Finding Meaning in Medical Education – how the hermeneutic window can help Primary Care educators

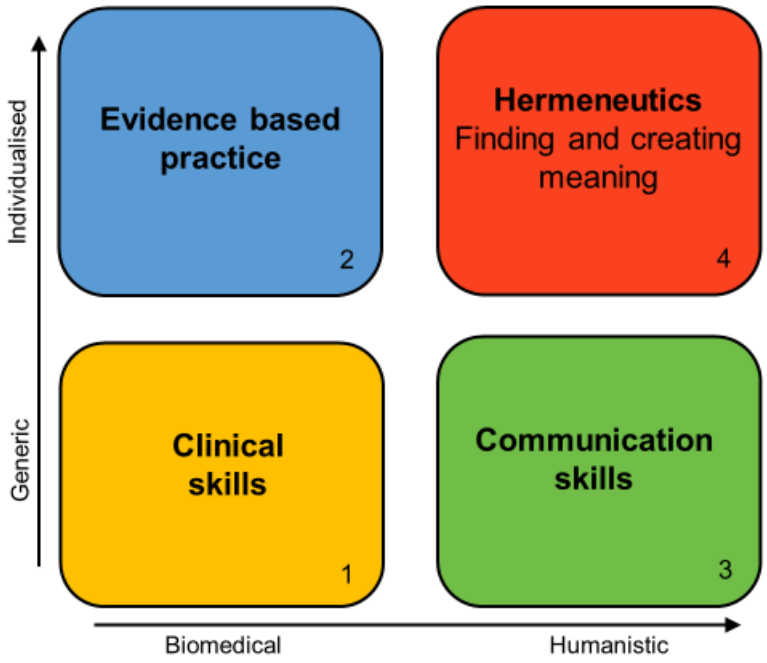
Dr Rupal Shah GP Partner Bridge Lane Group Practice; Associate Dean Professional Development Team Health Education England, London

Dr Robert Clarke Retired GP and Educator

Dr Sanjiv Ahluwalia Head of School of Medicine Anglia Ruskin University

Dr John Launer Programme Director for Innovation, Health Education England, London

We have published a model in which biomedical and humanistic elements of the consultation are seen as complementary[1,2,3] and where hermeneutics, the discovery and creation of meaning, plays an integral role in enriching conversations both between clinicians and patients and also between teachers and learners. We have also proposed that hermeneutics can be particularly powerful in exploring and making explicit elements of the hidden curriculum[4].



In this article, we consider how hermeneutics can be applied in primary care training and supervision, in order to enhance the experience for both teacher and learner. In the following case study we imagine how a training session for primary care learners might be designed, in order to address all four boxes of our model, and the hermeneutic window in particular.

Case Study 1- a supervision session

A GP trainee asks her supervisor for advice about a case during a group tutorial. There are two other learners present – a nurse training to be a practitioner and a newly qualified physician's associate. The case involves a 62 year old man who has been feeling weak and short of breath. He has had normal cardiac and blood investigations and his symptoms have been ascribed to COPD. The trainee wants to know if it's OK to give the patient a sick note for work as requested; and if so, what the duration should be. The patient works for the local council and since his symptoms arose, he has not been allowed to drive the bin lorry anymore but instead has been redeployed to light duties in the park.

Instead of directly answering the trainee's questions, the supervisor takes a different approach. The other learners are given the opportunity to clarify details of the case with the GP trainee. After this, the supervisor asks the trainee to turn her chair to face away from the group and to listen but not participate in the ensuing discussion. The two other learners and supervisor go on to discuss the case, mainly speaking about what interests them about it and what they are curious about, in the style of a 'reflecting team'[5]. Themes which arise include an exploration of the meaning of the term 'weakness'; the impact on the patient's sense of self of not being allowed to drive the bin lorry; the reasons underlying his request for a sick note; the impact on his family; and the way in which the judgements that professionals make about who is deserving and undeserving are influenced by class and social capital.

All learners agree that the discussion has changed their perspectives on the case, especially about what is at stake and what affects decision making. The GP trainee says she found the experience of listening without being expected to respond particularly valuable.

After the tutorial, the supervisor reflects on her own practice and the new insights that have arisen for her as a result of the group discussion. In particular, she thinks about her role as a supervisor in relation to addressing systemic and epistemic injustice (that is, whose stories are heard and whose aren't)[6].

Case Study 2- a GP specialty training scheme

The Training Programme Directors (TPDs) of a GP specialty training scheme are planning a session for their local half day release course. Trainees have indicated that they want teaching on a variety of clinical topics, including the management of atrial fibrillation.

Historically, teaching sessions on cardiology have been led by a hospital consultant or by a primary care clinician with a special interest and have been disease-focussed. The TPDs decide it is time for a change. One of them has a patient in his 60's, Mr B who was recently diagnosed with paroxysmal atrial fibrillation. With his permission, she records his story, which she plays back for the trainees:

I was going through a rough time with the lockdown. I lost my job, *things were strained in my marriage, the kids have left home so it's just the two of us and I've been around a lot more than before, which we had to adjust to. I felt..you know…a bit useless, like I'd lost my purpose. This wasn't how I'd pictured retirement..not that I even wanted to retire, it was forced on me, which was a real blow. I started drinking more than before, just a couple of beers with lunch and wine with dinner..a bit because of boredom, but also it helped to relax me and take my mind off the bad stuff. That's when I started getting the attacks. The first time, I thought I was going to die, my heart was racing, I felt like I might collapse. My wife was out and I didn't want to bother her. I just sat there and thought that maybe this was it, my time was up.*

The programme director asks the trainees to talk in small groups about their reactions to what they have heard; in particular, the feelings it evokes for them and what it reveals to them about Mr B. She asks them to write a few sentences or to draw a picture to capture their responses[7], and to discuss these in each small group.

In the next part of the session, trainees discuss the diagnosis and management of atrial fibrillation, reviewing the latest guidelines from NICE and refreshing their knowledge of stroke risk assessment (corresponding to box 1 of our model). They are then invited to consider what difference it makes to their approach to have heard Mr B's story and how this might change the consultation and their application of the guidelines (box 2). They think about the differences between a disease-centred approach and a patient-centred approach.

<u>Two different functions of role play</u>

In order to further explore the trainees' understanding of the guidelines and to practise communication skills, volunteers are asked to role play part of a consultation with Mr B, in which the discussion and management of risk are the central themes. The trainee taking the role of the clinician is the main focus, with self-evaluation and feedback from the group, aiming to improve the skills outlined in boxes 1, 2 and 3 of our model.

In an additional role play, a trainee plays the role of Mr B while other trainees in the group have a chance to ask questions about Mr B's experience of his illness and of the

consultation. The trainee playing Mr B is encouraged to imagine what it might feel like to be him and to respond accordingly. This is sometimes referred to as 'reverse role play'; it is not primarily about skills development but about gaining insight into the patient's experience and what they might be feeling as well as thinking.

The hermeneutic window

The TPDs now invite the group to discuss what they have seen and in particular to inquire about the relationship between the doctor and patient in the two role plays. For example: was it important to Mr B to explore his feelings of being "a bit useless", within the underlying biomedical context of paroxysmal atrial fibrillation and if so, why? In a similar vein, how did the doctor respond to the patient's admission that he felt "maybe this was it, my time was up" and what was the effect on doctor and patient? Did this matter?

The session concludes with an exploration of concepts of professionalism and the role of the primary care clinician, as well as the different ways of knowing about illness[8]. The group discusses the emotions generated within consultations such as this and how these feelings can be at odds with professional detachment.

The final reflections from the trainee who role-played Mr B are:

'*It made me think about atrial fibrillation differently – not just as a condition which increases risk of stroke. I thought about how it might feel to experience the fast heart beat and how it could be linked with thinking of yourself as an older person, where life is more fragile and disability and dying aren't so far off any more. It's like AF could be a metaphor for that new phase of life. It felt really heavy and I wanted the doctor to understand that*."

Discussion

Positivist approaches to education can result in both teacher and learner adopting a tick-box approach to learning, with the aim of achieving generic competences or capabilities as described in boxes 1 and 3 of our model. In our case studies, this might mean placing the disease and not the patient at the centre of the teaching -for example, focussing on how much sick leave a diagnosis of COPD can justify, or taking a purely biomedical approach to atrial fibrillation.

This approach fails to capture and teach what it is to apply evidence in an individualised way (box 2) and to give person-centred, relational care, creating meaning for patients and for clinicians (box 4). Quality of care relies on attention to patient experience. To achieve it therefore requires the clinician to be fully present, to be prepared to start with induction, not

with deduction[7] - that is, to be open to what emerges within the interaction, rather than starting off with a fixed set of hypotheses or categorisations to confirm or refute.

Conclusion

Meaning is generated not simply by technical knowledge, but also through emotion, which forges personal connection and recognition of the other person. Reconnecting to our own humanity in this way may prevent burn out and in fact help clinicians to flourish within their chosen careers[10].

There are also wider issues around societal justice, particularly about who is and who isn't heard and how they are heard[6], which may be revealed when a hermeneutic stance is introduced to supervision and which can't be captured by a generic capability framework.

We believe that educators should proactively introduce a hermeneutic element to formal and informal teaching sessions, so that learners are helped to become more reflexive and to examine conceptions of duty and role; thus equipping them to be able to practise in a more humanistic, compassionate manner.

1666 words

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