How can medical education be improved for the benefit of the patient?

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Introduction

'To cure sometimes, relieve often, and comfort always'[1] as a statement of the aims of medicine is a useful one to consider. It speaks to the practice of medicine as a beneficent act, and reminds us that the fundamental role of the doctor, notwithstanding the possibility of a cure, is one of psychological and emotional companionship and healing. In his moving exposition titled 'Caregiving as moral experience', anthropologist and psychiatrist Arthur Kleinman describes how being present, 'being there, existentially, even when nothing practical can be done and hope itself is eclipsed', is central to the giving of care[2].

It can be daunting to consider that medical education today has to enable the doctors of tomorrow to fulfil these roles, especially in a climate where austerity frequently trumps aspiration. Fortunately, education here is not an end-point but a process extending from undergraduate to postgraduate supervision, and arguably continues long after a specialist completes their formal training.

As technology continues to burgeon and bring an overwhelming plethora of options to patients and doctors, we need to refocus the attention of medical education on the centrality of the doctor-patient relationship. This involves helping doctors to discover the therapeutic benefit of the relationship itself, understanding communication training as more than a one-way process of information-giving, and, by developing doctors with a deep understanding of the powers and pitfalls of their roles, addressing the 'privilege gap'[3,4] that encumbers the profession. None of this has to preclude medicine's pursuit of scientific breakthroughs. Instead, patients benefit from having doctors they can trust to guide them in an increasingly confusing moral and technological landscape.

The therapeutic doctor-patient relationship

Most complaints raised by patients relate not to a doctor's technical capability, but to communication and attitudes[5]. High profile legal cases like the Montgomery ruling[6] highlight the centrality of the doctor-patient interaction, no less significant than the primary medical intervention offered. Unfortunately, doctors' and patients' perceptions of the quality of healthcare interactions are frequently mismatched[7]. While doctors are inclined to measure success through objective outcomes like cure and absence of complications, patients point out the shortfall in terms of how much they felt cared for[8]. Indeed, the concept of care is what we need to reacquaint with. The term is ubiquitous – care assistants, Integrated Care Boards, Care Quality Commission, care plans, care navigators, among others – but what does it mean for those learning to care?

One area of medicine where the intervention intended to benefit the patient is inseparable from the relationship between patient and clinician is psychotherapy. We can take a leaf from the books of psychotherapy for the benefit of medical education as a whole. Traditionally regarded as on the peripheries of medicine and even psychiatry, psychotherapeutic approaches are increasingly recognised as beneficial to all doctor-patient interactions. The Royal College of Psychiatrists set out in its 'Cradle to Grave' education strategy the case for psychotherapeutically informed training for all students and doctors, regardless of eventual specialisation[9].

A psychotherapeutically informed doctor treats with ample respect the therapeutic nature of the doctor-patient relationship. They recognise that they can bring something to a patient who is suffering even when there are no pharmacological or operative solutions left to offer. At a time when doctors face a crisis of moral distress and injury[10], it is difficult to overstate the potentially transformative impact of realising that there is *always* something you can do. Interestingly, guidelines on various treatment-resistant conditions, from seizures[11], to angina[12], and other forms of chronic pain[13] all recommend a shared exploration of the psycho-social factors that are important to the individual. This is not to say it is 'all in their minds', but instead speaks to the value of a doctor who 'acknowledges the personhood of the sufferer and affirm[s] their condition and struggle'[2].

Doctors need to be taught this, just as they have to be shown how to operate or prescribe. An unintended consequence of the European Working Time Directive has been the erosion of apprenticeship structures in the form of the 'firm' as well as reduced continuity of care[14]. The modular nature of medical school curricula also means that students rarely develop, or even witness, longitudinal relationships between patients and their trusted clinicians. It might be necessary to sacrifice exposure to the full breadth of specialties and prioritise longer placements to underscore the therapeutic value of a committed doctor-patient relationship.

Communication is not purely information-giving

Another crucial element in harnessing the therapeutic relationship is communication. Admittedly, the teaching of communication skills in medical school should begin with a framework for a competent consultation. Models such as the Calgary-Cambridge[15] propose an approach that allows doctors to achieve the two-fold aims of assessment through information gathering followed by delivery of a management plan.

What should set a medical encounter apart from a consultation for a kitchen makeover or with a mortgage adviser, is in fact, the element of 'building a relationship'[15] that is conspicuously sidelined as the icing on the cake – a 'good-to-have' add-on perhaps. The expectations patients and regulators have of clinical communicators, however, far exceed the demands placed on salespeople. A salesperson can give a convincing explanation of the benefits of their service, and if we're lucky, an honest account of its costs. They are unlikely, however, to apprise you of all the options available to you, and even less likely to recommend that you buy nothing at all.

When clinical pressures abound, doctors may feel forced to choose between telling and listening, the former nearly always taking precedence. The listening could, we would like to believe, be done by a myriad of other healthcare professionals, or indeed a sympathetic and available layperson, such as a volunteer or a family member. It is hopefully not only arrogance that drives this, but reticence towards the more uncomfortable aspects of our conversations with patients.

But the experienced among us would confirm that clinical communication cannot be a linear flow of information. It is, instead, to use a rather tired analogy, a dance between partners. The holy grail of 'shared decision making'[16] is more complex than negotiating a business deal. Doctors are reminded that the information we give and how it is given should be tailored to the individual patient. We must be clear and compassionate, ascertain how our words land, and indeed, respond appropriately to their response[17]. All this and more has to feature more explicitly in medical education, for we cannot expect students to master this intricate *pas de deux* any more than we would expect them to dance without prior instruction.

Information-giving is still important, but different in an age where information is eminently accessible. Many online and printed resources can convey information more comprehensively and effectively than the verbal explanations possible within the constraints of the ward or clinic. What these resources cannot replace is addressing patients' emotional need for comfort, companionship, courage, or a good cry. These needs exist not least because patients as individuals bring with them a lifetime of experiences and aspirations which are often irrevocably altered by the news we deliver.

Medical education should identify such patient-centred communication as a necessity, not a luxury. It is disappointing how in many self-scored, domain-driven application processes, from university to specialty recruitment, doctors do not accrue points for being an excellent communicator or a consistent advocate for their patients. Such attributes are difficult to measure, but that is not a reason to forsake them. In fact, we have managed, somewhat strenuously, to quantify other equally nebulous qualities like leadership and 'achievements outside medicine'. It is, therefore, probably a lack of will, rather than a lack of way.

Self-awareness as a way to seeing the other

Throughout history and geography, patients do not look like the doctors who treat them[3,4]. The socio-economic pre-requisites for completing conventional medical education continue to select disproportionately from privileged segments of society. Conversely, as described extensively by epidemiological studies[18] and Julian Tudor Hart's 'inverse care law'[19], ill health is disproportionately a predicament of the poor and marginalised.

The latter term can be interpreted in its widest sense, encompassing geographic, ethnic, religious, class-specific, and inter-generational disparities, to name a few. Even if we surmount the barriers such populations face in *accessing* healthcare, there remains a pivotal challenge – how do we train doctors capable of *identifying* with them?

Formal initiatives promoting equality, diversity, and inclusion and access to medical education[20] are commendable. However, since it is impossible for every doctor to match every patient in background and identity, diversifying recruitment is only part of the answer. Developing the ability to connect requires doctors to continually work at an honest and detailed understanding of the prejudices they bring to their roles. Through this, we begin to see beyond the 'us' and the 'other'[21].

This process of identification can occur *despite* how different we are to our patients. Indeed, medical education should include training on recognising our unconscious biases[22] and understanding its impact on quality of care. Many of us consider ourselves immune to overt forms of discrimination like racism and sexism. This is not true[23], but even if it is, there are other insidious ways in which we might treat someone unfairly. What assumptions do we make about a nonagenarian, a woman with short hair, a family with many children, or a man with a much younger spouse? Such prejudices become even more potent when they involve behaviours that society openly regards as vices – think drugs, alcohol, casual sex, or alas, even unemployment. The temptation for doctors to assume moral superiority is unignorable, fueling the risk of erroneous clinical judgment.

With the demise of the firm as a natural incubator for mentorship, there is greater need than ever for provision of meaningful clinical supervision and wider platforms, such as Balint Groups and Schwartz Rounds[24], to develop the reflective and socially cognizant doctors of tomorrow. Named supervisors for every resident doctor and mandatory regular meetings are positive steps. However, like many other worthwhile endeavours, the challenge lies in ensuring this is not relegated to another perfunctory exercise.

Conclusions

The late Harvard anthropologist and physician Paul Farmer, who ostensibly had a lot *not* in common with the people he served, once wrote: 'If access to healthcare is considered a human right, who is considered human enough to have that right?'[25]. In taking the weighty concept of human rights and recentring the focus on our definition of humanity, Farmer challenges us to reflect on what truly underscores the relationship between the healer and the beneficiary. In other words, if disease brings a patient to the doctor, what brings a doctor to a patient? It is, gratifyingly, a recognition of our shared humanity, which medical professionals passionately defend as their source of meaning and purpose[2], despite the economic and logistical troubles that define healthcare systems today.

The students and doctors of tomorrow can identify this enduring moral imperative within the heart of their hearts. It is the role of those in medical education to enable them to apply it in practice. We must continue to expect rigorous knowledge and technical competence, but more so, we should begin to reward individuals who employ the power of the doctor-patient relationship to the benefit of the patient. We must not allow ourselves the usual refrains of lack of time, money, or administrative possibility. The changes proposed require no groundbreaking invention, but a purposeful reimagination of our relationships with our patients. The patient – singular and individual – and not the disease, the relative, the regulator, the government, or the bottom line, is our goal. For that, the doctor – singular but powerful – must be taught that they can and should, despite the noise, reach across and meet the patient, human to another formidable human.

This essay is dedicated to Dr Lise Paklet and Dr Abigail Manjunath, who, in addition to the indelible marks they have left on me as a patient, inspire me every day to become the doctors that they are.

References

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