



INTERSECTIONS

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From the sidelines of healing: Medical students as observers or intruders?

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TAKE HOME POINT – In vulnerable clinical settings, health profession students often wrestle with whether their presence is supportive or intrusive. Approaching patients with humility and recognizing that sometimes listening can be a meaningful contribution can help build trust despite this tension.

INTRODUCTION

From my chair in the distant corner, I struggled to be both invisible and engaged. Earlier that morning, I had arrived to the first day of my psychiatry rotation feeling eager to learn. My attending asked me to observe an initial assessment for a new patient being admitted to the residential treatment program. As the patient described her feelings of hopelessness and recounted multiple suicide attempts, my excitement evolved into growing fear that I was interrupting a deeply personal exchange between patient and provider. I wished to remain present without influencing the dialogue taking place before me, so I sat quietly and listened.

The admission assessment involves gathering a psychiatric history along with an entire life narrative leading up to that point. While fidgeting with her bracelet, the patient shared a story marked by prior treatment failures, self-harm and traumatic experiences. Asking her to be open and vulnerable with one person was already a tremendous request; adding another stranger to the room felt like an unnecessary burden. This particular patient was gracious enough to speak freely with me present, intermittently asking if I had questions. Later, my attending remarked, “They won’t all be that open. You got lucky.”

After my time in admissions, I was assigned several patients to follow

throughout their treatment. My responsibilities included individual check-ins, attending their psychiatry appointments and observing group sessions. Although following patients longitudinally increased my understanding of their circumstances and diagnoses, I questioned the impact I had on their experiences. Would patients have disclosed more if I hadn't been there? Did my involvement make them feel more like case studies than people? One patient even asked me, "Oh, did you choose to follow me because I'm so f***ed up?" Although this patient's psychiatric history was indeed complex, I regretted having made her feel defined by it.

These concerns resurfaced when I attended a dialectical behavior therapy (DBT) core group, a daily session with a consistent patient cohort that serves as a home base during residential treatment. This group's close-knit nature made my outsider status feel even more apparent. Despite my gratitude for their willingness to welcome me into their space, I felt like I had created an invisible barrier to free and open discussion. Patients would share something deeply personal, then glance over at me, as if waiting for my reaction. Had my jaw dropped? Was I tearing up? I tried to keep a neutral composure, but, internally, I was fighting emotions.

During my time at the residential treatment center, I learned from patients' stories, their resilience and their therapeutic journeys. Still, I wrestled with an important question: at what cost to the patients? In following them on their path to healing, did I in any way impede it? Did my mere presence influence what patients chose to share, or did it come at the expense of their comfort and progress? During one of my final one-on-one check-ins, I asked the patient whether she found our sessions helpful. She replied, "Just saying things out loud was helpful." If there is anything we can consistently offer as students, it is a listening ear. Maybe that was more impactful than I previously understood.

To round out my experience, I attended a final DBT core group session. This time, we started with a friendly game of Scattergories. Hesitant to participate, I followed along in my notebook, writing words beginning with the letter "P". As the patients shared their answers in a circle, laughing and smirking at their creativity, I was happy to let my turn slip by. Then, to my surprise, the last patient turned to face my seat off to the side and asked, "Wait, what did you come up with?" This gesture meant so much, not because I wished to feel included, but because I wanted the patients to feel comfortable with me. In that moment, I saw the subtle evidence of the relationships I had formed.

Moving forward, I can acknowledge the inherent discomfort of being a medical student, witnessing physical or mental suffering from the periphery. Sometimes our presence feels intrusive, but it can

also be supportive. I have learned to approach patient relationships with hope for rapport rather than expectation, recognizing that there is still value in listening respectfully from the corner.

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AUTHOR NOTES

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