Negotiating Competence and Compassion: The UCSD Student-Run Free Clinic Project's Impact on the Development of Physician Identity

Abstract

Introduction: Identity is a self-conceptualization construct that helps us interpret our internal and external environment, answering the question of who we are, and how we think others perceive us. The objective of this study was to elicit an understanding of the UCSD Student Run Free Clinic Project's (SRFCP) impact on the development of physician identity using qualitative research methods. We hypothesize that programs such as UCSD's SRFCP play a key role in the development of physician identity in medical students, because UCSD's SRFCP creates an environment (through mentoring and direct patient care) that provides an excellent opportunity for physician identity growth.

Methods: Two sets of randomly selected reflective essays written by UCSD medical students participating in the SRFCP were analyzed. The first set of essays were from pre-clinical medical students and the second set were from the same students, but approximately three to four years later after completing a fourth year clerkship. Essays were coded by the content of what was written and the context (or intent) of what was written. Upon completion of coding, an analysis for key themes was conducted. The analysis focused on exploring the SRFCP as an education model from the student's perspective, as well as exploring the SRFCP's impact on the students' maturing physician identity.

Results: Both pre-clinical and fourth year medical students discussed competency and compassionate elements equally in their essays (75% vs. 85% for pre-clinical students, 65% vs. 85% for fourth year students, respectively). The frequency with which pre-clinical students and fourth year students discussed specific topics can be found in tables 1 and 2 respectively. Further qualitative analysis revealed the development of a competent physician identity and continued support of a compassionate physician identity. Pre-clinical students feel incompetent, but enjoy the direct patient interactions found at the SRFCP. The relationships they develop with patients, fellow students, and faculty reflect an environment that fosters the development of competence, as well as fulfilling their desire to be compassionate doctors. In contrast, the fourth year students display a mature physician identity. Students displayed their competence through increased responsibilities in patient care, as well as discussing mature issues in healthcare delivery that reflect their desire to be compassionate physicians.

Conclusion: There is a significant and measureable change in self-conceptualization as medical students progress through medical school. Confidence in clinical knowledge and clinical skills leads to the maturation of a competent physician identity, while continued exposure to an environment that fosters the patient-physician relationship, patient and student empowerment,

and humanism re-enforces a compassionate physician identity. It appears that UCSD's SRFCP educational model fosters both physician identities without compromise for the other. The UCSD's SRFCP provides a venue for medical students to negotiate and balance seemingly dichotomous identities.

Introduction

Identity is a self-conceptualization construct that helps us interpret our internal and external environment, helping to answer the question of who we are, and how we think others perceive us. Current identity theory postulates that identity is formed by intersubjective and external social processes, such that our understanding of identity requires a social context. Thus identity is not static or purely internal, but continually updating, changing, and responding through self-reflection and social activities.[1,2]

During medical school students adopt and begin to cultivate a specific identity, that of the physician. Previous studies have shown that physician identity develops throughout the four years of medical training[3], occurring concurrently with the acquisition of medical knowledge, although occurring less explicitly. As Monrouxe, advocates in, "Identity, identification and medical education: why should we care?" [4]

> *"Medical education is as much about learning to talk and act like a doctor as it is about learning the content of the medical curriculum. Developing a systematic understanding into the processes through which medical students develop their identities will facilitate the development of educational strategies [that] develop aspects of our students' learning experiences and better facilitate their development of doctor identities that are more in line with policy requirements."*

Current research articulates a dichotomy in identity formation between knowledge and skill acquisition, (i.e. competence), and development of a compassionate physician. In summary, Good and Good explain[19],

> *"Students' earliest interviews are marked by a concern to become caring practitioners, to practice medicine differently than they have experienced it in the past, or to live up to the model of some ideal physician they have known. However, as the pressure grows to learn the basic sciences necessary for competence, students increasingly express fears that they will not be able to balance these two goals, that they may be a "zero sum," that their struggle to achieve competence they may lose those caring qualities that led them to study medicine."*

MacLeod extrapolated this concept further, defining these two contradictory states. "Becoming a physician, then, means negotiating the need to balance professional identities that are consistent with discourses of competence with those consistent with discourses of caring."[8] That is not to say the formation of a 'competent' professional identity and the development of a 'caring' professional identity are mutually exclusive.

Many AAMC schools have now included patient-centered medical care in their curriculum. [5,6] These entities aim to infuse compassion, openness, and empathy into medical students

developing physician identities, for the advancement of patient centered care, and to meet changing health care reform.[7] However, there continues to be questions as to where in medical school curricula students develop physician identities, and which modalities are the most effective in shaping physician identity.[8] Recent qualitative analysis has suggested that identity development appears to be highly linked to "on the job" training, such as the hospital wards, and preceptor clinics. [9,10].

The UCSD Student-Run Free Clinic Project (SRFCP) is an example of an education modality that provides an opportunity for medical students to deliver patient-centered underserved medical care. Medical students participate in their pre-clinical and clinical years.[13] The value of Student-Run clinics has been established. The SRFCP acts as a health care safety net for those unable to access care, and for also as a model for medical student education.[14] The growing number of AAMC medical schools with student-run clinics is a testament to the educational utility of these clinics.[15] There have been advantages proposed for this model of education, especially for medical students in their pre-clinical years.[10] Additionally, a recent study conducted of UCSD medical students who participate in the SRFCP concluded that the clinic "helped [students] stay connected to a sense of purpose." Qualitative analysis suggested that students felt positive about the "physician teaching or role modeling," [11] which is central to the development of professional identity. [12]

As was demonstrated in previous studies noted above, students often develop a physician identity in many educational modalities, but seem to be greatly impacted by observing and participating in direct patient care with those perceived as mentors. It is in the encounters with patients that medical students learn to accept the role of 'doctor' that constitutes the beliefs (i.e. How a physician should behave, talk, relate) of this identity created by their mentors, the patients, and themselves. The objective of this study was to elicit an understanding of the UCSD Student Run Free Clinic Project's (SRFCP) impact on the development of physician identity using qualitative research methods. Our study featured analysis of the content by the authors, as well as a deeper analysis of medical students' self-conceptualization over time. We hypothesize that programs such as UCSD's SRFCP are integral to the development of physician identity in medical students, because UCSD's SRFCP creates an environment (through mentoring and direct patient care) that provides an excellent opportunity for physician identity growth.

Methods

Participants

The University of California, San Diego (UCSD), School of Medicine Student-Run Free Clinic Project was founded in 1997 and has expanded to four clinic sites in partnership with longstanding community partners that provide care for underserved populations. Participation in the SRFCP is now an integral component of UCSD's undergraduate medical education curriculum, with over

90% of pre-clinical students completing at least one elective course combining didactic sessions, reflective discussions, and the students first clinical experiences under direct clinical supervision at the free clinic project. In the preliminary course, students are assigned to second, third, and fourth year students and supervised by excellent primary care faculty role models to participate in direct patient care. Further courses are available where students can become clinic managers for general as well as specialty clinics (e.g. neurology, nephrology, pulmonology, or orthopedics). As a part of their course work, medical students are required to write contemplative reflective essays about their experiences.

Study Design and Coding

The study began by collecting and anonymizing a sample of SRFCP reflection essays written in the past 10 years. Two sets of reflective essays written by medical students participating in the SRFCP were analyzed. The first set of essays were from pre-clinical medical students upon completion of FPM 272: Community Advocacy (UCSD SRFCP), a course in which the students participate at the SRFCP for the first time. The second set were from the same students, but approximately four years later when they have completed a fourth year clerkship, FPM 432: Underserved Medicine Clerkship. The first and fourth year essays were paired for comparison and analysis. The reflection papers were randomly chosen by an administrator at the UCSD SRFCP, who removed the names from the papers, replacing them with a numerical identifier. Thus the research team was blinded to the names of the authors of the reflection papers. Twenty sets of essays were included in the study.

These essays were used to generate initial ideas about emerging themes expressed by the students, looking specifically at the impact SRFCP has had on identity development. This was accomplished by coding the papers, per stream of thought by the author (the writer of the reflective essay). Papers were coded by; content of what was written (ie. the topic the author choose to write about), and quality of what was written (ie. analyzing thought process of the author). Particular attention was paid to the author's self-conceptualization, how this has changed throughout medical school, while linking programs like UCSD's SRFCP to the direction and impact on that change.

An example from the pre-clinical medical students;

Categories of self-reflection / Content of thought	Meaning / Context of thought
Free clinic allows one to do the things they came to medical school to do	**Not just learn medicine, but practice medicine, be a patients doctor**
A01: "I think I just grew up a little bit today". My friend told me this after coming back from free clinic one day, and these words really hit home for me. As almost second-year medical students, we've had to grow up a lot this past year. Aside from devoting countless hours to schoolwork, which frequently involves forgoing time spent with family and friends, we have embarked on the process of caring for another's health. It's a terrifying concept to think of, especially considering that sometimes I feel like I can barely take care of my own needs. But every single time I come back from clinic, I realize how incredibly "fulfilling" growing up can be, and how there is no place that I would rather be.	This student is a bit farhter along, almost a 2nd year, but clearly has a very positive feeling toward the clinic, and sees it as a place where he/she si becoming a "real" doctor. "we have embarked on the process of caring for another's health." - Growing up is referring to leaving the text books behind, and practicing medicine. The changing from identifying self as a student, and identifying self as a physician
A01: One clinic session in Downtown, the fourth year was asking me if I had ever done a pulmonary exam before. I had literally learned how to do the exam about four hours earlier in my Intro to Clinical Medicine class. Earlier that day, as I struggled to hear lung sounds on my classmate, I had no idea that the transition to a real patient would be so quick. I could not have possibly asked for a more supportive environment as a first year medical student. The attendings and fourth years are so incredibly encouraging and positive. I learned that day how to properly perform a pulmonary exam, and I will never forget it as a result.	Again the student is bridingng comptency development as a part of classroom learning, and that found in the clinic. The student feels that learning in the rotation is much more likely to lead to permenant acquisition of skills, then in the classroom.
A02: I had the wonderful opportunity to be in the exam room while our attending spoke to and took a physical of the patient. The attending was great in explaining everything that he did, and he even let me listen to the patient's heart murmur. After completing a thorough examination, the attending prescribed the appropriate medications.	A route description of a 1st years experience. You can tell this first year really had little to do with this patient's care, and the student's description shows the she/he was predominantly an observer. Interestingly, he/she enthusiastically claims, "even let me listen to the patient's heart murmur." This passage reflects to me acceptance at his or her stage of identity development, which is mostly an outsider, incompetent.

Upon completion of coding, an analysis for key themes was conducted. The analysis focused on exploring the SRFCP as an education model from the student's perspective, as well as exploring the SRFCP's impact on the students maturing physician identity.

Quantitative data was created by coding the number of observations of each thought process.

For example coding for the MSIV essays;

Name	Competency Elements	Compassion Elements
B01	1	1
B02	0	1
B03	1	1
B04	3	2
B05	1	2
B06	0	3
B07	4	2
B08	0	1
B09	1	3
B10	2	1
B11	0	2
B12	2	0
B13	0	3
B14	1	1
B15	1	0
B16	0	1
B17	2	1
B18	1	0
B19	2	1
B20	0	2
Total	**13**	**17**
%	**65%**	**85%**

The research team determined that a sample size of 20 sets of essays (a total of 40 essays) provided sufficient content for our thematic analysis. We based our determination on idea that the themes we gathered from the essays have reached a point of saturation. [20]

Qualitative Analysis

Upon completion of the coding and quantitative analysis, we returned to each individual paper to assess the thought processes of each author, delving deeper beyond the content to interpret the authors' thoughts in the context of their growing physician identity. We analyzed each thought as a part of the essay as whole, and analyzed each essay within the total sample of essays for continuity. Our interest was gaining a better understanding of the sample of authors' growing physician identity; whether they valued competency or compassionate identity formation, and how the SRFCP has impacted that development.

Results

Quantitative Analysis

Quantitative analysis of the author's thought content revealed the frequency for which each topic was discussed in our sample of essays.

Pre-clinical students: Analysis of thought content	Total	Percent
Free clinic is chaotic - Integration into the physician culure	4	20%
Dealing with the limited free clinic resources	2	10%
Free clinic allows one to do the things they came to medical school to do	7	35%
Feeling incompetence and/or developing competence - Learning tasks of doctors (history, PE, etc.)	12	60%
Feeling humility and/or learning to respect patients- Learning to be compassionate doctor	14	70%
Working with and/or learning about underserved population (homeless, jobless, etc.)	8	40%
Patients as teachers	8	40%
Health care delivery as a system and/or healthcare policy reform. Free clinic as a healthcare delivery model	5	25%
Free clinic as rejuvinating and/or life balancing.	9	45%
When to say, "I don't know" or "I can't do that"	1	5%
Patients perception of student	3	15%
Barriers to patient care, eg. Language	2	10%
Competency elements	**14**	**75%**
Compassion Elements	**16**	**80%**

Table 1. Quantitative analysis of first year medical students' thought content. P-value >0.05 (Non-statistical significance) when comparing competency and compassionate elements in pre-clinical students.

Fourth year students: Analysis of thought content	Total	Percent
Looking back then vs. now compentence development	6	30%
Looking back then vs. now compassion development	8	40%
Teaching at the free clinic - developing competence in junoir classmates and patients	8	40%
Teaching at the free clinic - developing compassion in junoir classmates	1	5%
Discussing the plan with patients	5	25%
Doctor vs. patient agenda conflict, or patient-centered vs. doctor-centered medicine	6	30%
Desire to continue to serve the underserved	1	5%
Confronting career choices	1	5%
Discussing the limits of practicing medicine	3	15%
Working with and/or learning about underserved population (homeless, jobless, etc.)	15	75%
Developing relationships with patients / Empowering patients	6	30%
Patient's as teachers	0	0%
Barriers to patient care, eg. Language	2	10%
Competency Elements	**13**	**65%**
Compassion Elements	**17**	**85%**

Table 2. Quantitative analysis of fourth year medical students' thought content. P-value >0.05 (Non-statistical significance) when comparing competency and compassionate elements in fourth year students.

The quantitative analysis of the first year medical students' essays revealed that students expressed feelings of incompetence and humility the most. Their scores of competency and compassion were about the same. The fourth years spoke much more broadly (likely due to the increased number of experiences in medical school to draw upon), but most discussed working with the underserved. The fourth years discussed competency and compassion about the same, perhaps a slight skew towards compassion.

Qualitative Analysis

Qualitative analysis of the authors' thought process, including interpretation of context within each statement revealed the authors' physician identity preferences. Additionally, we interpreted the impact the SRFCP had on physician identity development.

Competency Development

Many first and second year students discussed competency development by contrasting themselves to the 4th year students they worked with, often citing a vast gap in competency. Pre-clinical students were impressed with the accumulation of knowledge displayed by the 4th year students.

> **A02:** "Since it was my first time at clinic, I had absolutely no idea what to do when first talking to the patient or even how to take vitals. Even though I was very inexperienced, the fourth year helped me feel comfortable and taught me how to take vitals easily. I learned how to take blood pressure, temperature, and heart rate. It was overwhelming at first because it was the first time I was learning how to do what are normally simple tasks done by a doctor."

The passage above describes a common first year medical student feeling. The student feels overwhelmed by something he/she believes to be a "simple task done by a doctor." The student expresses a feeling of incompetence. He/She has been accepted as a member of the physician community, but feels something close to guilt about not having any skills despite his/her "role."

> **A02:** *"I had the wonderful opportunity to be in the exam room while our attending spoke to and took a physical of the patient. The attending was great in explaining everything that he did, and he even let me listen to the patient's heart murmur. After completing a thorough examination, the attending prescribed the appropriate medications."*

The earliest stage of identity development is that of an incompetent observer. The student is enthusiastic about developing competence, but has no ability to show any competence at this point.

The passages above also indicate to us the role the SRFCP plays in competency development. Unlike the majority of their time in the first 2 years of medical school, the students directly participate in patient care. They are tasked with performing all aspects of the history and physical that they feel comfortable performing, and observe through mentorship these same tasks. Thus the SRFCP acts directly in competency development.

One such clear example;

A17: *"All of this patient exposure during the preclinical years is a refreshing escape from all of the lectures that are presented to us. The lectures can almost make you lose sight of your reasons for going into medicine, but the Free Clinic allows you to see that this learning is truly a means to an end- admittedly, a semi-end because a good physician never stops learning. Seeing diabetes in action after having learned extensively about it help to solidify the condition to a level of understanding that cannot be ascertained from books. It offers a balance where neither can sufficiently stand alone. I have experienced both sides of this balance independently and it was not until the Free Clinic that I was able to see how much more powerful learning can be when they are presently simultaneously. ..[in comparison to lecture, or other undergrad shadowing experiences] .. And as previously noted, preclinical learning is not nearly as fun, instructive, or intrinsically motivating without a balanced amount of clinical experience."*

In contrast to pre-clinical students, fourth years discuss their growing responsibilities in patient care, the trust that they have earned through their time in medical school and at the SRFCP, and the excitement of displaying their acquired competence.

B07: *"The thing that struck me the most [about the patient I had seen] he was so aware of how the free clinic works that he could recognize the different levels of training. Both times that I saw him he told me: you must be very close to being done, right? So what did he mean by that? I think what he meant is that he recognized that I had advanced in my training. That I had learned all the skills that we are supposed to learn during medical school. He also believed that I was competent enough to graduate and take care of my own patients.*

That gives me the greatest satisfaction. It is not that he went out of his way to tell someone else about me, but that that he told me himself. It is the fact that recognized that which we all long for someone to recognize in ourselves: that we have done our best to get trained so that we can become the best physicians out there."

The medical student took on ownership of this patient as their doctor, performing all aspects of care; from the history and physical through education and follow-up instructions. This level of responsibility is a clear example of a mature competent identity. The student above is clearly very happy that this identity is recognized not just by himself/herself, but someone else as well.

B17: ***"****Although I returned to the UCSD Student-Run Free Clinic Project after only one year of absence, it felt like an eternity because of the information that I had learned in the interim. Among other things, UCSD Student-Run Free Clinic has thus served as a constant that has allowed me to see my changes as I advance in my*

clinical training. It is difficult to consider how much information is learned in medical school, but also how much still remains. This is a simultaneously humbling and inspiring concept. As we approach internship and more freedom to actually make mistakes, it becomes ever so evident that these last few months of fourth year must be utilized to prepare for internship. To a certain degree, I feel like this was accomplished in Free Clinic….There is autonomy that is well-balanced with oversight to create a nearly ideal clinical scenario."

The last sentence of the passage above speaks to the impact the SRFCP has on competent physician identity development in fourth year students. As this and many other students express, being given autonomy is the utmost sign of respect. Autonomy is a feeling of validation for 4thyear medical students

Compassion Development

In contrast to competency development, where pre-clinical students express feelings of being overwhelmed, anxious, or inadequate, it appears as though students of all years have an understanding of compassion. Many pre-clinical students discuss the delivery of healthcare, and the diminishing of patient's own thoughts and feelings in the process of their healthcare.

A06: *"The patient is not an isolated biomedical system. This is among the most important lessons I took away from free clinic. All too often I have seen medicine selfishly attend only to the problems related to its own immediate interest--the problems of the heart, or maybe those of the brain. But is it any surprise that so many of the other aspects of life, those many human strings, affect health and disease in ways we cannot ignore? We as a health care system have plummeted into the trenches of disease care and management, with little emphasis on health promotion and advocacy. It isn't anyone's fault of course. The system harbors distance between the physician and the patient."*

This student expresses a well formulated thought that clearly shows compassion for his or her patients. In addition, we see that the student (although he or she doesn't express when or where this learning took place) gained some validation through the SRFCP that patient's ought not be treated like "biomedical systems." Implied is that doctors must attend to the patients thoughts and feelings, a core principle of compassion. Lastly, the student expresses the thought, "The system harbors distance between the physician and the patient." Though this student hasn't gained much competence in his or her own clinical skills and reasoning, it's clear that he or she identifies these competing physician identity paradigms. The focus on competency distances physicians from patients. It's interesting that many students appreciate this concept, even at this stage of learning.

Many first year students also discuss working with specific underserved populations and how their perceptions change over time.

> **A09:** *"Many of my assumptions about homeless people were dismantled that day. I hate to admit that I thought that homeless people would be noncompliant and uninterested in their health. I was definitely proven wrong. He actually knew a lot about his disease and when he had been asked during a previous visit to test his blood sugar and keep a log he did so. He never really told us why he stopped taking the medications, though he indicated that he was feeling better for a while. This encounter showed me first hand how we can make a large impact on the community."*

The author displays a coming to terms with previous assumptions. It's clear that experiences like the one mentioned above go a long way to removing the "distance" between the physician and patient, allowing for a more complete physician-patient relationship.

Many students expressed feelings of compassion, and their belief in the importance of doctors showing patients compassion. Perhaps compassion is simply a basic human emotion and therefore can not be schooled into a student. It appears that unlike competency, for which gains are made by leaps and bounds in medical school, compassion identities are intrinsic to students, and they either believe in acting compassionately or do not.

The fourth year students expressed similar thoughts to the pre-clinical students, although their sentiments were much more specific to certain situations and populations.

> **B02:** *"These home visits were such an incredible experience for me. During medical school, it is so easy to get caught up in the medicine and forget about the patients, even though the patients are the real reason why most of us went to medical school to begin with. It was such a humbling experience to be so welcomed into the homes of these patients and to have the opportunity to see how they truly live. Despite their small homes and meager incomes, they were so welcoming and happy to have us there and so willing to share with us aspects of their lives that we may not have otherwise been able to see if we had only seen them in clinic."*

The student reflects on developing a true relationship with a patient, commenting later, "During medical school, it is so easy to get caught up in the medicine and forget about the patients, even though the patients are the real reason why most of us went to medical school to begin with." This statement reflects a few interesting changes that take place over the course of medical school. Students come to school to care for patients. Students believe in the compassionate physician identity. It's not until later in their development that students begin to contrast and compare the development of competence vs. compassion. As B06 explains;

> **B06:** *"I was forced to regress into my earlier ambitions, and consider once again why I had applied to medical school in the first place. I remember volunteering in the emergency room at a local community hospital during my undergraduate years. I remember following my mentor, and marveling at his ability to diagnose and treat. Like him, I wanted to be able to diagnose the root of any complaint, and treat appropriately. As a volunteer, of course, my responsibilities were different. I would "round" on the patients, offering chairs, water, and support. I met so many ailing patients and their concerned families. Yes, this was my reason for wanting to become a doctor. I remember now how I wanted to have the knowledge and skill to diagnose and treat. But even more profoundly, how I wanted to alleviate suffering, to hold another's hand and offer a kind smile and reassuring words."*

This student offers a value judgment for the competing physician identities, stating that when he/she came to medical school the being competent was important, but it was the compassionate component of the physician-patient relationship that was the driving force to become a physician.

> **B09: "***[After working with a patient who needed urgent imaging and surgery, but was denied due to medical insurance] I was amazed to see the power of the relationship we had built in such a short time. We motivated each other to keep fighting. I continued to follow her in clinic while we applied for charity services and finally after two months she was approved. Coming back to free clinic helped me recommit to forming the type of doctor-patient relationships I highly value. With more time for each encounter than I was used to on other rotations I was able to learn more about each patient's life and often that helped me understand some of his/her health problems."*

The student expresses gratitude in the flow of free clinic, giving her the ability to really develop a relationship with the patient, something she/he felt was lacking in other third year rotations. Efforts such as these are rarely possible outside of the SRFCP, yet have the most profound effect on fostering the compassionate physician identity. The student's story above is a great example of how medical student empowerment and patient empowerment allows for these relationships to develop. This teaches students how to express compassion to patients. There are a multitude of examples similar to the passage above which details ways in which the SRFCP fosters the compassionate identity through direct interactions with patients, and also through observation of the staff.

> **B05:** "*It made me realize that there are populations that are truly vulnerable, and that free clinics are the end of the rope. It is amazing to see how tightly the patients hold onto this lifeline and it is touching to see the providers take such pride in ensuring that this lifeline stays for those who need it. My time at free clinic has shown me a beautiful outlet for this amazing training that we receive. There is no*

doubt that I will continue to serve these populations and be involved in my communities' health as a whole."

This last statement epitomizes compassion, with extension beyond the patient. Compassion can involve the patient, their family, and the community as a whole. This experience is unique to UCSD's SRFCP. It complements the training of the competent physician identity so that the two are not in competition, but can be successfully employed synergistically.

B11: "*Even 3 years later and after many patients that I had seen in hospitals and clinics, I still remembered her story and remembered the encounter that I had as a first year. With a fair measure of trepidation, I approached the patient and reintroduced myself. She recognized me immediately, and we quickly caught up on how everything had been going. It turns out that she is still suffering through many of the same problems that we addressed at that initial encounter, but she is managing them and taking control of her health as best as she can. To find her again and interact with her was to let the patient know that she was not forgotten and that the free clinic would be there for her. To realize that the patient remembered our encounter over three years ago was to experience great satisfaction and to realize that the work we do in the free clinic affects both our patients and us deeply. I am thankful to have been a part of this experience."*

Comparing and Contrasting the same author as a pre-clinical vs. fourth year medical student

Interestingly, when comparing first and fourth year essays the level of compassion stays mostly consistent; first year students who discuss the importance of patient-centered medical care or compassion tend to speak about it again as fourth years. In contrast, students universally discuss feeling woefully incompetent as first years. Many students discuss feeling like they will never amass the knowledge base displayed by their fourth year partner. In their fourth year the students often remember this feeling but name it "anxiety," "bewilderment" or some other term. They display their level of competence in the manner in which they write about their patients, often presenting them as if they were on rounds. Lastly they cherish the opportunity to discuss their management decisions, often keying in on how this greatly changes their relationship with the patients, as they are now seen as "the doctor."

Discussion

The formation of a physician identity in medical school comprises two components, the compassionate physician and the competent physician. Through quantitative and qualitative analysis we've concluded that these identities are nurtured throughout a student's four years of training at the SRFCP. The students in our study population composed reflective essays which

were categorized by thought content and split into two categories; thoughts deliberating on the development of competence, and thoughts that dealt with acting compassionately.

Overall students in both the pre-clinical years and those in their fourth year discussed competency and compassion approximately equally (Non-statistical significance). It appears as though many first year students begin feeling woefully incompetent, but enjoyed the direct patient interactions found at the SRFCP. The relationships they develop with patients, fellow students, and staff reflect an environment that fosters the development of competence, as well as fulfill their desire to be compassionate doctors. In contrast, the fourth year students display a mature physician identity. They display their competence through their increased responsibility with patient care, as well as discussing mature issues in healthcare delivery. Fourth year students discuss compassion through specific patient populations and situations as noted above, often citing the SRFCP as allowing them to "remember" why they decided to become a physician in the first place.

In contrast to the Good and Good's "zero-sum" dichotomy, it appears educational modalities like the SRFCP can build competence while fostering compassion. An environment that encourages clinical knowledge and skill acquisition, while remaining cognizant the physician-patient, physician-society relationship builds an identity in which competence and compassion (or caring) do not compete, but flourish together. This was validated by both cumulative and individual analysis conducted above. The ability of the SRFCP to facilitate both competency and caring results from total integration and culture acceptance of this role. As the SRFCP models, the competent and caring physician identities can be developed through immersion of students in a culture that encourages these ideals. This includes the nature and purpose of the course (caring for the underserved in the case of the SRFCP), and the beliefs and attitudes of the faculty, students, and even patients themselves.

As is described by Mossop et. All [21], the institutional culture or "hidden curriculum" is integral to identity development. If the development of a caring physician identity is important to medical education, educational modalities in which students and faculty develop a culture of caring must be adopted that facilitate this process. An example of this is the defined philosophy of the clinic, which rests on four foundational pillars. Briefly they are; patient empowerment, humanism, transdisciplinary model, and community as teacher. [18] These tenets are modeled and expected of students, and in doing so have become ingrained in the culture, so that they are practiced universally by all that participate with the SRFCP.

The findings of this study suggest the possibility of future research projects. Researchers could use the categories modeled in tables 1 and 2 to pick specific survey questions or interview questions to discuss with students. This would help further characterize identity development in students' own words, rather than relying on unprompted writings. Likewise, the findings in this

study are limited to students participating at UCSD SOM's SRFCP which does not include all students. A comparison across all other UCSD SOM clinical rotations might suggest differences in the data found here.

The limits of this study include the number of student responses used for quantitative analysis. A survey featuring specific questions would be much more efficient in the analysis of the data, and allow for much more power to determine the true differences in student responses. Likewise, the unprompted essays allowed for students to write freely without boundaries regarding their experiences at the SRFCP. While this gave the researchers an honest essay, it also resulted in much more interpretation of authors' thoughts rather than explicit information. Lastly, the involvement of the researchers within the SRFCP (participation in all capacities from student to attending and administration) likely biased the interpretation of student essays by the researchers own experiences.

Conclusion

There is a significant and measureable change in self-conceptualization as medical students progress through medical school. Confidence in clinical knowledge and clinical skills leads to the maturation of a competent physician identity. While continued exposure to an environment that fosters the patient-physician relationship, patient and student empowerment, and humanism re-enforces a compassionate physician identity. It appears that UCSD's SRFCP education model fosters both physician identities without compromise for the other. The UCSD's SRFCP provides a venue for medical students to negotiate and balance seemingly dichotomous identities.

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