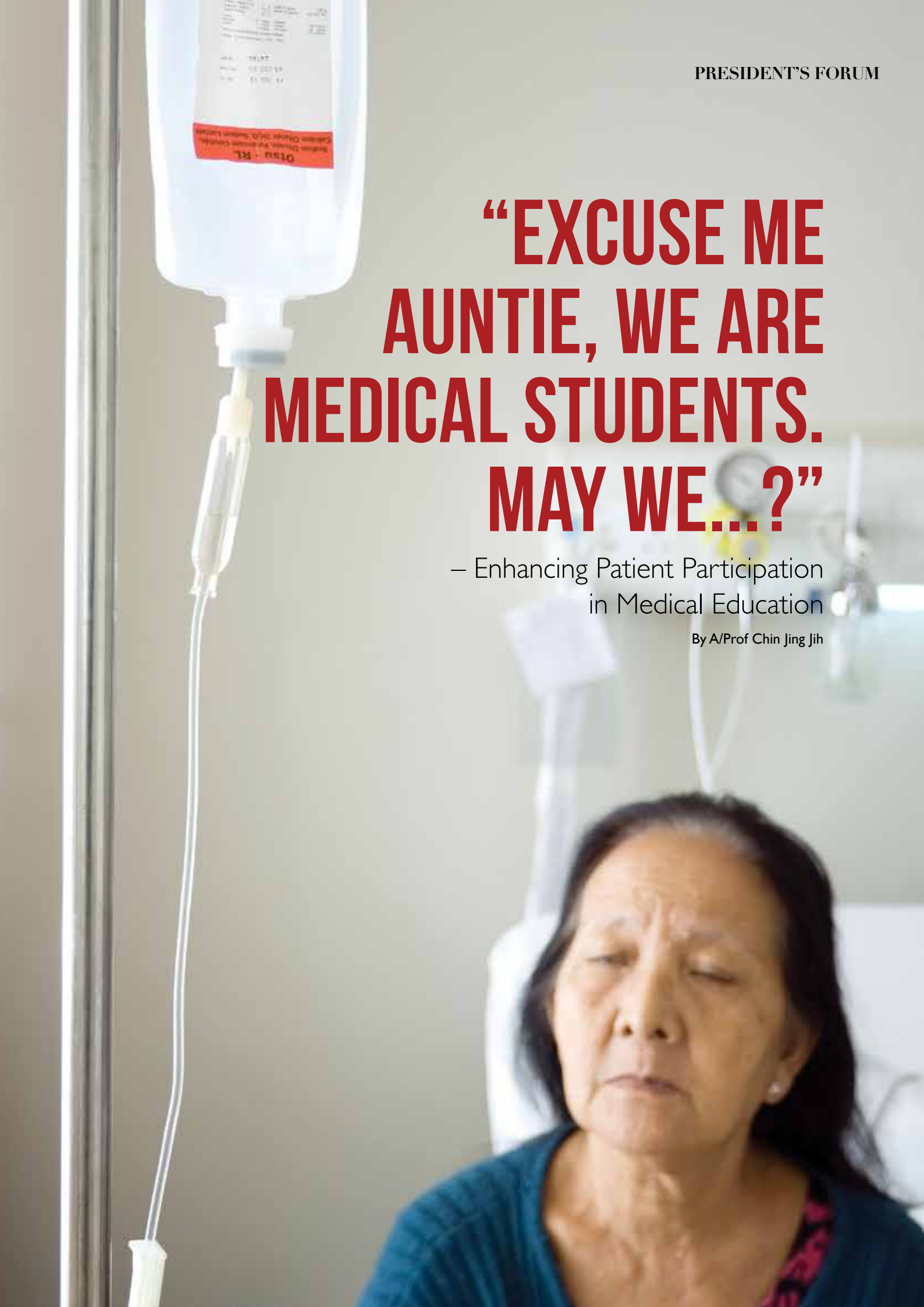

"EXCUSE ME AUNTIE, WE ARE MEDICAL STUDENTS. MAY WE...?"

– Enhancing Patient Participation in Medical Education

By A/Prof Chin Jing Jih

I RECENTLY served as an external examiner for the final year examinations of a medical school in Malaysia. Through my conversations with the faculty of the school, I realised that medical schools in both Singapore and Malaysia are facing similar challenges in finding adequate clinical materials involving real patients for both teaching and examinations. Two developments in the healthcare landscape account for a large part of this difficulty that we currently face.

Firstly, patients with clinical features suitable for teaching and training are becoming increasingly scarce. Many of those once common physical signs like heart murmurs, severely deformed joints and large thyroid goitres are fast diminishing in numbers. Successful primary and secondary prevention programmes, wider and earlier access to curative and progression-arresting treatments have helped to prevent, remove or halt the deterioration of many previously untreatable conditions such as rheumatic heart disease, rheumatoid arthritis, grossly enlarged thyroid goitre – just to name a few. Undeniably, this is a good thing for patients and society, but it inevitably poses difficulties to an experiential learning model that requires direct observation and interaction with patients who have actual clinical features.

"A strong partnership with our patients is critical to producing future generations of technically and ethically competent doctors."

The second problem is the growing reluctance among patients to consent to participation in medical education. While patients in general have remained obliging to requests from their treating hospital or physician, many are also complaining of "fatigue" from repeated rounds of history giving and physical examinations purely for the benefit of the students and trainees. Furthermore, patients are now more aware of their rights and know that they can say "no" to the long queue of medical students waiting to interview them and to probe their thorax, abdomen or inguinal regions, or to subject them to repeated routines of exhausting neurological examinations.

The scarcity of suitable and willing patients, coupled with a parallel increase in the number of medical students and trainees, is beginning to give rise to a subtle "competition" among medical educators and students for the limited pool of patients. This challenge is not limited to Internal Medicine or General Surgery, but also extends to the teaching of Paediatrics, Obstetrics, Ophthalmology and other medical disciplines.

Patient participation – right or obligation?

Many doctors who came from the "good old days", when patient cooperation was a given, do question if patients have a right to decline participation in medical education and training of future doctors and specialists. After all, the patients themselves are the likely beneficiaries from well-trained and competent doctors. But we are living in a time where it would be difficult from both the legal and professional perspectives to mandate participation and cooperation from patients. The laws governing individual privacy rights and the right to be left alone will prevail. It would also be easy to argue that an unlimited conscription into medical education activity can work against the best interest of patients, many of whom require rest as part of their therapy in hospitals.

However, this best-interest consideration should perhaps be reframed as achieving an appropriate balance between immediate protection of patients' right of privacy and well-being, and a longer term best interest of producing well-trained and competent doctors. Of course, medical teachers and students must still ensure that the educational activities do not harm patients, and set reasonable limits to ensure that they are not hurt or harmed. Therefore, while one can easily argue that patients, with all their intrinsic vulnerabilities, must not be compelled or coerced into submitting themselves as "clinical training materials", one may not be able to ignore the counterargument that patients do have a moral obligation to help sharpen the clinical skills of future doctors that will benefit present and future patients, including themselves. This moral obligation is distinct from a legal compulsion, and is premised upon the reality that only patients with relevant diseases can provide future doctors with the much needed experiential training to hone their clinical skills.

Patient cooperation and participation in clinical training should therefore be framed as part of the larger social compact between patients themselves and the medical profession. In this social alliance, medical educators, trainees and students should recognise their duty to protect patients from harm and fatigue, while

patients acknowledge their obligation to assist in relevant clinical training. Many teaching hospitals in other parts of the world proactively notify their patients that by choosing a teaching hospital, they stand to benefit from the school's excellent academic activities and cutting-edge Medicine. They should therefore be willing to assist in clinical training; consent for medical education is therefore obtained implicitly from them.

Some have also argued that in Singapore, where subsidised and non-subsidised or private patients coexist under one public healthcare system roof, only subsidised patients should be obliged to assist in clinical training, while the right to refuse is a privilege reserved exclusively for private patients. I would argue against such a position as the obligation towards clinical education does not stem from an inability to afford the extra non-clinical comforts and frills, and thus should not be linked to how much patients pay for their healthcare.

Alleviating the shortage of patient volunteers

One of the more definitive responses to the shortage of real clinical material is the development and use of simulation in medical education. With rapid technological advancements and innovations, simulation is fast becoming popular in medical schools as it provides a legally protected yet highly realistic learning environment for medical students. Compared to real patients, simulation also offers a more predictable and controlled environment, not to mention the actors or dummies are generally much less likely to fatigue. Thus, simulation is able to train many students at much lower risk in terms of patient safety.

There is just one problem. The predictability of simulation is also the reason why it is not perfect. Without contact with real patients, medical students will never have the opportunity to come face-to-face with unexpected scenarios and learn how to respond appropriately. When dealing with a real patient, a hundred and one unexpected scenarios can happen. Like trainee pilots who need to clock actual flight miles despite spending hours on flight simulation, students may never be ready for real work in the wards and clinics, until they have some exposure to the unpredictable nature of clinical practice. Therefore, while simulation is a useful and effective innovation to reduce patient risk and dependency on patient cooperation in medical education, it can never completely replace interacting with real patients, doing a digital examination on a case of benign prostatic hypertrophy, or inserting an indwelling catheter into an actual patient.

It is therefore important for the medical profession and patients to look at a sustainable framework of solidarity based on common and wider objectives that are mutually beneficial. We need to see patients not merely as providers of suitable clinical materials, but as part of the education and training faculty. We need to nurture a relationship of empathy and respect, so that patients feel that they are valued as part of the medical education endeavour when they volunteer themselves. The profession needs to actively engage and manage this social compact, and medical teaching institutions will need to devote resources and attention to nurture the relationship.

An example of how far a model of reciprocity and mutual respect between patients and medical community can go in medical education is the Silent Mentor programme which originated some 18 years ago at Tzu Chi University in Taiwan. Upon the deaths of those who sign up with the programme, their bodies will be donated and assigned to medical students and trainees for anatomy lessons and simulated surgery. But before the commencement of dissection, the assigned students will visit the families of the deceased to learn about the donors' lives and get to know them as persons, a process which teaches students to "respect the lives" of the donors. After dissection has concluded, the students will hold a ceremony and respectfully suture the parts of their silent mentors together. At the donors' funeral, the students will publicly read a letter of gratitude to their "silent mentors" and bow respectfully to pay their final respects. After the donors are cremated, their ashes are placed in specially designed crystal urns and housed in a reserved space in a columbarium at Tzu Chi's medical faculty, where family, students and teachers may return to pay their respects.

As a result of this open respect shown by the medical students participating in this programme, many more are now willing to donate their bodies for medical education. Through the noble act of patients, medical students involved are also enriched by the learning of important human and professional values like altruism, respect and empathy. (Editor's note: read about medical student Denyse Lee's participation in Tzu Chi's Silent Mentor programme in last month's issue of *SMA News*, or http://goo.gl/5Z53mb.)

Medicine is a noble profession, and it is apt that the teaching and training of future generations of doctors be sustained and enriched by noble and altruistic intentions of patients, and reciprocated by the respect and empathy from doctors, that are defining qualities of the profession. A strong partnership with our patients is critical to producing future generations of technically and ethically competent doctors. SMA

A/Prof Chin is President of the 54th SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.