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Commentary

Constructing ALL identities through individual consultations with medical students

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In this commentary, we examine how our identity as ALL practitioners is constructed through individual consultations (ICs) with medical students. While ICs offer us the space for drawing on our multidisciplinary backgrounds and educational expertise, our complex identity may be viewed and shaped differently by the various stakeholders, such as students, clinical and Faculty staff. Our discussion reveals significant tensions between who we are and what we teach, and the various ways we are being constructed by others. We illustrate the delicate navigation of daily boundary crossings in order to be effective in enabling students' growth and learning, and hope to call others to also document their multiple identities when working with students in ICs.

Key Words: Individual consultations, medical students, placement support, professional identity, academic language and learning (ALL).

Medical students grow their clinical knowledge and skills rapidly through placements immersing them in health contexts related to their future careers. These environments provide fertile ground for some students to thrive, while others require more scaffolding, care and support. Academic language and learning (ALL) practitioners embedded on placement are well-placed to nurture such students and provide personalised micro-teaching through individual consultations (ICs), as well as other teaching modes. There have been repeated calls to explore more thoroughly the role of ALL practitioners complementing the landscape as part of the teaching and learning team (e.g. Chanock, 2007; Edwards et al., 2023). In this commentary, we expand on how, through our ICs with medical students, we are both "constructing and being constructed as an agentic actor" (Edwards et al., 2023, p. 75) in the medical teaching team.

After two years of pre-clinical and campus-based study, medical students transition into year-long clinical placements for the final three years of their degree. This transition requires significant adjustments in terms of integrating the different layers of knowledge with a range of placement-based teaching and learning modes. Students acquire biomedical knowledge and procedural skills through scheduled lectures and tutorials and are expected to regularly study and revise core content in their own time. On clinical specialty rotations, students attend ward rounds, clinics and theatre, thereby experiencing everyday clinical activities. Students make connections between textbook knowledge and patient care through interactions with doctors, nurses and allied health professionals. However, clinical practice is messy, and ward-based learning activities often occur "on the run", sometimes appearing or disappearing unexpectedly, and the students need to learn to quickly embrace uncertainty. In our ICs, we can explore and harness these fleeting moments for student learning.

Important learning, often underrated by the students, occurs in the patient layer where students learn from individual patients in clinical bedside tutorials, as well as through a mix of supervised and unsupervised ward practice. Approaching and obtaining consent from patients for an interview or examination is daunting for most students in the early clinical years. Going on the wards can feel like arriving in another country, operating in unfamiliar linguistic and cultural territory. Bedside tutorials with sick patients can feel like an imposition on the patients. In their daily contact with patients, students come across many life stories that will make them happy or excited, at other times helpless or sad. During our ICs, we can assist the students with processing their experiences and emotions while on placement.

By training, we are academics and professionals with expertise in many disciplines, including education, linguistics, arts, science, health communication and medicine. Our roles and practices within the course are viewed differently by the various stakeholders, which can affect the level of opportunity and engagement with our teaching. Stakeholders in our work include both local and international medical students, on-site clinical and administrative staff, health service partners, clinical school governance staff, and central Faculty staff. Often overlooked as silent stakeholders, patients themselves benefit greatly from empathic medical students who can engage with them on a human level to build trust and care in the relationship.

Medical students generally welcome teaching and support from multiple agents, including us, to assist them in their journey to becoming effective clinicians. Because of our adjunct role, students may think that we are only there for those students who are "not good enough to make it on their own". Consequently, students referred to us may view this referral as a sign of impending failure. Students may also worry they will be stigmatised if others know they are meeting with us, or that details of ICs will be shared with others. We emphasise that our meetings are confidential and that there is no limit to the number of times they can meet us.

These concerns may develop due to indirect messages and negative attitudes from other students and staff, often due to misconstruction of what we do in our individual consultations with the students. Efforts to construct our agency with students include being visible to them on site, offering group classes to assist with unpacking clinical communication and ward-based learning activities, team teaching with other clinical educators, and advocating for improved learning environments.

Staff at clinical sites within various clinical schools may have differing views of who we are (our qualifications and background) and what we do, and therefore limit referrals to us. Some may see the inclusion of us as team members as a commentary on a perceived deficit in their own teaching and learning activities, and consequently seek to limit the scope of what we offer or incorporate similar teaching into their own curricula. Indeed, some of our adjunct group workshops previously offered are now incorporated into mainstream teaching, often without us.

Our legitimacy in this teaching space is frequently perceived as less important than core clinical knowledge taught by clinicians. Many staff fail to see the importance of communication and interactional skills in connecting content knowledge with clinical reasoning and human interaction. Communication skills are seen as something separate that students should naturally pick up through observation and practice alone. We are also often narrowly constructed as "language specialists", only focused on assisting with English language skills and grammar, rather than holistic practitioners helping students to make the connections between content knowledge and clinical reasoning and human interaction.

Other clinical school staff may construct us as remedial agents, assisting in the development of students to achieve success if they are in danger of failing academically. Still others may see us as part of the disciplinary pathway, although we are separate from progression activities and do not formally assess students. In this context, they may see student success as a direct result of support from us, or students' continued failure as a lack of our effectiveness, often ignoring the student's agency in their progress. In contrast, we see our rich discussions with students during

ICs as assisting them to develop their professional identity as they continue their transformative journey to their future career.

In addition, we see ourselves as advocates for the students we support, adding to the voice of the students based on our experience in individual consultations. This advocacy arises because in health professional courses, there are criteria to be met for the accreditation body, AHPRA, regarding professional practice and communication skills. At course, Faculty, and university levels, the existence of our unit fulfils a requirement for student academic and communication support, particularly for international students. However, while we can act as advocates for the students we support, there is limited power for us to effect change in curricula. While our voice is present on site and at meetings, it is often ignored or discounted as less important, even after seeking our input. Nevertheless, we believe it is important to see student advocacy as an important part of our identity.

A core part of our identity is also that of communication skills specialists. Patients and simulated patients highly value medical students and clinicians who are able to communicate with them effectively. Indeed, we have developed and participated in programs focused on practising clinical communication skills and receiving feedback, not just from ourselves and other clinicians but directly from the patients or actors themselves. This is an important part of enabling the patient's voice to be heard; they frequently express their appreciation to us in our role in improving future clinicians' "bedside manner". In ICs, we frequently assume the role of a patient as a bridging agent to provide feedback and fine tune the student's communication skills and approach to placement-based learning.

Constructed by others as being chimaera, fringe-dwellers on the margins, crossing boundaries between teachers and learners, with ambiguous professional identities can make us vulnerable to situational factors which challenge our place (Bennett et al., 2015; Grossi & Gurney, 2020). While we struggle with these multiple assigned identities and perceptions, we believe our place in the shared space of ICs with the students is valuable and allows us to holistically draw on our multifaceted academic and professional expertise in response to student needs. A student may come to see us to work on a specific issue (e.g. study techniques or history taking practice), however, as the IC unfolds, the dialogue usually covers a range of topics intersecting with the student's ability to embody new ways of doing. If a student finds it difficult to connect with patients and build rapport, the IC can be a refuge of personalised support so the student can ask questions about unfamiliar and uncomfortable environments and interactions. If a student experiences ill health, we work with the student to identify university or community-based support. If a student has difficulties in completing an assessment task, we provide academic and discourse specific advice and listen to or read student work and give personalised feedback. If a student feels overwhelmed by the intensity of placement demands, we work with students so they learn to prioritise tasks and responsibilities while attending to self-care. (For more details on the types of issues discussed in ICs, go to Schmidt & Schneider, 2023).

As ALL practitioners, we have worked with thousands of students across disciplines and embodied various professional roles such as educator, mentor, counsellor and critical friend. It is in ICs that we can develop true partnerships with students; partnerships which can last for an hour, a week, a month or years. We are proud of our many professional identities and the unique insights ICs afford us without which we would not be able to effect positive change in our students' growth. We call on other ALL colleagues in similar roles to construct and document their professional identities in ICs and other teaching and learning activities to assert their place in whichever teaching landscape they find themselves.

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References

Bennett, R., Hobson, J., Jones, A., Martin-Lynch, P., Scutt, C., Strehlow, K., & Veitch, S. (2015). Being chimaera: A monstrous identity for SoTL academics. *Higher Education Research & Development*, *35*(2), 217-228. https://doi.org/10.1080/07294360.2015.1087473

Chanock, K. (2007). Valuing individual consultations as input into other modes of teaching. *Journal of Academic Language and Learning*, *1*(1), A1-A9. https://journal.aall.org.au/index.php/jall/article/view/1

Edwards, E., Goldsmith, R., Havery, C., Mort, P., & Nixon, D. (2023). Academic language and learning practitioner identity shifts in the context of an institution-wide strategy Implementation. *European Journal of Applied Linguistics and TEFL*, *12*(1), 71-90. http://hdl.handle.net/10453/171663

Grossi, V., & Gurney, L. (2020). 'Is it ever enough?' Exploring academic language and learning advisory identities through small stories. *Discourse Studies*, *22*(1), 32–47. https://doi.org/10.1177/1461445619887540

Schmidt, E.L., & Schneider, B. (2023). Trends in targeted academic support for medical students before and during the Covid-19 pandemic. *Journal of Academic Language and Learning*, *17*(1), 118-133. https://journal.aall.org.au/index.php/jall/article/view/905