ABSTRACT

Medical students need to be equipped with knowledge and the attitude to tackle clinical complexity. The transition from classroom to clinical practice can be eased by the application of innovative student-centered learning methods. Through user-driven learning, which is asynchronous conversational learning in the web space between computer users, students can be encouraged to develop a comprehensive fund of experiential knowledge to enable them to quickly build physician-patient rapport and to apply decision-making skills in the face of uncertainty. This process offers medical students the opportunity to develop empathy and to participate in evidence sharing peer support groups. This article explores the concept of user-driven learning and discusses how this approach could be used in current health care settings to address knowledge gaps and inspire students and teachers alike.

Keywords: Clinical Case Solving, Empathy, Learning, Medical Decision-Making, Medical Education, Online Medicine, Patient and Public Participation, Students, User-Driven Learning

INTRODUCTION

Medicine is an art and a science, the practice of which requires an intricate blend of scientific expertise, practical aptitude and moral competence. In this era of evidence-based patient-centric medicine, the physician has to work in tandem with each patient to decide, not just “what is the best option” but “what is the best option for my patient”. To inculcate the traits required of a good physician, the mere mastery of theoretical concepts and clinical skills is not enough. The horizon of medical syllabi needs to be expanded to incorporate the shift in healthcare paradigms. A flexibly structured and adaptive program that focuses on creating a strong bal-

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anced foundation rather than merely completing pre-set syllabi is of immense benefit to both the trainee physician and society in general.

THE PRACTICING PHYSICIAN AND PATIENT CARE DICTUMS

In addition to medical knowledge and clinical skill, patient care is reflected in the interpersonal skills of a physician. Sir Frances Peabody succinctly stated “The care of the patient is caring for the patient” (Peabody, 1927). In a study conducted at the Mayo clinic, patients used terms like “confident, empathetic, humane, personal, forthright, respectful, and thorough” to describe an ideal physician (Bendapudi, Berry, Frey, Turner-Parish, & Rayburn, 2008). An ideal program will work to incubate these positive physician characteristics and build a foundation for therapeutic relationships with patients. The importance of translating these skills into practice is reflected when positive behavioral patterns amongst physicians result in improved patient outcomes and increased patient satisfaction (Hojat, Louis, Markham, Wender, Rabinowitz, & Gonnella, 2011).

ROADBLOCKS FACED DURING MEDICAL TRAINING

Indian medical schools use periodic objective structured clinical examinations (OSCEs) that assess the clinical competence of students (Sloan, Donnelly & Schwartz, 1995). Interpersonal skills form an integral component of such evaluations, and are often categorized as an independent parameter (Warf, Donnelly & Schwartz, 1995). Narratives from Indian medical students (authors SC and TB) touch upon the key roadblocks a medical student faces in identifying and developing these skills in India as well as their potential reward.

LEARNED INSIGHT

The typical student’s insight into the physician-patient relationship is based on observed clinical exchanges and anecdotes shared by senior physicians. It is a passive learning experience with little interaction with patients. In this atmosphere we learn about patients rather than with them and as a result we fail to explore patient values. Many medical students start out with empathy and optimism; however in the absence of judicious tutelage and active learning; the ‘humane’ aspects of patient-centric care can be lost. The vital question is how can this most valuable factor be cultivated and incorporated into our medical curriculums (Magalhães, Salgueira, Costa P & Costa M, 2011; Neumann, Edelhäuser, Tauschel, Fischer, Wirtz, Woopen, Haramati & Scheffér, 2011; Cooper & Mira, 1998)?

A supervised-environment, where students can be mentored on the nuances of patient care in real time before embarking upon an independent

Narrative 1.

Teaching modules and textbooks are not sufficient to teach a medical student how to be a good physician. We learn by observing our peers and seniors, but our most important teachers are our patients. My conversation with my first patient was more of a viva-voce examination, punctuated with abrupt pauses—my voice was trembling and I was trying hard to remember all the “questions” as per the training manual. Suddenly, I looked up to find my attending standing there. A legend in the hospital, his presence made me feel even more embarrassed at my apparent ineptitude. Instead of ridiculing me however, he gently taught me an important lesson—“Talk to the patient as you would to your own family member or friend. Extend them the same courtesy, and also the same level of comfort. You’ll learn ‘what’ to ask as you grow as a physician, so do not worry about that aspect. Right now, focus on ‘how’ you will interact with him”.

Emboldened and enlightened, I went back to my patient and proceeded to ‘talk to him’ rather than merely ‘taking a case’. Not only did I finish taking a complete history in a shorter time than anticipated, I also gleaned some important information, which he had not shared with the resident. This helped me consider a new differential. Over the years, I have had many such physician and patient encounters teach me the value of compassion, empathy, trust and the value of empowerment and inclusion for the patient in the decision-making process. These values enhance my personal and professional growth.
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