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Educational Strategies

Doctors' role in long-term care: How do students learn about it?

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ABSTRACT

This paper is an attempt to answer the question of how to help undergraduate medical students learn about the principles of long-term healthcare management. The authors are concerned that undergraduate medical students are often not formally taught about this matter except from the purely technical aspects of longitudinal healthcare provision, and that it is necessary to be aware of certain issues as undergraduate students to facilitate improved expertise as they become qualified doctors. The authors suggest that the topic requires consideration in light of newer concepts of the role and value of long-term health care for patients in general.

The authors propose several ideas about how to achieve this in small group settings, and this paper includes a series of points for discussion within these groups. The list of issues to be discussed includes encouragement for all teachers to discuss long-term healthcare issues with undergraduate medical students, how to develop and maintain positive working relationships over multiple clinical encounters, to be aware of the overall concepts of doctoring, holding relationships, spiritual values within long-term healthcare, and heartsink. The authors hope this novel addition to the curriculum will prove useful as an adjunct to student learning about professional roles.

INTRODUCTION

This article was originally inspired by some recent meetings at which experienced and inexperienced Cardiff General Practitioners (GPs) received post-graduate education from Hospital Specialists. At each meeting the Specialists were asked about patients with difficult long-term care needs, and they each indicated that they had received no useful, formal tuition on how to provide long-term health care as medical students. This raised questions on the whole notion of teaching about long-term care, and whether it is still as undervalued as has been described in the 1970s [1].

The authors wanted to consider whether students had been explicitly taught about this in the past and present curricula, and if it is feasible to include this subject in future curriculum changes. The central issue is this – do clinicians dealing with difficult long-term ill health learn to do so primarily and/or solely over a period of post-graduate work? This paper will consider these issues from the vantage point of the authors as teachers to undergraduate medical students.

The authors emphasise that the paper will not discuss appropriate testing and follow-up for long-term conditions such as Diabetes or Asthma where primary care provides clinical management within defined parameters, though this model is itself contentious [2]. Neither is this written from a Social Sciences perspective about the respective roles of the care-provider and the patient. Rather, the authors hope this paper may clarify some of the issues involved in students' learning about more difficult issues involved in maintaining long-term healthcare management (for instance how to maintain high levels of ongoing health care relationships), although it is not intended to be a formal review, but instead an attempt to stimulate debate.

TEACHING ROLE

The Cardiff University Medical school undergraduate curriculum has evolved during the twenty years that some of the older authors have been teachers. However, in essence the curricula so far have comprised two years of primarily lecture-based medical sciences work followed by three years of clinical-based teaching, mostly in hospital. There is to be a major curriculum change in 2013, where students will start seeing patients much earlier in their undergraduate career and there will be greater integration of pre-clinical and clinical study.

The authors' personal roles within the present curriculum are myriad covering teaching of basic clinical skills and they have further made contributions to the literature on the teaching of professionalism, the role of teaching about care, the role of 'living history', the role of the history of medicine, and roles of drama to help with public health messages among others. It is inherent to these roles that the authors subscribe to the concepts of education based around patient-centredness, an holistic view of the patient, in essence allowing the patient and the patient's views to be at the centre of any illness and doctor-patient interaction [3].

Students undertaking the present Cardiff curriculum do learn about patients in the longer-term involving following specific families for about nine months during their first years of undergraduate study. Students have to complete two studies, one is of a patient with a cancer and one is with a patient with either a new baby or one with long-term health problems. The authors recognise the literature which demonstrates these to be useful and valuable resources; students from other countries gain enormously from variations on a theme of these educational inputs [4-8].

However, the authors wonder if this has been sufficient to learn about continuing long-term care, and they propose a series of small-group discussions with students about some of the values and principles involved in long-term care as a form of extra 'involvement' in an attempt to counter the views expressed from the 1970s [1]. The authors also propose these can be led by GPs with some involvement from secondary care clinicians to discuss strategies for maintaining clinical interest and involvement, whilst maintaining the 'cool headed clinical stance' [9].

Community-based Teaching and Care

In essence GPs look after patients for their immediate primary healthcare needs in the context of an ongoing, potentially lifelong personal doctor-patient relationship; consequently GPs also plan for long-term conditions and there are always potential opportunities to consider long-term health matters [10]. Primary care is now increasingly wedded to the notion of increased long-term 'health promotion' to facilitate better long-term health, even though one of the authors of the original paper argued that using this dictum inappropriately may not reap as many benefits as expected [11].

Thus, students may see primary care medicine in particular, but perhaps also medicine in general, as a subject where the definition of 'good' in the phrase 'good medicine' means merely providing good episodes of care, rather than of seeing general practice as a potential long-term caring relationship with its attendant health benefits [12]. The authors feel that emphasising short-term measures of 'good care' will result in students not appreciating the longer-term role of community medicine.

In this context 'holding relationships' (in essence providing long-term care and support without looking to provide overt short-term health benefits) are not perceived as good, although this is partly because they are difficult to quantify. However, a recent paper and accompanying editorial are challenging this view [13,14]. The authors feel this concept needs to be discussed with under-graduate medical students, allowing them to become aware of these principles, albeit in small group discussions akin to learning about issues such as professionalism, empathy and care [15-17].

There is a further concern that patients with long-term health issues may be perceived as potential 'heartsink' patients (literally giving the doctor a sinking feeling when a particular long-term patient requires ongoing healthcare) [18]. The authors feel this should be explored further as suggested by a recent article revisiting the concept [19], although in a reply to this latest piece the original author of the 'heartsink' paper feels the term is disrespectful [20]. It is possible that this is a further manifestation of negative comments from the 1970s, and should be further broached.

The authors pose the rhetorical question as to whether all students are encouraged to look after those patients who can be cured and/or ameliorated and this leaves undergraduate students and junior doctors frustrated when this does not come to pass. It is interesting that a number of newer undergraduate medical courses, and in particular one in the US, are providing more teaching and learning on the wider concepts of 'doctoring' [21]. In this they specifically include the idea of addressing the wider implications of providing care for more than one episode of illness, and to appreciate the skills needed to achieve this, going onward into the longer term. The authors support the 'face validity and 'utility' of this approach.

Professional roles and integration

There is a professional role for all doctors to be aware of difficulties in providing long-term care for patients, whether they are in primary or secondary care, and it is of note that this is specified as a professional role by the General Medical Council [22]. As Teachers, the authors recognise the difficulties of preparing doctors for the future, and it is to be hoped that this is where the GMC can continue to act as support and resource, both to medical schools and to individual (future) doctors.

The provision of long-term care is a subject that is relatively devalued, partly because there is a paucity of longitudinal studies into its effectiveness or otherwise, and partly because the ethos of the NHS is perhaps changing into one of episodic health care management [23]. Further, the nature of work within the NHS has changed with more part-time work, more short-term working arrangements, and less continuity of care [24], a situation applicable to both primary and secondary care.

The best place to see and learn about long-term care concepts in action is within the community. Here, students will have an opportunity to see the GP as advocate, provider of long-term support, and as a consistently available practitioner in diffuse cases where care is provided from myriad secondary care sources [24,25]. Inevitably, there are issues which may not be so pertinent to inexperienced students; as examples the experienced authors have noted that the experience of being GPs in their respective communities had led to issues of maintaining long-term goals and support for troubled individuals, and 'mini-bereavements' around patient deaths.

These long-term care aspects can at least be discussed with students, in the context of a more long-term relationship, and that this may entail bringing in concepts from non-medical fields. In their piece about 'brief communication', Crawford and Brown discuss the role of long-term care for all health professionals [23], and the authors concur with their views that it is pertinent to consider the role of appropriate communication from short-term and long-term perspectives.

Further, the doctor's role has a spiritual dimension and understanding the role of a doctor in these terms may be helped by looking to more traditional beliefs, such as the value Islam places on serving the community [26], the role of the doctor as akin to a priest from Christianity [27], the role of good service from Judaism [16], and the role of care from Buddhism [17]. This spiritual dimension of health has been largely ignored until recently, although this is changing [28]. Research in this field is inconclusive [29], but contemplating spirituality and its effects on health may better help students understand patients within their communities.

These aspects need to be integrated into a more coherent role of future teaching such that students can understand - and perhaps empathise with - the value of long-term professional health care relationships. It is useful for students to appreciate good communication in its short-term, and in its long-term contexts [23,24]. Further, these aspects will help students to gain a population-based as well as a person-based perspective on health care [7,30].

CONCLUSIONS

The authors note that the subject of long-term health care is difficult to teach formally, may be more of a post-graduate subject to be taught in the specific Specialty individual doctors take up in their careers, and that all qualified doctors need to learn for themselves the skills required. However, it is important for undergraduate students to be made aware of these matters prior to qualification, even if it is an implicit part of the 'hidden curriculum' which may be how the authors themselves learnt about at least some of the issues described [31].

In Cardiff, a new curriculum is hoping to equip medical students with more potential learning about the provision of long-term care. The authors specifically advocate that the issue of long-term health care should continue to be considered, especially in the potentially different, more complex, less organised, future NHS. In this manner future doctors will be able to agree that this subject had at least been broached during their undergraduate study, that it was discussed in a positive light, and that all doctors will be equipped to maintain good long-term healthcare relationships.

In conclusion, a potential list for inclusion of issues to be discussed with students in small groups comprises; (a) developing positive working relationships over multiple clinical encounters, (b) long-term relationships as doctors' careers progress, (c) maintaining professional boundaries, (d) maintaining levels of care, (e) the overall concept of doctoring, (f) short-term and long-term communication, (g) discussion of holding relationships, (h) spiritual values within long-term healthcare, (i) encouragement for all teachers to discuss long-term care in their dealings with undergraduates, (j) accepting heartsink as an entity but viewing this positively.

As stated in the Introduction to this paper this list is not intended to be exhaustive but is intended to represent an initial consideration of the subject to be discussed further with undergraduate students. Perhaps, in this manner future qualified doctors in any Speciality may feel more able to manage long-term health care, and undergraduate students may feel better prepared as they go through the transition from students to qualified doctors.

REFERENCES

1. Kutner N. Medical students' orientation toward the chronically ill. J Med Educ 1978;53:111-18.
2. Mangin D, Toop L. The Quality and Outcomes Framework: what have you done to yourselves? British Journal of General Practice 2007;57:435-37.
3. McWhinney I. A textbook of family medicine. Oxford University Press, Oxford, p 61, 1996.
4. Puvanendran R, Vasanwala F, Kamei R, Hock L, Lie D. What do medical students learn when they follow patients from hospital to community? A longitudinal qualitative study. Med Educ Online 2012;17. doi:10.3402/meo.v17io.18899 Epub 2012 Jul 10.
5. Wee L, Xin Y, Koh G. Doctors-to-be at the doorstep – comparing service-learning programs in an Asian medical school. Med Teach 2011;33:e471-78.
6. Walters L, Prideaux D, Worley P, Greenhill J. Demonstrating the value of longitudinal integrated placements to general practice preceptors. Med Educ 2011;45:455-63.
7. Muir F. Placing the patient at the core of teaching. Med Teach 2007;29:258-60.
8. Lumma-Sellenthin A. Talking with patients and peers: medical students' difficulties with learning communication skills. Med Teach 2009;31:528-34.
9. Sokol D. How to be a cool headed clinician. British Medical Journal 2012;8:344:e3980 doi: 10.1136/bmj.e3980
10. Stott N, Davis R. The exceptional potential in each primary care consultation. Journal of the Royal College of General Practitioners 1979;29:201-05.
11. Stott N. When something is good, more of the same is not always better. British Journal of General Practice 1993;43:254-58.
12. Freeman G, Hughes J. Continuity of care and the patient experience. Research paper for the King's Fund Inquiry into the Quality of General Practice in England 2009–10. Available via www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/continuity_of_care.html (Accessed September 2012).
13. Cocksedge S, Greenfield R, Kelly Nugent G, Chew-Graham C. Holding relationships in primary care: a qualitative study of doctors' and patients' perceptions. British Journal of General Practice 2011;61;506-07.
14. Freeman F. Holding relationships in primary care: What are they? How do they work? Are they worth having? British Journal of General Practice 2011;61; 486-87.
15. Hilton S, Slotnick H. Proto-professionalism: how professionalization occurs across the continuum of medical education. Med Educ 2005;39:58-65.
16. Jacobson L, Hawthorne K, Wood F. The 'Mensch' Factor in General Practice: a role to demonstrate professionalism to students. British Journal of General Practice 2006;56:976-79.
17. Jacobson L, Cunningham A, Greene G, Melbourne E, Morris L. Do you really care doctor? British Journal of General Practice 2009;59:460-62.
18. O'Dowd T. Five years of heartsink patients in general practice. British Medical Journal 1988;297:528–30.
19. Moscrop A. 'Heartsink' patients in general practice: a defining paper, its impact and psychodynamic potential. British Journal of General Practice 2011;61:346-48.
20. O'Dowd T. 'Heartsink' patients in general practice. British Journal of General Practice 2011;61:437-38.
21. Wilkes M, Usatine R, Slavin S, Hoffman J. Doctoring: University of California, Los Angeles. Academic Medicine 1998;73:32-40.
22. General Medical Council. Good Medical Practice. London; General Medical Council. 2012.
23. Crawford P, Brown B. Fast healthcare: Brief communication, traps and opportunities. Patient Education and Counselling 2011;82:3-10.
24. Silverman J, Kinnersley P. Calling time on the 10-minute consultation. British Journal of General Practice 2012;62:118-19.
25. Abbott D. NHS changes: David Cameron's dodgy prescription. Available via http://www.guardian.co.uk/commentisfree/2011/jan/17/nhs-reforms-cameron (Accessed 28 February 2012).
26. Al-Ghazali. Ihya 'ulum al-din. The Revival of the Religious Sciences. 5 vols., Matba'ah Lajnah Nashr al-Thaqafah al-Islamiyyah, Cairo, pp 1937-38.
27. Pink J, Jacobson L, Pritchard M. The 21st century GP: physician and priest? British Journal of General Practice 2007;57:840-42.
28. Chattopadhyay S. Religion, spirituality, health and medicine: why should Indian physicians care? J Postgrad Med 2007;53(4):262-66 Epub 2007 Dec 22.
29. Koenig H, McCullough M, Larson D. Handbook of Religion & Health. Oxford University Press, New York, pp 5-13 2001.
30. Howe A, Billingham K, Walters C. Helping tomorrow's doctors to gain a population health perspective – good news for community stakeholders. Med Educ 2002;36:325-33.
31. Lempp H, Seale C. The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. British Medical Journal 2004;329:770-73.