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Postgraduate Education - a personal view

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[Health professionals education. Here, ‘doctors & nurses’]

‘Postgraduate’ : that variable time for the successful acquisition of a ‘package’ of experience (prescribed)

‘Education’ : broad term - includes both the providing of, and the acquiring of knowledge and ability - overtly or covertly learned. Not quite the same as ‘training’

Personal learning and experience is unique to each person, ‘education’ is difficult to measure in depth.

Plenty of tests and assessment tools to measure ‘training’

Training changes or improves what a person **does**

But *Education* - changes who the person **is**

Professionalism can be observed and discrete elements can be tested, but impossible to truly measure full extent of individual deep change.

Focused tools assess a doctor's or nurse's knowledge, skills and performance – typically MCQs and OSCEs, WBA

Some 'soft' measures: changes in personal behaviour, formal /informal interviews with patients or staff, observation of clinical encounters, peer discussions, self reflection. Cannot be rigidly assessed. Observer bias?

Postgraduate education is a combination of:

- *Specific training* - in named skills + linked knowledge (directly influencing clinical practice)
- *Professional development* – through mentorship, and acquiring skills and interests (directly or indirectly influencing clinical practice)

- hobbies: chess and similar (improve strategic thinking skills),

- creative art, reading (deeper understanding of human behaviour)

- learning new languages, immersion in different cultures (empathy; opening self to a wider world)

- *Personal growth* – eclectic acquisition of non-medical knowledge and skills (self-reflective understanding, social awareness, flexibility and adaptability, philosophical beliefs, compassion, relationships)

Why not just focus on training good practical and procedural skills? Are the other factors a luxury? Not really.

•*People are complex creatures. When as patients, even more so*.

• Nurses and Doctors need to read a person well to understand their symptom and illness well. The best procedural skill may not be sufficient to “cure” someone’s illness or physical distress because of:

~ Personal or relationship problems / underlying stresses

~ Secondary gain

~ Fear or distrust of treatment / bad previous experience

~ ‘Doom’ conviction / false information / cultural beliefs

~ Undeclared other illness (eg eating disorder, depression)

The good doctor must be not only a good physician and practise medicine safely, but be an empathetic and wise storyteller, to explain illness well, gain trust, and connect as a human being.

So, how can all that be taught? Can it be learned in a course? Or by example? Who teaches excellence - the university? The expert? The patient? The experience?

We all know that CME is only part of CPD

At some point ‘education’ becomes ‘wisdom’ – and here is where the wise doctor transforms into the excellent mentor.

But CPD is only part of '*CPPD*'

CPPD = Continuing Professional and Personal Development

CPPD is not only lifelong learning, but *learning life*

So, for doctors, should postgraduate medical education look again at how to enable good doctors to grow into wise doctors?

Or, should personal development education be a mandatory part of the medical curriculum and start at early undergraduate level?

Why is CPPD as important (if not more) than CME?

Risks in medical career:

- Stress from self doubt - fear of missing diagnoses or failing to provide timely treatment (even risk of PTSD)
- Time and work pressures – burnout syndrome
- Higher suicide rate – doctors and dentists
- 'Medical personality' – tendency to set too high standards for self, tendency to perfectionistic and obsessive traits
- Risks of litigation
- Others (financial or partnership conflicts, 'in public eye')

In UK, for female health professionals (aged 20 – 64), the risk of suicide is 24% higher than the female national average, due to high suicide risk among nurses. (Office for National Statistics, England, 2011 – 2015).

In USA, one doctor takes their own life every day. Risk factors for suicide among doctors include complaints and a lack of support structure, poor emotional resilience, stigma of mental health issues such as depression. Depression is even more common in medical students and residents in USA (30% of all).

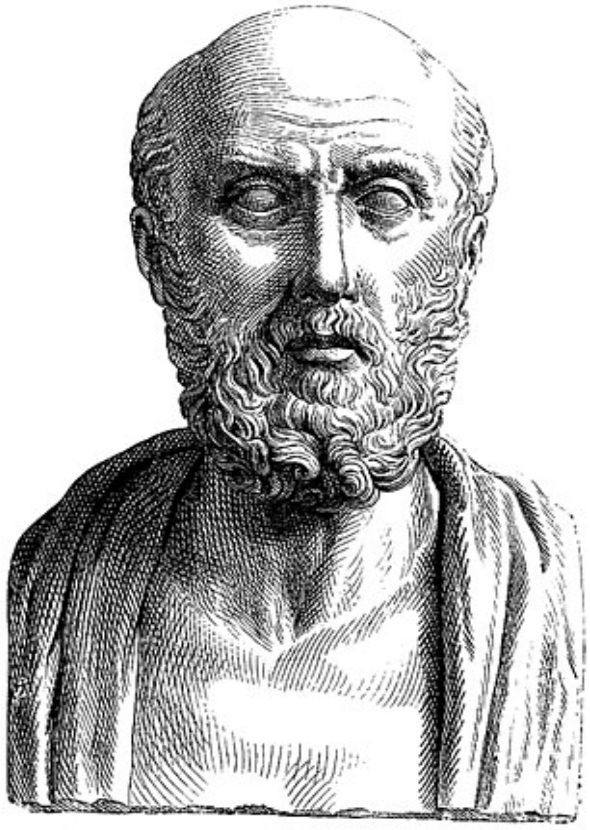
Studies from Finland, Norway, Australia, Singapore, China, Taiwan, Sri Lanka, and others have shown increased prevalence of anxiety, depression, and thoughts of suicide among students and medical practitioners. (Medscape 'Physician Suicide', Aug 2018)

Not easy to ‘educate’

Easier to ‘train’

But knowing that 1 in 3 consultations in PHC are for indeterminate or psychosomatic illnesses, then helping family doctors and nurses to become stronger and ‘wiser’ persons will benefit patients and themselves, (and maybe even reduce healthcare costs where complaints can be managed without unnecessary drugs or invasive procedures).

Thank you



QUESTIONS ?

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