GUEST EDITORIAL PREFACE

Special Issue on Patient Centered Learning and Early Clinical Exposure in Undergraduate Medical Education

Pranab Chatterjee, Department of Community Medicine, University College of Medical Sciences, New Delhi, India

P. Ravi Shankar, Xavier University School of Medicine, Aruba, Kingdom of the Netherlands

The Institute of Medicine defines patient centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." (Institute of Medicine, 2001) Based on the notion that the patient is at the center of the care-giving system, the modern healthcare system has built up the fortress of evidence based medicine, with the other founding pillars of best available evidence and physician experience supporting it.

It follows from simple logic thereafter, that any medical education system that aims to train physicians who provide patient centered care, should, therefore, by default, administer a patient centered learning curriculum. However, research has shown that although there is a wide and general understanding of the concept, the application of patient centered care is too vague, varied and non-uniform to make any meaningful impact on physician attitude and practice in the real-world setting (Haidet, Kelly, et al., 2006). The system becomes redundant in the developing world settings, where medical education and care provision are often dichotomous and divergent systems.

The growing advocacy for implementation of patient centered care in medical education from an early level has found interested takers at the policy-making levels in several countries. In India, the Medical Council of India has taken a radical step by declaring in a publicly accessible policy document, called "Vision 2015", the goal of implementing early clinical exposure.

Although specific micro-level details on the objectives, the methods of implementation and the curricular goals are not outlined, in what seems an admirable idealistic philosophy, the document states:

The clinical training would start in the first year, with a foundation course, focusing on communication, basic clinical skills and professionalism. There would be sufficient clinical exposure at the primary care level and this would be integrated with the learning of basic and laboratory sciences. Introduction of case scenarios for classroom discussion/case-based learning would be emphasized. It will be done as a coordinated effort by the pre, para-clinical and clinical faculty. (Medical Council of India, 2011)

Early clinical exposure (ECE) is becoming common in medical schools in various countries. In Nepal, ECE is offered to first and second year undergraduate medical students who follow an integrated, organ system-based curriculum and student feedback about ECE has been positive (Piryani et al., 2013; Rani et al., 2002). In Indonesia, ECE in primary healthcare centers during the preclinical years reduced difficulties commonly encountered by students during their first clerkship during the clinical year (Widyanadana et al., 2012). In Europe, ECE was implemented in 32 of the 40 medical schools studied and general practice/family medicine departments were widely involved in the teaching activity (Basak et al., 2009).

Medical humanities (MH) programs are common in developed nations and offer the contrasting perspective of the arts and humanities in a medical curriculum dominated by science. At KIST Medical College, Nepal a MH module titled *Sparshanam* was offered to all first year medical students (Shankar et al., 2012). At the University College of Medical Sciences (UCMS), New Delhi, India various activities related to MH are regularly conducted (Singh, 2014) and in India, the Centre for Community Dialogue and Change (CCDC) frequently conducts workshops on Theatre of the Oppressed for educators, students and other interested persons (Gupta et al., 2013). MH is becoming more visible and increasingly discussed in South Asia and has a number of advantages in medical education. MH provides glimpses of whole person understanding, and insights into shared human experiences (Shankar, 2011). Literature, drama, music, painting has specific benefits and introduces students to the 'art' of medicine. MH introduces and reinforces the patient perspective and is important to develop patient centered learning and patient centered practice.

In keeping with the rapid transitions in the terrain of medical education and evidence based practice, the International Journal of User Driven Healthcare has dedicated the current issue to the theme of "Patient Centered Learning".

This issue opens with an editorial commentary by Chatterjee, Price and Biswas (Chatterjee, Price & Biswas, 2014) in which they outline the contribution of the user driven healthcare model of providing patient centered care in developing primary care and public health core competencies by medical students involved with the system. The editorial comment concludes with the remark that the transition is imminent and patient centered learning is an effective way in developing core competencies, which may sometimes get ignored during the traditional training in which development of practical and clinical skills take up the most focus.

The editorial commentary is supported by the findings of Arora, Tamrakar, et al (Arora, Tamrakar, Price, et al., 2014) who conducted a mixed-methods study to assess the acceptability, feasibility and perceived benefits of a pilot patient centered learning sessions in clinical medicine. In a similar vein, Singh and Biswas (Singh & Biswas, 2014) have reported on a conversational learning experience around a patient who experienced a rare side effect of an often-prescribed drug: ranitidine-associated hepatitis. The article takes us through the conversational cues over social networks and both the teacher and the taught share their experience, expectation and take home message from the encounter. Instituting such short, planned,

pilot sessions administering patient centered learning could help in maturing the educational demands of medical students and help in transforming them into informed decision-makers and stakeholders in the transition of medical education in a system.

In a bid to demonstrate the tenets of patient centered learning, the issue then concentrates on case reports, which represent different facets of using real patients in teaching medical students the theoretical principles as well. Shrikhande, Galvez, Langendorfer, et al (Shrikhande et al., 2014) exhibit the coexistence of two common pathologies (pneumonia and stroke) tied together by a single explanation, a classical learning example of Occam's razor (Narain, Smeets, et al., 2014). In another case, Gupta et al (Gupta, Verma, et al., 2014) demonstrate the need for understanding the epidemiology of risk and exposure factors, which may manifest as clinical diseases. Using the example of glaucoma in patients who had been exposed to *Argemone mexicana* infested oils, they drive home the point succinctly. Verma et al present a case of ocular tuberculosis, where the stress is on having a high index of clinical suspicion for rare presentation of common pathogens or pathological entities (Verma et al., 2014). And finally, Damle et al (Damle, Agarwal, et al., 2014) walk us through a clinical encounter with a case of atypical ocular hemangiopericytoma, the proverbial zebra of clinical diagnoses and raises awareness regarding the rare presentations of rare diseases.

Perhaps it is Shankar (Shankar, 2014) who best epitomizes the philosophy underlying the current theme in his reflections on the fourteen aphorisms, based on David Loxterkamp's book, which every physician should aspire to live by. He takes us through the tenets and extensively annotates them with evidence as well as personal reflections on their adoption or modification in the real world context, especially in a developing country set-up. In a recent handbook on rural medical education, published by the World Organization of Family Doctors (WONCA), Reid and coauthors mention that rural communities and rural healthcare providers should be in-

volved, engaged and supported in the provision of rural medical education (Reid et al., 2014). Students from rural communities should be proportionally represented and content relevant to rural areas should be maximized and optimized and experiential learning in rural areas should be provided through community involvement (Strasser & Neusy, 2010). Developing closer links between medical education and the public healthcare system is also important.

Pranab Chatterjee
P. Ravi Shankar
Guest Editors
IJUDH

REFERENCES

Arora, N., Tamrakar, N., Price, A., & Biswas, R. (2014). Impact of a patient-centered learning model implemented through medical-student driven user-networks in a global online community: Acceptability, feasibility and perceived benefits. *International Journal of User-Driven Healthcare*, *4*(3).

Basak, O., Yaphe, J., Spiegel, W., Wilm, S., Carelli, F., & Metsemakers, J. F. (2009). Early clinical exposure in medical curricula across Europe: An overview. *The European Journal of General Practice*, *15*(1), 4–10. doi:10.1080/13814780902745930 PMID:19229784

Chatterjee, P., Price, A., & Biswas, R. (2014). Editorial Commentary: Developing public health and primary care competencies through patient centered care in a user driven framework. *International Journal of User-Driven Healthcare*, *4*(3).

Damle, V., Agarwal, R., Garg, N., & Gulwani, H. V. (2014). Atypical presentation of orbital hemangiopericytoma. *International Journal of User-Driven Healthcare*, *4*(3).

Gupta, S., Agrawal, A., Singh, S., & Singh, N. (2013). Theatre of the Oppressed in medical humanities education: The road less travelled. *Indian Journal of Medical Ethics*, *10*(3), 200–203. PMID:23912737

Gupta, S. B., Verma, D., & Singh, D. P. (2014). Glaucoma in epidemic dropsy. *International Journal of User-Driven Healthcare*, *4*(3).

Haidet, P., Kelly, P. A., Bentley, S., Blatt, B., Chou, C. L., Fortin, A. H. VI, & Inui, T. S. et al. (2006). Not the same everywhere. Patient-centered learning environments at nine medical schools. *Journal of General Internal Medicine*, 21(5), 405–409. doi:10.1111/j.1525-1497.2006.00417.x PMID:16704378

Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st century. Available from http://iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Loxterkamp, D. (2013). *What matters in medicine; Lessons from a life in primary care*. Ann Arbor, MI: The University of Michigan Press.

Medical Council of India. (2011). *Vision 2011*. Available from http://www.mciindia.org/tools/announcement/MCI_booklet.pdf

Narain, D., Smeets, J. B., Mamassian, P., Brenner, E., & van Beers, R. J. (2014). Structure learning and the Occam's razor principle: A new view of human function acquisition. *Frontiers in Computational Neuroscience*, 8, 121. doi:10.3389/fncom.2014.00121 PMID:25324770

Piryani, R. M., Shankar, P. R., Thapa, T. P., Karki, B. M., Kafle, R. K., Khakurel, M. P., & Bhandary, S. (2013). Introduction of structured physical examination skills to second year undergraduate medical students. *F1000 Research*, 2, 16. doi:10.12688/f1000research.2-16.v1 PMID:24555027

Rani, M. A., Sharma, K. S., & Koirala, S. (2002). What do students say about the early clinical exposure at B.P. Koirala Institute of Health Sciences, Nepal? *Medical Teacher*, 24(6), 652–654. doi:10.1080/01421590216084 PMID:12623464

Reid, S., Worley, P., Strasser, R., Couper, I., & Rourke, J. (2014). What brings us together: The values and principles of rural medical education. In Chater, A.B., Rourke, J., Couper, I.D., Strasser, R.P., & Reid, S. (Eds.), *WONCA rural medical education guidebook.* World Organization of Family Doctors (WONCA): WONCA Working Party on Rural Practice. Retrieved from www.globalfamilydoctor.com

Shankar, P. R. (2011). Medical Humanities. In R Biswas. & CM Martin (Eds.), User-driven healthcare and narrative medicine: Utilizing collaborative social networks and technologies. Hershey, PA: Medical Information Science Reference.

Shankar, P. R. (2014a). Fourteen aphorisms: From problem-solving to relationship-building. *International Journal of User-Driven Healthcare*, 4(3).

Shankar, P. R., Piryani, R. M., Singh, K. K., & Karki, B. M. (2012). Student feedback about the use of role plays in Sparshanam, a medical humanities module. *F1000 Research*, 1, 65. doi:10.12688/f1000research.1-65.v1 PMID:24358816

Shrikhande, A., Galves, T., Langendorfer, N., Jain, K., & Biswas, R. (2014). Stroke and Diaphragmatic palsy leading to Pneumonia. *International Journal of User-Driven Healthcare*, 4(3).

Singh, S. (2012). Multiple ingredients and not just spoonful of humanities. *Urological Annals*, 6(2), 180. doi:10.4103/0974-7796.130665 PMID:24833839

Singh, S., & Biswas, R. (2014). Ranitidine-induced hepatitis in a young man with myalgia and insomnia: Narratives in conversational learning experience. *International Journal of User-Driven Healthcare*, 4(3).

Strasser, R., & Neusy, A. J. (2010). Context counts: Training health workers in and for rural and remote areas. *Bulletin of the World Health Organization*, 88(10), 777–782. doi:10.2471/BLT.09.072462 PMID:20931063

Verma, D., Gupta, S. B., & Singh, P. (2014). Resolving diagnostic uncertainties in the clinical presentation of ocular tuberculosis. *International Journal of User-Driven Healthcare*, 4(3).

Widyanadana, D., Majoor, G., & Scherpbier, A. (2012). Preclinical students' experiences in early clerkships after skills training partly offered in primary health care centers: A qualitative study from Indonesia. *BMC Medical Education*, 12(1), 35. doi:10.1186/1472-6920-12-35 PMID:22640419

P Ravi Shankar is Professor of Pharmacology at the Xavier University School of Medicine, Aruba, Kingdom of the Netherlands. He is Chair of the Institutional Research Committee and Curriculum Committee. Dr Shankar facilitates a Medical Humanities module for first semester undergraduate medical students at the institution.