is to prepare the medical student for the responsibilities of a first-year resident.

Table 2 shows the qualifications for the learning goals of the course, described as required of the Bologna process. In this article, skills and competencies are both referred to as skills.

Table 2. The qualifications for the learning goals of the course.

At the completion of the course, the student is expected to be proficient in:
Psychiatric skills • Carrying out a comprehensive psychiatric interview including the MSE examination, and being able to determine whether the patient is psychotic or suicidal • Mastering psychiatric terminology
Competencies • Completing a full medical and psychiatric record, including diagnostic suggestions and initial assessment and treatment plan • Completing coercion documents as required by the Danish Mental Health Care Act

In the Batalden model, the first-year resident is a graduate medical student moving from well-prepared and functioning advanced beginner toward the fully competent stage (Batalden et al., 2002) (see **Table 1**).

2.3. Method

Our study was based on ethnographic methods (Atkinson & Pugsley, 2005). Where possible, the key informants were observed every day of their rotation (198 hours in total). The remaining students on the three rotations were also observed as they participated in settings with the key informants. Over time, C's role gradually changed from observational to more participatory. Field notes were taken according to the principles of capturing the course of observations and conversations through original statements (Borgnakke, 1996). Notes were handwritten and

usually amplified on the same day, sometimes later (Phillippi & Lauderdale, 2018). At the end of their clerkship, students were interviewed by C, following a semi-structured interview guide (Kvale & Brinkmann, 2007). Interviews were audio-recorded and transcribed.

We included three rotations of medical students in participant observation and interviews. All students gave their informed consent.

The first rotation included six students, the second included four students, and the third included two students. Students Allan, Eric, Sonya, and Annie volunteered to act as key informants representing the three different rotations (Annie and Eric were in the same rotation). Each rotation lasted three weeks and the key informants were observed daily by the first author (henceforth, C). **Table 3** provides an overview of the involved students.

Table 3. Overview of medical students.

	Rotation 1	Rotation 2	Rotation 3	Total
Number of students	6 (3 females/3 males)	4 (3 females/1 male)	2 (1 female/1 male)	12 students
Key informants	Annie (1st week) Eric (2nd-3rd week)	Sonya	Allan	4 students
Participant observation	73 hours	64 hours	61 hours	198 hours
Group interviews	2 groups of 3 students	2 groups of 2 students	1 group of 2 students	5 (12 students)

All types of activities in which the key informants took part were observed by C. Hand-written field notes were taken by C during observations (Atkinson & Pugsley, 2005) to capture the characteristics of the training (Borgnakke, 2015).

At the completion of their clerkships, C interviewed the students in groups of two or three, following a semi-structured interview guide (Kvale & Brinkmann, 2007). The guide was structured by three main headings: Use of the video library; Learning situations during the clerkship; and Attitudes concerning psychiatry and the clerkship. The five interviews were sound recorded and afterwards transcribed (Kvale & Brinkmann, 2007). The field notes and the transcribed interviews where gathered to a unified data material as the foundation for the later analysis.

2.4. Analytical Strategy

To describe the characteristics of medical students' skills acquisition in the psychiatric clerkship, we initially used the expectations stated in the curriculum *patient interviews, MSEs,* and their *terminology acquisition* to frame the analysis. In step one, we clustered the material under these three headings. Step two was to code the elements by content. Third step was to sort codes according to headings, however, discussing the results with second and last author, the codes where organized in themes and subsequently reject the headings. The final themes were: ***Being a Newcomer, Psychiatry is Different, Imitating Others, Strictly Following***

the Guide, Seeing Examples and Getting Explanations.

However, the students referred to an unfamiliarity with the field throughout the clerkship and the unfamiliarity seemed to permeate across headings and themes. The unfamiliarity is therefore understood as a meta-theme relating to all the themes in the analysis.

We find that the Batalden model is important as an analytical perspective on students' skills acquisition in our study as it helps clarify the stages in the training situations that we captured and characterizes the students' approaches. The themes are then related to the stages in the Batalden model to finish of the analysis.

3. Results

Mastering the curriculum seemed to be the main motivation behind the students' approach to training, although general curiosity and openness also made some perform tasks that were less directly connected to the curriculum. While they appeared to approach the clerkship tasks in different ways, they all emphasized patient contact and feedback as important for their learning. The themes, which are detailed below, show that the students were not only newcomers, but felt unfamiliar with the field of psychiatry. This alienation appears to have permeated their approach to practice. The students initially approached patient interviewing with inspiration from the residents' questions or by copying them verbatim. When they were tasked with leading the interviews or MSE writing, they took inspiration from the interview guide or MSE form, although they gradually became more spontaneous, which led to serious omissions. For terminology acquisition, students looked for examples of phenomena or diagnoses online or asked for explanations.

3.1. Being a Newcomer

Students initially spent some time adapting to the new environment. As newcomers, they met a number of practical challenges; for example, they had to learn the task organization on the ward, how to access medical records, and they often forgot to wear a personal alarm device.

Annie describes her approach to a new clerkship:

> I often spend the first days getting to know people's functions, like…who is the resident, how do they do their job […] and also the nurse…who is charge nurse, who is…like who is who. […]. Basically, I make sure to learn the names, so that I can say: "Greta, could you please…?" My experience is that this is a great help in establishing collaboration. (Group interview)

This quote illustrates the students' familiarity with tackling the more practical challenges, such as identifying gatekeepers from the start of the new clerkship.

3.2. Psychiatry Being Different

Some of the characteristics of psychiatry contrasts their former clerkships; an

underlying feature of danger implied in the introduction to the clerkship, admonishing them to carry an alarm, never to be alone with patients, and avoid wearing clothes posing the risk of strangulation. The students likewise pointed to differences from a somatic setting, such as the absence of residents' scrubs, the possibility of coercion, and the lack of solid diagnostic criteria.

> One student says that entering the field of psychiatry "is just like starting over!"
> Another student: "It's totally different than the somatic setting…In the somatic setting, you can always write a medical record. Here you don't know what you [are doing]…but it gets better over time. In the last weeks, you can handle much more. It's always like that." (Field note)

Psychiatric terminology, such as names of signs, symptoms, diagnoses, and drugs, was new to them. This was illustrated by the students' reactions on the introduction day when they were asked to prepare a patient description, using terminology from the received handouts:

> One student [skeptically]: "The terminology!" [all the students laugh]
> "Megalomania? …metonymic? …substitution?" [they all search for the right words in the handouts]. (Field note)

Asked about differences between specialties, they mentioned the approach to patients and the examination tool. Whereas hitherto, they had viewed the patient interview as an introduction and a guiding tool, they now saw that in psychiatry, the interview was *the* toolbox for diagnostic examination. One student explained how she used the interview to explore the patient's reactions:

> "…and then you try to challenge…what do they say when I ask about this? Or…what can I get him to do when I…" (Group interview)

Some expressed a feeling of insecurity and inability to help the patients, in contrast to their earlier clerkships.

3.3. Imitating Others

Most students initially approached the patient interview observing the way the residents conducted the interviews. They approached the MSE writing by looking into medical records to see how it was done. However, a key informant said his approach had been to talk to the patients from the first day.

Our observations show that the students spent considerable time during the clerkship sitting beside the residents, passively observing the patient and the resident during consultations, occasionally taking notes or, a few times, asking questions that had usually been approved beforehand by the resident. Though the video library was not aimed at improving the students' patient interviewing skills, the students claimed they had used the video library as a source for learning interview technique:

> Annie: "I used [the video library] to learn conversation techniques; that is, to find examples of good questions, or questions that make the patients open up. Because that's probably what I've been most nervous about…that I'd use some stupid formulations, or be too leading, you know. I think the interviewer in the videos is really, really good…" (Group interview)

Annie gives a typical expression of the students' concerns about psychiatric interviewing. Using the videos to study an experienced resident's interview technique, they sometimes copied questions asked in the videos verbatim for later use. Students also sought inspiration from or copied the professor's patient descriptions in the MSEs in the video library or the residents' notes in medical records as illustrated in this observation:

> Sonya is writing something in her interview guide. I ask her what she is doing. Sonya: "It's just that someone used a noteworthy formulation about something I didn't know how to describe." (Field note)

Although not all students copied sentences directly for later use, studying residents' MSEs and the medical records was the first step in learning to describe the patient.

3.4. Strictly Following the Guide

As the students began interviewing patients on their own, they adhered closely to the interview guide, as shows when Allan interview with a male patient in the second week of the clerkship (A nurse and a resident were also present):

> Allan has a medical chart template, pencil and paper in front of him. Shuffling his papers, he asks the patient a question. The patient answers, repeatedly moving uneasily in his chair. Allan says, "Just need to take a look at my papers." The nurse asks the patient a question. The patient answers briefly, and Allan continues by asking about allergies and somatic diseases. He frequently looks at his papers for the next question, repeatedly bringing the conversation to a standstill. (Field note)

Focusing on what questions Allan had to pose next, the contact with the patient seemed to be neglected.

The students gradually became less focused on the interview guide and concentrated on the interviewed patient. Our observations show that they kept forgetting important questions. For example, in the last week of his clerkship, Allan forgot to bring his interview guide and started the interview quite differently from before. When asked about it, he explained that he had forgotten an important question in the previous interview and now wanted to begin with that. Later, when writing up the medical history, he realized that he had omitted some routine questions:

> Allan explains that in the somatic setting, interviews ordinarily start with a quick succession of questions about allergies and other physical illnesses and

> that the questions come like…He bangs the table quickly three times for illustration. (Field note)

The success of the interviews also depended on the complexity of the case. Both Allan and Eric interviewed patients who talked incessantly, without minding the questions. None of the students had observed a resident perform such a challenging interview and their interview guide offered no help.

In contrast to the interview guide, the structure of the MSE and the medical record was fixed. Throughout their clerkships, the students thus found it challenging to place information from the patient interview in the correct sections of the medical record or the MSE, and the placement of elements was often corrected during the small-group teaching. Over time, however, the students seemed to become more familiar with the structure. Field notes from the third week show that Eric was able to correct himself when he had misplaced an element in the MSE.

In addition to gaining familiarity with the MSE structure, the students also wanted to know the recommended duration of its different parts, such as the social and occupational history.

At the end of her clerkship, Sonya explained a change of her approach to the MSE from stringently following the guide to seeking a freer form:

> I realized that, sometimes, you can actually make the formulations different from how they are formulated in the introductory documents […] you can describe things a little differently…" (Group interview)

3.5. Seeing Examples and Getting Explanations

None of the students had read the recommended textbook prior to their clerkships. They spent much time looking up words, consulting the diagnostic classification booklet and the hand-outs from the introduction session, or searching online, the latter mostly for pharmacological terminology. The students found that the clerkship provided good opportunities for studying examples or ideal types of symptoms or diagnoses. Eric was clearly affected by his encounter with a patient diagnosed with depression, whom he found to be an ideal diagnostic type. In our subsequent interview, he described how this patient became an "ideal example of a depressed patient":

> For many medical students, learning is…more or less about being able to tie the concept to a patient. Like, you can remember the patient. I think I'll remember her [the depressive patient] for the rest of my life, you know? Whereas if I had to remember all the symptoms of depression, then I'd have to look it up [and be] like: "What the heck WAS it?" (Group interview)

The observations showed that the students used both the residents' medical records and the video library to understand the meaning of the terminology used. They would also sometimes ask residents for explanations of terms.

While watching videos and writing up the MSEs in small groups, the students frequently discussed the interpretation of terminology. The library offered no

explanations when they were challenged by the professor's advanced terminology in the MSEs.

Students continued venting their frustration about the arcane vocabulary, even at the very end of the clerkship.

3.6. The Students' Skill Acquisition Structured by Batalden's Model

During the three weeks of the clerkship, the students typically took four approaches to learning to perform the prescribed tasks: observing and copying, following the guideline, identifying examples or seeking explanations. Using the Batalden model to characterize the students' approaches, we observe that the students categorized themselves as novices with statements such as "it's like starting all over". This was confirmed by their approach to the patient interviews and the MSE writing, initially following the patient interview template strictly. Also, as they looked for specific questions or phrases to use when asking about difficult subjects or describe symptoms, the students handled the questions as if they were context-free elements that could be used in any situation. This is characteristic of skills acquisition at the novice stage, which Batalden et al. (2002) equals to the freshman student stage. Dreyfus et al. point to the importance of experience in progressing toward the next stage in the model (Dreyfus, Dreyfus Stuart, & Athanasiou, 1986), which the students gained by watching others, practicing the tasks during the clerkship, and getting feedback. Yet, the students were slowly moving toward the advanced beginner stage (junior medical student) during their clerkships, as they became less focused on the guidelines and more familiar with the setting.

4. Discussion

Our results have implications for the content and structure of psychiatry courses in medical school. The students found psychiatry essentially different from the other specialties, apparently feeling they had to start from scratch. During the three weeks of the clerkship, the students typically took four approaches to learning to perform the prescribed tasks: observing and copying, following the guideline, identifying examples, or seeking explanations. Relating these findings to the Batalden model, it indicates that the students during their clerkship barely become advanced beginners, a stage Batalden relates to the skill acquisition of junior medical students.

In the Batalden model, the first-year resident is a graduate medical student moving from well-prepared and functioning advanced beginner toward the fully competent stage (Batalden et al., 2002). Apparently, the students had not read the curriculum before commencing the clerkship. Combined with the acknowledged inaccessibility of the core elements of psychiatry (Parnas & Zahavi, 2013; Chur-Hansen & Parker, 2005; Huline-Dickens et al., 2014; Blaabjerg et al., 2020), our findings indicate that the students were not even at the novice stage when they started the clerkship. Calls have been made for the introduction of a stage before

that of the novice stage. Park (2015) combines the Dreyfus model with Miller's pyramid, a model that illustrates the process by which different competences are learnt (Park, 2015). In his model of the relationship between knowledge and skills, Park adds an absolute beginner stage (Park, 2015). This stage seems to offer a more accurate description of the students' approach to learning psychiatric terminology and explain their alienation from it. Whether this is due to the lack of preparation, i.e. of reading text books before the clerkship is an open question. Had the students studied the terminology prior to the clerkship, they might have been able to reach higher stages in the Batalden model, and the three weeks of clerkship would have enabled them to reach the competency stage prescribed in the curriculum. However, it is debatable whether the students would be able master the terminology before starting the clerkship or, as our findings indicate, they would need to encounter examples to understand and retain it. Likewise it has been argued that students in psychiatry need to experience firsthand the phenomena covered by psychiatric terminology in order to acquire it (Blaabjerg et al., 2020).

Our findings are supported by those of a recent study of medical students' perceptions of their clerkships in intensive care units. The students were nervous and they found the intensive care units to be "a brand new world" (O'Connor et al., 2017; Hagg-Martinell et al., 2017). This either means that the feeling of unfamiliarity is common when starting a new clerkship or that the intensive care unit was different from other units (O'Connor et al., 2017). This aligns with our finding. O'Connor et al. (2017) report that the students valued the possibility of encountering things they had hitherto only read about, something our students also mention. The ambiguity in interpretation indicates a gap in medical education research about how and if the field of psychiatry is different from other specialties and if more preparation is needed before the clerkship to strengthen the training of skills.

A 2003 study has indicated that students' confidence is improved by skills training in laboratory settings before entering the clerkship (Nielsen et al., 2003). Pedersen et al. (Pedersen et al., 2018) have shown that video cases are beneficial for preparation before entering psychiatry. An earlier analysis about the video library implemented in our setting indicates that the video library may thus be useful for the purpose, but this has not yet been investigated (Fog-Petersen et al., 2020). Our findings further indicate the usefulness of more theory-based teaching prior to the clerkship.

The relation between the duration of the clerkship and the acquisition of skills provides another starting point for further investigation. A 2012 study has compared associations between the length of clerkships and scores in the Psychiatry Shelf exam (PSE) (Bostwick & Alexander, 2012). It showed significant better results for students who had taken an elective six-week psychiatric clerkship, compared to students who had followed a mandatory three- or four-week long clerkship (Bostwick & Alexander, 2012). Though the results demonstrated an association

between clerkship duration and PSE scores, they could not exclude the possibility that the reason for the better scores among students in the longer clerkship was their possibly greater interest in the subject.

Our study does have some limitations. Primary limitations of the study stem from the restricted number of participants and the single location, thus restricting the possibility of extrapolation from our findings. However, our rich data material presents in deep knowledge, found by a systematic and rigid approach that lend our study a transparency that supports its transferability.

The absence of audits of the medical records prepared by the students is another limitation. They would have been of relevance if the observations had focused on the content of the patient encounters rather than their form and structure. It would also have been interesting to follow the students' exam preparations and observe their final long case exam to see whether they would progress to a higher stage in the Batalden model. Likewise, a more thorough exploration of the students' preparation for the clerkship could have deepened the understanding of the unfamiliarity of the speciality.

5. Conclusion

On completion of the course in clinical psychiatry, medical students are expected to be able to work as residents in psychiatry, the stage which, according to Batalden, is characterized by the graduate medical student moving from well-prepared and functioning advanced beginner toward the fully competent stage as resident (Batalden et al., 2002). However, our study has shown that students are at risk of reaching no further than the advanced beginner stage during their psychiatric clerkships. This substantiates developmental and research efforts in the preparation of the students prior to the clerkship, and the optimal duration of the clerkship.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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