ORIGINAL ARTICLE

Exploring the Students' Experiences from Complex Situations in Clinical Training

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ABSTRACT

Aim: To explore experiences of students of clinical training in complex situations.
Methodology: This study was qualitative with phenomenological approach. The participants include clinical medical and nursing students in term 5 or higher from Jahrom University of Medical Sciences. Data were collected using focus groups or individual interviews, which was carried out through purpose-based method on a selection of students from different groups of nursing and clinical medical field. Content analysis was used for analysis.
Results: 113 primary codes were extracted following the analysis of results based on the content analysis. The themes resulted from the data analysis were inefficient educational planning, lack of knowledge, hidden aspects of training, knowledge conflicts and conflicts between professional ethics and patient rights.
Conclusion: Support of professors to review the curriculum suits the professional needs and any change in order to reduce the gap between theory and practice is essential. Also applied presentation of medical ethics during the clinical training course and commitment of professors to observe principles of professional ethics in education as a hidden curriculum are of the outstanding issues.
Keywords: Clinical training, students, experiences, clinical situations

INTRODUCTION

Education in medical sciences must take a different approach in comparison to other trainings because knowledge of learning styles can be effective in organizing the learning environment, the interaction between the professors and students and the trend of teaching and learning content[1].

Clinical setting is the main center of students' training and clinical experience is an essential part of training programs of universities, which creates an opportunity for professors and students to organize a participatory status for better performance of students to function effectively as a clinical team[2].

Clinical training is considered as the primary source of learning and shaping professional identity medical students [3] and the more clinical training is productive, training would go ahead with more acceleration and better quality. That's why the clinical training and preparation of students for various roles in the areas of health is the main objective and mission of colleges[4]. Clinical training is a process in which students gain experiences slowly in the presence of the patient and get prepared mentally by using logical reasoning and experiences to solve the problem of patient[5].

In fact, clinical training is a complex and dynamic process in which students gain experience and use their knowledge in practice. The process occurs through interaction between faculty, students, staff, patients and the environment[6]. This is while some experts write that clinical training has some defects more than other areas of education, and this area is most forgotten component of training[7]. Effective clinical training is a multi-dimensional issue, and in some circumstances, training situations take complex situation[8].

Clinical education environment is as a complex and interactive network of forces and thus, is effective in clinical learning outcomes[9]. However, there are barriers and limitations in the clinical setting, which can interfere with the effectiveness of clinical training[10]. In this regard, in the study Pardanjani, majority of students believed that clinical training has some difficulties; therefore, paying attention to clinical training is considered important[11]. In other studies, the number of students[12], the level of preparation of students for inclusion in clinical situations and efficacy of clinical training, instructors[13] have been considered as important factors in students' experiences in clinical situations. Alavi et al also concluded in their study that the factors, which have an effect on educational opportunities, are

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related to cases such as clinical setting, preparation of students and factors related to instructors including personality traits and behavior of instructor, his theoretical and practical skills[8].

According to Burns et al, although some of the situations of educational problems arise from students' performance, some issues originate from dissatisfaction and lack of a proper fit between student learning styles and the styles of clinical instructor or characteristics of clinical unit[14].

Since maintaining optimal levels of educational services, particularly in the area of clinical services which associate directly with clients life and will have a wide application in the future on the basis of professional duties after graduation of students, accurate and continuous evaluation to understand the strengths and weaknesses of clinical training is of prime importance[15]. If the presence of students in hospital is limited to implementing and providing hospital services and only staff shortages are resolved without providing appropriate training situations no problem would be solved[9].

Thus, factors threatening the effectiveness of clinical training should be evaluated on a continuous basis. Therefore, the researchers try to identify training complex situations and talk about such experiences to help manage these situations. Taking into account this point that the problems of clinical training have been examined using quantitative and qualitative studies, and qualitative studies in this field are limited, to achieve true and deep understanding of the experiences and views of the participants, qualitative approach was used. This study was conducted aiming to explore experiences of students in complex situations in clinical training.

METHODOLOGY

The method used in this study is qualitative phenomenological approach, conducted in 2016. The population of the study included all students of Jahrom University of Medical Sciences. Inclusion criteria were inclination to participate in the study and being-nursing students in term 5 or higher and clinical medical students (externs and interns).

Data collection was carried out through personal interviews (by the specialist's views with focus groups) or in semi-structured form using general guidance. It continued to apply a purposive sampling until data saturation is completed. During this process, in addition to forming the target group, the members (4-3 focus groups) express their opinions, and then content analysis was carried out to analyze their views. In individual interviews, general questions were designed so that the answers were open and interpretive as the interview guidance. The sample questions for interview include as following: what is the complex situations in clinical training? What complex situations do you encounter in clinical training? What factors affect the complexity of clinical training?

Sampling based on inclusion criteria continued gradually until reaching data saturation. Interviews lasted between 60-45 minutes. Interviews were recorded using digital devices by granting permission from the participants ensuring them of confidentiality. Specified codes were used instead of names during the study to observe the principle of confidentiality. All interviews were recorded and written word by word. Again, interviews were listened and the manuscripts were reviewed by the investigator.

To analyze content, qualitative content analysis was used. In this method, codes and categories, directly and inductively were extracted from the raw data through systematic approach process of classification. In this method, the key concepts and patterns hidden within the data content were extracted and data collection and data analysis were performed simultaneously. Moreover, in this way, the initial codes were extracted from semantic units and then the codes were divided based on the similarities and differences into classes and then sub-classes into abstract and key concepts. Accuracy standards of content analysis were expressed through the validity, transferability, dependability, and verification.

To determine the validity, strategies such as review of participants and colleagues were used. In addition to revise speech and experiences of the participants, the full text of the codes and classes were presented to five familiar professors for qualitative research and their comments were used for modification or confirmation. To evaluate balance, the full text along with codes and classes were presented to two faculties and the views of two experts for qualitative research were used.

In order to comply with ethical requirements some measures were taken to gain their consent to participate while creating an intimate atmosphere in the group. After reviewing the comments and documents, first two colleagues studied the plan separately, adapted with each other, then identified the resulting content of areas and sub-areas, and analyzed the group. To increase the reliability of the method, participants' approval were also used and presented after the conclusion.

RESULTS

Out of 113 obtained codes in the research the results were presented as inefficient training planning, lack of knowledge, hidden aspects of training, knowledge conflicts and conflicts between professional ethics

and patient rights. One of the main extracted themes was hidden dimensions of training achieved by sub-class of defect professional ethics and humiliation of the students.

"There is no place for us to stand up while the instructor explains. Some other day, we were sitting in the nursing station the head nurse shouted with temper tantrums and nursing students stood up. We are going to sit there. She was shouting while she could tell us a lot more quietly. Sometimes we are losing our job identity; we don't know what to do and what to say. Standard principles of professional ethics are not observed" *(Nursing interns and interview no 11).*

Another one states, "Some attending physicians humiliate their students in the face of patients. Strictness is good, but when interns and externs have wrong diagnosis, attending physicians rebuke us in the face of the patients. It makes the patient do not trust us and even do not let us touch or examine them and they tell us to test it on someone else. The issue of the patient's trust is very important, and this must be realized that examination of a student is not dummy, while the patients do not think so. Well, this very bad mentality has been created as the result of humiliation and worthlessness of students *(Interview No. 3 and intern medical students).*

"Some of the instructors do not respect students and when the they do not respect, the patients do not respect either. We could do the same behavior while the instructors' aim is training but it makes an indecent picture.

One of the themes extracted in this field was inefficient training program, along with two sub-categories, the gap between theory and practice, the massive curriculum, and being cliché make the students lose their concentration on the specific program. Inefficient scheduling cause students have no opportunity to keep updated and compensate their knowledge defects and deficiencies. In the experiences of these students massive class schedule as an obstacle can challenge their efficacy in clinical learning environment, and in addition to time reduction to improve theoretical and clinical skills, provide training complex situations.

In terms of massive curriculum one of the student says, "Nowadays, we have four-day training in a week. The difference between the interns and us is that they are here for 5 days. How can a student tolerate? Morning from 7 a.m. we have internship until 5 and in the afternoon we have class. I have no time to do anything. We are like internship in addition to our class and it's really terrible. Perhaps someone wants to do something else, go to club; we can do nothing. It means that you are not responsible for anything and irresponsibility challenges us *(Nursing student. Interviewee no 5).*

One of the students says that repetitive skills make us lose our preparation for challenging situations.

There is no patient in screen section in the morning shift. The patients get there since 10-11. We are tired of checking emergency box and DC devices shock. We really do not learn at the bedside. The main problem is in educational planning. Visiting repetitive cases makes this problem that if a rare case visits, we cannot manage him *(Nursing student interns, interviewed no 7).*

Another student says, "The problem is the lack of diversity in cases because lack of center is observed. There is no variety in cases, like other universities, for example, Shiraz University. For instance, we have common cases, and we don't see the cases that other students may see in other universities. We just read in the books. Until we don't see the patient, we cannot realize this problem actually. These issues make challenge in clinical situations *(externship students, interview 17).*

"For example, medical students study chronology while we did not have pharmacology instructor for one month. He was from Shiraz and he came to class on Wednesday from 1 to 5. Nobody listened. On the weekends, we were shattered, while the pharmacology should be started from the next semester and they continuously explain one or more categories in details. This is the best form of learning and even the instructor does not know the medicine and he asks us to look for the medicine in our cellphones" *(intern nursing student, interview no 4)*

Another one states, "The number of students in the rounds is high and it makes the learning gain decline. For example, in this course we are 14 students, 5 extern and 6 interns, which is large in number. In addition, the nurses are present which makes the round too crowded and only the ones who are in front receive the training and back students receive no training (interns Student, interview no 18)

In the next theme, the students point to the gap between theory and practice in a complex situation and consider it as a challenging issue in clinical training.

One student says, "I ask the instructor in the ward what this medicine is and I am going to give it to the patient, he says: why are you asking me? Find it in your mobile phone and tell me the next session. I say that I am going to give it to the patient; he says it is not my duty; it is yours."

A student expresses the sources we have studied do not suit what we have in bedside. For example, diseases such as pancreatitis, diverticulitis. We haven't seen so far. The only thing we see that

there is competition for handling angiocat. Nursing care is not that. Theory and practice do not match. Nursing care must be in the emergency situations. For example, I myself asked the instructor what I should do if someone had a heart arrest. Tell me please. If I am in the emergency department and a patient is brought, I really don't know what I should do.

Students consider lack of theoretical information as a problem that make training situations complex. Lack of knowledge declines the possibility of applying skills in critical situations and forces the person challenge to fighting with stress.

I shouldn't make film like other people if a person has an accident on the street. I need to know if I have to take him out or not, touch him or not. I should have proper knowledge to use. However, when there is nothing in what I read and what is in practice, what should I expect myself? *(Medical student interns in emergency, interviewee No. 9).*

Students consider lack of knowledge as one of the challenging themes, which can cause complex situations in training.

A students with emotional stress and high tone of voice says, "The number of patients is very low in some rounds and they may even have no rounds. For example, in the psychiatric ward, in which there is no patient, there are only four beds, which are not rounded. We do not have resident here, it makes us keep in touch directly with the attending physician. It has some benefits for us. On the one hand, we try to call the attending physician for everything we need, and on the other hand they say why we call them so much and some of them do not have any proper behavior. I don't know how to compensate this lack of knowledge *(intern medical student, interview no 19).*

Another student states, "In an emergency and acute situation such as epilepsy, CPR is repeated and we have seen a lot. Sometimes it is rare. For example, if you suspect VT, the patient's life depends on it and lack of confidence prevents you to implement what you have practically. It stems from lack of knowledge"*(extern student, interview 23).* The contradictions seen in the statements of professors in scientific and care rounds can create a complex clinical situation.

Our patterns are not consistent with each other. The medications that the patient receives are not the same. For example, we had round yesterday and an attending physician stopped the medication that another one had just started, and even they have differences over the dose of medicines. In addition, a physician gives twice as much as the other physician and it makes duality for the students *(medical student, interview no 7).*

Another challenging situation in bedside, which requires management of complex situations, is the legal and therapeutic contradictions of the patients. Students in this situation have to resolve conflicts and it is necessary to manage positions, and provide optimal conditions for the care of the patients.

"I see an AmI patient in emergency ward. She is there for pethidine, he has gone to Peymanieh then to Motahhari hospital. Now that we are in dilemma. On the one hand, it is the treatment of patient in which we do not know what to do with, and on the other hand, it is ethical issue that we must deal gently but not aggressively *(Intern student interview 22).*

One of the students says, "Sitting in the screen and emergency sections is on nerve. Obviously, the patient attendant is restless and irritable. This is understandable, but they shouldn't be so. At first, I deal them gently and then I suppress them. It's partly related to us and it sometimes happen which is out of the control of the physician and other people such as supervisor should be engaged but the physician should not compromise himself *(Intern student, interview no 25).*

Lack of knowledge and theoretical information and inadequate training programs were important issues in this study. In line with the results of this study, Beyea et al stated in their study that preparation of new graduates for clinical work does not cover the needs of the workplace and educational programs do not adequately prepare graduates for real clinical environments[16], while clinical training is one of the ways through which students achieve their desired clinical competency[17]. To grow competence and confidence in graduates, the students should be able to run theoretical information learned at the bedside[18].

However, the research indicates significant differences between taught theoretical courses in universities and their applications in bedside[20,19]. Hence, Cunningham (2015) considers reduction of the gap between theory and practice as one of the fundamental keys to success in clinical training[21]. This gap makes the students encounter the contradictions between expectations and existing realities[4] and indicates that training has not been effective.

Contradiction in adapting training needs with the educational goals makes the gap between education and bedside. The gap between education and bedside is a challenge that can be a factor for change and professional development despite many problems in the process of training[22]. Elliott et al emphasize the standardization of education by revising course content according to the needs of society and compliance with the theoretical objectives[23]. Oermann (2009) et al write: the gap

between theoretical knowledge taught in the classroom and clinical performance have long been of interest to educators and students[24].

Regarding educational policies in line with the results of this study, Abbaszade et al (2013) write that Intended time for training is not enough and there is not coordination between the different wards that sometimes their number is too high and it makes the students confused. Due to the lack of proportionality in the tools and facilities in the ward for students' training and low capacity of the ward compared to the number of students, the quality and quantity of education encounter problem[25].

Another theme was hidden dimensions of training which were distorted by the themes of professional ethics and identified by students' humiliation. In medical education system, student spend major part of their educational times in hospitals or clinics under the supervision of experienced trainers. And since in these environments three elements, i.e., trainer, student and patient, as the three men, have close relationships to reach common goals of improving patient conditions and training the students, paying attention to ethical issues either in the treatment of the patients or training the students to promote knowledge and skills seems highly significant[26].

On the other hand, education in universities is more sensitive than other levels due to communication with students in their youth; since in terms of personality the students have self-esteem and the desire for self-expression. Although they may make mistakes, the principle of tolerance and calmness is essential at this moment[27].

In line with the results of this study, Lash et al (2006) write that students encounter verbal violence in the clinical settings for reasons such as being alone and working alone to meet their learning needs, lack of sufficient experience and being stranger in clinical workplace[28]. From the students' viewpoints, nursing and medical staff do not cooperate properly with them. Disrespectfulness of staff and lack of support from the trainer is of important issues of communication, which can be regarded as a complex situation and affect the effectiveness of clinical training[29,30].

In this regard, Sand-Jecklin (2009) believes that clinical trainers should possess the behavioral characteristics such as positive role models for students, providing constructive feedback, having an open mind, and having supportive and encouraging behaviors[31]. Trainers should not adopt arrogant behavior towards their students or treat in a way that humiliate them. Caring student's opinion is important and creates self-esteem and confidence in them and if students feel they are accepted on the side of their trainer, they pass their educational process healthily and more successfully[27]. Ramani and Leinster write that though all the physicians are usually well prepared for their clinical roles, few of them have educational roles. Simply, it is assumed that professionals who have graduated from medical schools and colleges can begin teaching automatically after graduation[32]. Since the trainees make up an important part of training, in medical education, this responsibility is on universities and colleges to practice their monitoring role in the training process.

The last extracted themes was the knowledge cotradictions and conflicts between professional ethics and patient's rights. In other studies, the students consider medical ethics teaching important in their curriculum[33,34].

The results of the study of Fryer-Edwards[35], Mattick, and Bligh[36] showed that the majority of instructors and students consider training sessions useful and effective for ethical issues such as discussion at bedside and challenging discussions about the experiences of colleagues and partners.

Based on the results of the studies and the educational condition of medical ethics, it is necessary to consider the study of medical ethics during the clinical courses through changes in curriculum. The results of the study of Yousefi et al showed that considering the existing capacities, including rich Islamic culture, and clinical experienced and knowledgeable faculty members, the abilities of the education system and facilities make it possible for the teaching of medical ethics during clinical medical studies. If the two credits in current training of medical ethics course are not theoretically sufficient for the students to improve the functioning and development of students' attitudes, they may encounter difficulties to maintain and develop their professional behaviors in challenging situations[37].

On the other hand, due to high knowledge and awareness, the instructors can have an influential role on the students through the maximum observance of principles and values of professional ethics, which can provide the opportunity to transfer moral values to students and society[27]. Kohlberg expresses it in form of hidden curriculum. In fact, the hidden curriculum is more effective in transferring the values than the formal curriculum. In his view, most of what students learn is through the setting and ethical environment in the hidden curriculum than textbooks and educational materials[38].

CONCLUSION

Clinical education is a complex process. In this study, the complex training situations and acquiring medical

sciences at various levels, including inefficient educational planning, lack of knowledge, hidden aspects of education, knowledge conflicts and contradictions between patients' rights and professional ethics. It seems that the support of instructors to revise curriculum and modify it to suit the professional needs of students and changing it in order to reduce the gap between theory and practice are essential. In addition, providing medical ethic course during clinical training and the commitment of the instructors to observe the principles of professional ethics in training as a hidden curriculum are highly important.

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