Learning from patients – unfashionable but effective

The conclusion of one of the working groups of the Core Values Conference1 that the consultation between doctor and patient remains at the heart of medical practice must have struck a cord with most if not all members of the medical profession. It surely follows that the primary aim of medical education must be to achieve the highest standard of patient care in all aspects. In recent years undergraduate, postgraduate and continuing medical education have all been subjected to the most intense scrutiny which has spawned a series of reforms, reports and recommendations. In addition, postgraduate and continuing medical education have had to grapple with the conflicting demands of clinical work on the one hand and the need for education and training on the other.

Against this frenetic background and the increasingly strident views of educational experts, the value of the patient as the most effective learning resource is in danger of being overlooked. After many years of study, pre-registration house officers relish the opportunity of making a positive contribution to patient care and the acquisition of appropriate attitudes by junior medical staff is not helped by constant denigration of the contribution which service makes to their education and training.2 Doctors repeatedly comment on how much more they learn from patient contact than by other educational techniques. “In medicine, learning takes place continuously and patients take part in this process. Years after an encounter, doctors can instantly recall a particular patient who led to reappraisal of the pathophysiology or management of a disorder”.3 In a contribution to the Patients who changed my practice series published in the British Medical Journal, Bennett reflected “There is always another patient waiting to teach me something new”.4

The value of learning from patients is appreciated just as much in the US as in the UK. An editorial in the New England Journal of Medicine commented “The acquisition or teaching of clinical skills is largely dependent on working with patients. Books, journals, lectures and research contribute greatly to the life-long learning of medicine, but they are not a substitute for patients”.5 Referring specifically to the residency, Melinkoff concluded that “The system is most effective when the processes of learning medicine and caring for patients are synergistic, as they should be throughout our professional lives”.6 Personal experience confirms this view with “the patient is my book” and “patients teach” being typical opinions of residents of the central importance of patient-focused medical education. Teachers and trainees repeatedly commented that “You won’t learn if you are not there to see” and adequately supervised clinical experience was the most highly valued component of a residency programme.6

The acceptance that education and training should be at the point of service will inevitably mean change as a consequence of the trend for medical practice to increasingly take place in day-care, out-patient and community settings. These environments will need to be utilised for medical education and training on a much larger scale than at present.7

Teaching clinical skills through the use of standardised patients confers certain advantages8 but is not a wholly effective substitute for the real thing. Students inevitably regard discussion of management issues on standardised patients as artificial. “Without sufficient bed-side experience with real patients the students fail to learn to recognise and comprehend the clinical significance of common physical signs. The depth and breadth of this experience can only be achieved by examining and presenting tens, if not hundreds, of cases to the experienced physicians on ward rounds and case conferences”.9

What do patients think of their educational role? Provided their consent is obtained and they are treated with dignity, kindness, courtesy and respect (which is surely their entitlement) the vast majority thoroughly enjoy the experience and appreciate being the centre of attention. Patients participating in the MRCP (UK) examination confirmed this view.10 Swales makes the situation abundantly clear. “The criteria for a successful setting for postgraduate medical education should be straightforward. The fundamental necessity must remain a high quality clinical service for adequate numbers of patients”.11 When doctors stop learning from involvement in clinical activity it will prove a retrograde step both for them and particularly the patients under their care.2

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