



# Medical Education Immersion Learning: Student Lives the Life of an Elder Nursing Home Resident

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### Abstract

**Introduction:** At the University of New England College of Osteopathic Medicine (UNECOM), students have traditional lectures and case-based medical education plus geriatrics practicum to provide foundational learning on how to care for older adults. However, a medical student's ability to both empathize with and understand the challenges faced by older adults living in nursing homes, in particular, is limited without first-hand experience. This case study research project required the student to be immersed in a nursing home to live as an older adult resident, complete with diagnoses and standard procedures of care, for an extended period of time to answer the question, "What is it like for me to live the life of an older resident?" This article presents one student doctor's experiences.

**Methods:** Ethnographic/auto-biographic research designs were applied. A 23-year-old male osteopathic medical student was admitted into a nursing home for 10 days with a diagnosis. He was cared for by staff as a resident. Data were in journal format for pre-fieldwork, fieldwork, and post-fieldwork including subjective and objective reporting of observations, experiences, and resident encounters. Analyses included journal review and thematic categorization and coding through content analysis.

**Results:** Three significant themes were identified: (1) Adaptation; (2) Communication; and (3) Loss. Being immersed in a nursing home, the student experienced the losses and challenges faced by older nursing home residents as well as gained perspective on creating community. This process helped the student to identify skills for meaningful and empathic communication with older adults and engage in the nursing home community.

**Conclusion:** This experience imparted knowledge and challenged the student doctor's attitudes about aging, loss, and the critical role of making meaningful connections in order to adapt to challenging circumstances. These insights provided an understanding of osteopathic care gained through immersion learning that is person-centered, comprehensive, and empathic.

### Keywords

Medical education; Immersion learning; Empathy; Patient-centered care; Nursing home care

### Introduction

With today's older adult demographics, of which Maine is the oldest state and whose median age is rising more rapidly than most states in the United States [1], providing medical students with foundational knowledge, attitudes, and skills in the care of older adults is important. One avenue primed for teaching geriatric medicine is the nursing home. Yet, education in nursing homes tends to be accomplished through traditional medical education methods, such as lectures and bed-side teaching. However, according to White [2] "Long-term care...represents a growing aspect of our medical system that receives little attention in medical education". Furthermore, medical students' training and experiences in nursing homes are often viewed as negative [2], which mirrors the views expressed by the general public.

However, the University of New England College of Osteopathic Medicine (UNECOM) has taken a bold step to educate medical students about older adult care within the nursing home environment. The *Learning by Living Nursing Home Immersion Project* (heretofore referred to as *Learning by Living*) "admits" student doctors into nursing homes for an extended period of time to assume the role of an older adult nursing home resident, complete with diagnoses and standard procedures of care (see methods). The goal is for students to answer the question, "What is it like for me to live the life of an older adult nursing home resident?" [3]. This article provides a case report of one medical student's lived experience as an older adult nursing home resident, including how this life altering medical education research affected his views on holistic and empathic care for older adults.

### Patient centered care

The Institute of Medicine (IOM) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" [4]. As a student in medical school and after living in a nursing home for an extended period of time as a recipient of care, the stated definition of patient-centered care above offered only part of the equation. Even though I appreciated being respected it was only when I felt the bond with my care providers that I felt valued and cared for as a person rather than as a patient.

To me, this is a step beyond patient-center care, representing a higher quality of care. According to Donabedian [5], he suggests that quality of care can be divided into at least two interrelating aspects: technical care, defined as the application of the science and technology of health science to the management of health problems; and interpersonal processes, specifically, the psychosocial interaction between client and practitioner [5,6]. Donabedian's perspective is perhaps a more apt description of care with the first part of the definition focusing on the patient and second part focused on the person. The IOM definition was incomplete for me as it missed the importance of having a provider view me as a person. This emphasis on psychosocial interaction between practitioners and patient is separate from interactions geared only towards clinical decision making. In other words, this definition of quality care acknowledges that patients are people too and benefit from interactions with their

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care-provider that are not centered around their illness. The *Learning by Living* project was a unique way to learn this lesson. As a resident of a nursing home I received all the care the other residents received, but as a medical student I needed to be thoughtful about this care and the responsibility of conducting this research.

For many medical students, the choice to become a doctor has been guided by the desire to develop meaningful connections with the people they care for. However, the nature of this bond is as complex as the two people it connects. The osteopathic profession recognizes this, and teaches that each person is a multifaceted unit of mind, body, and spirit [7]; making them more than patients. Aiding a person to attain a sense of well-being, especially when ill or physically compromised, is essential and begs the question: What role should the physician play in nurturing the mind, body and spirit of those s/he cares for? This is the question I pondered as I lived in a nursing home for 10 days with diagnoses that made me wheelchair reliant, unable to transfer on my own, unable to walk, and needing to be bathed, toileted, and eat pureed food. The situation I was in highlighted how little I understood the unique challenges of caring for an older adult nursing home resident; how the definition of patient-centered care was merely a string of words with little meaning; and how important bonds with all care providers and fellow residents contributes to one's sense of self.

### Older adult person centered care

The early years of medical school provided ample opportunity to learn about the body; through text, lecture, and in simulated patient encounters. At UNECOM there are programs in place specifically to give students an introduction to working with older adults. Actually, UNECOM dedicates 32 hours to geriatrics education and older adult encounters, far more than most medical schools. Still, young student doctors are challenged to engage with and understand the mind and spirit components of the older adults they work with. These components are dynamic, developed over time and shaped by an individual's unique experiences, as well as by the personal beliefs which are formed and tempered by these experiences. Younger practitioners raised in a different generation may have difficulty understanding the daily challenges faced by older adults and their families. Living the life of an older nursing home resident for an extended period of time highlighted these challenges and how understanding and connecting with the person (not the patient) is essential for the delivery of holistic and empathic care. As osteopathic physicians, we need to consider person-centered rather than patient-centered care.

Berwick [8] states that person-centered care in a nursing home means to adopt the resident's perspective resulting in a recognition of the resident's and the family's values. He predicts that this shift in health care design will require some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it [8]. After my experience living in a nursing home, I believe that while the effects may be radical, the process of shifting power into the hands of nursing home residents is not radical. It involves acknowledgement that the most distressing elements of an individual's life are often unrelated to their actual medical diagnoses. Nakrem [9] notes that in-depth interviews with residents underpinned the importance of seeing each resident as an individual person [9]. As compassionate person-centered practitioners, our challenge is to identify insults to each individual's mind, body and spirit. Identification of these insults is facilitated through the creation of meaningful relationships with patients which do not focus exclusively on illness. The experience of spending 10 days as a nursing home patient allowed me to form deep connections with

the residents I lived with, from this I identified several themes and challenges that were also experienced by my fellow residents. These themes may be used as avenues to provide more comprehensive person-centered care in the future.

### Methodology

The UNECOM *Learning by Living* Project was designed and implemented in 2006 by Marilyn R. Gugliucci, MA, PhD, Project Principal Investigator (PI), Professor, and Director of Geriatrics Education and Research. She has since admitted 40+ students into 14 different nursing homes in 4 states. Nursing homes volunteer to participate in the project providing, at no cost to UNECOM or the student, a bed, standard care by staff, and meals.

### Research design

The *Learning by Living Nursing Home Immersion Project* applies qualitative ethnographic/autobiographic research methods based in phenomenology and hermeneutics [10-14]. This methodological approach is used to collect the student's perspectives and experiences about life lived as a nursing home older adult resident [3]. Phenomenology, the study of the human phenomena of the lived experience [12-14], was the foundation for capturing the student's experiences of being a nursing home resident with a "typical" diagnosis and standard procedures of care. Hermeneutics, the interpretation of those experiences [14], provided the student an approach to discover meaning and understanding from his experiences and observations and eventually apply these to the practice of medicine. It is important to note that a student must focus on his own experiences; interpretations are always in relation to "self" rather than on the nursing home residents, staff or nursing home practices [3].

### Participant information

A 23-year-old male osteopathic medical student volunteered to conduct this non-credit immersion research project. He was "admitted" into a New Hampshire nursing home during July 2014 for 10 days and was diagnosed with right-side paralysis secondary to stroke and aspiration pneumonia. He lived in the nursing home 24 hours a day sharing a room with an 85 y/o male resident with dementia. The student was cared for by staff as a typical resident of the home. As a result of his "stroke" diagnosis, he was wheelchair reliant which required him to be toileted, bathed, transferred with assists; and due to his "aspiration pneumonia," he experienced a pureed (honey thickness) diet for 36 hours. Only non-dominant hand usage was allowed. Physical therapy and occupational therapy were observed in a buddy situation with a 75 year old resident who had the same diagnoses.

### Pre-fieldwork

Prior to the immersion the student completed a form that included demographic data, an essay on his interest in participating as a researcher in this project, and a list of his assumptions about older adults and nursing homes (being conscious of one's assumptions is an essential component to qualitative research) [3]. The student also created his 85 year old personae, the story he relied on when he was admitted into the nursing home. This recently added component to the research helped the student to answer the myriad questions on social history, family history, medical history, medications, and personal likes and dislikes. Once the admission and discharge dates were determined, the student was oriented to the project. This initial orientation included an overview of the *Learning by Living* Project,

information about the research design and data collection methods, the diagnoses that the student assumed, the role of the diagnoses (it guided the staff as to the type of care the student receives as an older adult resident), the support systems for the student, and open dialogue to address any questions. One week prior to admission the secondary orientation took place, which included providing the student with a preparation document – what clothes to pack, items the student may want to bring along to aid in creating a feeling of home, and information about data collection. The admission process was then discussed and plans were made for student arrival at the nursing home [David drove from NY and met Dr. Gugliucci at the nursing home in New Hampshire]. Additionally at this meeting, conducting qualitative note taking or journaling was reviewed as the student was required to journal 2 to 3 days prior to being admitted into the nursing home. The student recorded reactions by friends and family members about him entering a nursing home, also his thoughts and feelings about being admitted into the home, packing, deciding what to do with plants and possessions, and how it feels to leave “home”. The journal was reviewed and commented on prior to admission as this is the first chance to respond to the student’s journaling technique and content prior to fieldwork [3].

### Fieldwork

Fieldwork began on the day of admission. The student was admitted as if he had just been released from the hospital emergency room, so no pre-admission visit was required. Upon entering the home, the student assumed the role of a resident complete with a diagnosis of right sided weakness (his dominant side) from a stroke and pneumonia secondary to aspiration. These diagnoses required that the student remain in a wheelchair for at least 5 days, have a 1 or 2 person assist (by certified nursing assistants ~ CNAs) when transferring from the chair to bed or toilet, to be bathed, and to eat pureed food and drink thickened liquids (24-36 hrs) before assuming a normal diet again. Once the student was wheeled to the room and met his roommate, normal nursing home procedures took place including the admissions process (forms, resident’s rights, social inventory, payment review, etc); an assessment by the nurse including vital signs, additional questions and a skin check; occupational therapy and physical therapy assessments; dietary assessment and plan; activities therapist interview; and a tour including introductions to various staff, residents, visitors, etc.. The student attempted to unpack his suitcase; he maneuvered around the room in his wheelchair using only the non-dominant side and experienced challenges of furniture placement, mirror heights, opening dresser drawers and reaching for clothes hangers. Fieldwork continued for the next 10 days. Journals were sent each evening and reviewed each morning by Dr. Gugliucci, the project PI, who maintained contact with the student during his stay via phone, email, texting, and visits – as a daughter might for an elder parent. The fieldwork phase ended with a debriefing session by the student and project PI with the nursing home administrator, staff and about 20 residents. This session was scheduled for one hour and included information sharing about the student’s experiences of life lived in the nursing home as an older adult resident. The debriefing was monitored closely by the Project PI and was followed by an “official” discharge [3].

### Post fieldwork

Post fieldwork began once the student was discharged from the home. The student returned to his home in NY and for the next 3 days was asked to continue with journaling about leaving the nursing

home, what it was like to regain functional ability, to be reunited with family, friends and pets, and include post impressions of the experience. The journal was emailed to the Project PI for final review. This officially ended the experiential learning portion of the *Learning by Living* Project [3].

### Data and data analysis

Data were collected in the form of subjective and objective note taking/journaling (field notes). Qualitative note taking involved the student presenting a descriptive and detailed account of his experiences, thoughts, and actions. Each entry required day, date, and time accountability, as the student wrote at varying times of the day or when presented with a significant event. Notes included subjective accounts “my feelings” as a younger person living in a nursing home—and objective accounts “my thoughts” as a medical student. While the student lived in the nursing home, his notes were reviewed daily and feedback was provided to ensure data collection met qualitative research standards. This process also monitored the student’s well-being as he experienced a new culture. The journal notes taken throughout the pre-fieldwork, fieldwork, and post-fieldwork stages of the research were the key data source for the *Learning by Living* Project. The student’s journal was shared as a confidential document with the nursing home administrator at the close of the project [3].

After post-field notes were written and approved, data analyses commenced and included journal review, thematic categorizations, and coding through content analysis. The completed journal was read through four times by the student and project PI and 23 themes were identified. For this case study, the student identified three key themes and grouped representative quotes under each of these themes. He then highlighted key quotes that defined each theme. These themes epitomized the learning about person-centered care. However, the richness of the journal with its other identified themes and associated data represented the full depth and breadth of this immersion research for the student.

### Results

The student wrote a 75 page journal. Overall, the 10 day immersion period: (1) allowed the nursing home staff and residents to become desensitized to the new resident (the student) so that daily activities fell into routine again (days 1-3); (2) gave the student the time to experience the changes in staff shifts during weekdays and weekends (days 1-8); (3) provided the student with feeling that he was a part of the culture (days 6-10); and (4) permitted time to build relationships with residents in the nursing home (days 7-10) [3].

Additionally, the extended immersion provided the medical student with experiences and challenges parallel to those expressed by the nursing home residents he lived with. As mentioned, for this case report the student focused on three key themes: (1) Adaptation; (2) Communication; and (3) Loss.

### Adaptation

*It was a frightening moment to be sitting in the [wheel] chair for the first time. Several things hit me all at once. The first is that I suddenly have to look up at everyone in order to make eye contact, and they have to look down at me...I was conscious of the feeling that staff were “talking over my head” literally. I was physically lower down, and staff would do this thing where they would say something to the person pushing me around, which meant that they were speaking in a direction that was both above and behind me. It made me feel vulnerable to have*

someone consistently direct their attention to a source that was both above and behind me. And I realized... I am totally dependent on their care.

As I was being wheeled around I was doing my best to take in my surroundings, but I only had as much time as the person who was pushing me allowed. Had I been walking independently, I would have stopped to read a sign or look down a hallway or paused at a painting. Adapting to this environment was complex; a mix of new surroundings, new modes of transporting myself, dependence on others and strangers all around me. As I enter new environments now in my role as student doctor, I am reminded of these past feelings and remain conscious to the fact that all the people I encounter and provide care for are also adapting, which is far more challenging than I would have ever thought had I not lived in a nursing home. The word "pride" is more prevalent in my lexicon – the importance of being allowed to struggle through things on your own, without initial assistance. And I wonder to this day what happens to people when they can no longer experience a sense of accomplishment; how do they adapt?

### Communication

*The conversation with Jane [pseudonym] (a resident with cognitive impairment) was important...At first, she spoke in cycles. She... repeats over and over "aloha...aloha...aloha" [but] the third time I communicated with her she greeted me with "HIYA David, how ya doin?"...What struck me about Jane was that when she sits alone I can hear her just repeating "aloha, aloha, aloha". It is interesting what a different person she becomes when people are talking with her. She really comes to life.*

The heterogeneity of older adults is well known in the field of geriatrics, but experiencing it while living in the nursing home was new to me. As I lived there and made friends I began to understand how people varied in their communication. I was acutely aware of body language and voice tone, especially if non-verbal. These cues spoke volumes about how the residents were feeling, and what they wanted to communicate. I coined a term "present silence" which involves validating a person and the importance of the thoughts and feelings they share by allowing silence in the conversation. Prior to this experience I might have avoided Jane and certainly didn't understand the power of silence to build connections. Now, I am aware of various forms of communication; for example, when I interject to speak it is no longer the person's story, it is my story. I understand that my body language, voice tone, and words can either open pathways to communication with people or close them down.

### Loss

*Leaving the nursing home presented the challenge of saying goodbye to people whom I had come to care very much about. One of these people was Helen (pseudonym), a stroke patient who became my teacher and my friend. We talked about what the most difficult changes have been since her stroke. She said she really struggled with the loss of dignity and freedom, that her biggest struggle was the loss of control... Helen put this in perspective for me when she stated: 'you measure progress not in days and months, but in little steps. Measure in inches'... It reminded me of a line from a Rudyard Kipling poem I really like "Turn the unforgiving minute into 60 seconds worth of distance run."*

Within minutes of entering the home I experienced loss. Even with kind and professional staff I felt my dignity slip when being toileted or bathed; my freedom was confined by losing my

independence; I required the aid of others to fulfill my most basic human needs. Dealing with loss presents significant challenges to many older adults; its manifestations are varied as are the methods of coping. The concept of "measuring in inches," a variation on the idea of celebrating small victories, was a concrete approach that has been added to my doctoring tools; a concept that applies to all people regardless of their age.

### Discussion

By spending time immersed in nursing home life as a fellow resident, the medical student experienced and identified challenges and adaptations necessary to maneuver within a culture that was foreign. He gained insights through discussions with older adults especially when experiences appeared to be parallel.

At UNECOM, when second year medical students enter a nursing home for the 4 hour UNECOM geriatrics practicum; two students are paired with an older adult resident in order to conduct a history and physical. When each pair of students reports their findings and provides a differential diagnosis, the narrative is one of illness, medications, dependence, and loss. In most cases the students fail to see the humanity, the essence of the resident they have just met with for an hour, the small joys that makes the resident whole even in the face of physical frailty and the community that is alive and well in the nursing home environment. As future doctors, the potential harm of making assumptions or taking a situation at face value without considering the full context are not new concepts in limiting patient care. For example, it could also be posited that regardless of whom the patient was *before* her stroke, she is a stroke patient now and her treatment will be based on the realities of her present situation. However, the *Learning by Living* experience affirmed the significance of getting to know the person one cares for as a physician and the importance of treating the person not the disease.

### Conclusion

For older adults in a nursing home, loss represents a common bond: loss of health, loss of freedom, loss of friends, loss of comfort, and loss of dignity. And yet, in the face of these losses, many older adults are able to adapt and grow in their new environment. *Learning by Living* has allowed this student an intimate look into the lives of older adults who are much more than their challenges. This experience imparted knowledge and challenged the student doctor's attitudes about aging, loss, and the critical role of making meaningful connections in order to adapt to challenging circumstances. These insights provided an understanding of osteopathic care gained through immersion learning that is person-centered, comprehensive, and empathic.

As stated by the student doctor: *This experience is something I want to talk about; it is not done with just because my 10 days are up. It is a part of me now, and I think it will take a lifetime to sort it out in full* (D. Drozda, 2014).

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