



Medical education—An ideal remedy to cure our health care systems?

by Ursula Kramer

Health care systems all over the world are suffering from a growing financial burden. Nobody can deny the rising economic pressure all players—physicians, patients, pharmaceutical companies and health insurance companies—are faced with. Physicians are no longer the only decision makers determining which drug to use or which treatment to start with, and they are increasingly obliged to act within the narrow framework of guidelines based on criteria of evidenced-based medicine. Reimbursement is controlled by government-associated institutes that assess what is an innovation and needs to be paid for. Ultimately, physicians are faced with the worsening dilemma of finding a reasonable balance between optimal and rational medical treatment. That puts a great strain on the trustful patient relationship and threatens physicians' role of being patients' advocates.

Patients' role is gaining in importance

In parallel with the increasing regulative control of government, official bodies intend to strengthen the role of patients. Patients expected to pay for their health out of their own pockets may demand concessions regarding decision processes and quality control. How they should exercise their new rights in a reasonable manner remains unclear. It's true—medical knowledge was never accessible as easily, cheaply and conveniently as it is today. The variety and depth of information concerning health or diseases is impressive. Physicians' lead in the field of medical knowledge seems to be melting away. Patients' expectations are growing, but also their need for guidance, since a confusing jungle of information is growing steadily.

What role can medical education play?

Facing the landscape in which medical education is embedded, it is legitimate to ask what the future contribution of medical education can really be. Isn't the battle already lost? Wouldn't it be better to drop the idea of enabling every patient to gain access to the therapeutic innovations that medical progress is offering today and will be offering tomorrow? Is it an unattainable goal to improve overall health and quality of life since ethics have already been superseded by monetary considerations? On the contrary—prospects were never better to make a real difference by means of medical education.

Leveraging the partnership between physicians and patients

Most of our health care money is spent to cover the cost of diseases caused by eating the wrong food, overeating and

lack of exercise. Treatments for hypertonia, diabetes and arteriosclerosis are the main cost drivers, and a lot of money is wasted due to a huge lack of patient compliance. If this fatal development cannot be stopped, growing health care expenditures will ruin economic systems all over the world.

To start implementing change, we don't need better treatments to control symptoms and prevent or slow progression of the above-mentioned diseases. Physicians with a changed mindset are the cure! They need to stop seeing their role primarily as treaters of disease, but must instead learn to think of themselves as enablers of disease prevention. Accordingly, patients need to be guided so that they accept personal responsibility and actively contribute to staying healthy. Prevention and preventive medicine are the buzzwords here, and medical education, focusing on physicians and patients, is the communication channel that can help leverage their future partnership.

Helping physicians adapt to future challenges

The impetus of this article is to highlight opportunities that may arise from defining medical education in broader than usual terms. In addition to merely making knowledge available, this broader definition of continuing education also includes offering solutions on how to implement and convey this knowledge (organisation, division of labour, delegation, workflow). We believe that gradually establishing a physician-patient relationship based on partnership involving empowered and self-determined patients is more easily achieved by involving and training physicians by helping them, in very practical terms, to improve communication with their patients in daily practice. To get physicians to participate in this vision, they first have to become aware of and understand the benefits for themselves and their practice.

From medical expert to expert motivator

New skills are necessary to motivate patients to become partners, partners who are willing to take responsibility for staying healthy. In addition to their medical expertise, health care professionals have to develop additional skills, similar to teachers or coaches, to become efficient motivators of their patients. Therefore, special training in the fields of communication and organisation is required. Services that support optimised workflows and reveal new time resources are also needed so that physicians can find the time to create an empathic and caring atmosphere as a basis for effective interaction with their patients.

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An example: Your vaccination status

Let's take a look at an example from the field of preventive medicine. It begins with a short experiment in the form of three simple questions you should try to answer honestly:

1. Do you know your vaccination status documented in your vaccination certificate?
2. Has your gynaecologist or GP ever asked you to check your vaccination certificate?
3. Do you know which preventive check-ups are offered and paid for by your health insurance?

You probably answered “no” to all three questions. Welcome to reality, the starting point of our efforts. When physicians were asked to give an explanation for this dire situation, the main answers were:

1. We agree, vaccination is important, but unfortunately we are not thinking about it—not on purpose, it just happens. There are so many other diseases and problems we have to tackle.
2. We really don't feel able to delve too deeply into the complex topic of vaccination. Every single year the experts' recommendations change, so that we are not sure whether we are acting according to recent recommendations. So we step back and wait until patients bring up the subject. And unfortunately, that doesn't happen very often.

The Vaccination Watch—Complex recommendations made easy to use

After consultation with physicians and their staff we developed two handy information tools. The first was the Vaccination Watch (Fig. 1) which condenses and transforms recent experts' recommendations (20 pages!) and makes them easy to use and remember by physicians and assistants in real-life situations. The watch was implemented in three different versions to meet the demands of three medical

Figure 1 Vaccination Watch for Physicians and Assistants (GPs)
Facilitates the checking of vaccination certificates based on recent experts' recommendations (*STIKO-Empfehlung, Ständige Impfkommission am Robert Koch Institut, Berlin*)
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target groups—GPs, gynaecologists and paediatricians, that all deal with different patient profiles. Demand for the Vaccination Watch was high after its launch: to date, more than 100,000 watches are being used by physicians across Germany.

The Prevention Watch—Supporting access to healthy patients

The second tool was the Prevention Watch which has an interactive, self-explaining display that creates awareness for vaccinations and preventive check-ups, depending on the age, sex and health status of the patient. It is placed in the waiting area of doctors' offices or in pharmacies. Physicians who already use this watch confirm that engaging healthy people on the topic of prevention is easier now, since patients themselves take the initiative and ask the doctor's team about it more often.

Team training in vaccination management

Besides introducing these hands-on tools, we also trained the physicians' teams by confronting small working groups with real-life problems in a positive and interactive learning atmosphere. First they learned to check the vaccination documents and discussed vaccination schemes, indications and adverse effects. Then they were given the opportunity to apply their new knowledge directly and show what they had really understood.

Nearly as important as leveraging the medical facts is improving vaccination management, e. g. by discussing proven concepts and implementing examples of how to organise a more efficient workflow. And since this question concerns the whole team, our training involved the assistants as well. Over the last four years we trained more than 2,000 teams. By strengthening team spirit and supporting a common understanding of how to divide labor efficiently, training helped garner acceptance for the changed workflow and subsequently helped foster success.

Patients need to be addressed proactively

One of the most important steps to improve vaccination management is to address patients proactively. In order to do this—to ask for the vaccination certificate, to deal with patients' constraints properly, to inform comprehensibly within the restricted time frame in real-life situations—assistants and physicians need to master far more than medical facts. First they need to be made aware of the impact of communication, including the underlying rules and tools of empathic, caring and comprehensible transmission of verbal and non-verbal messages.

Communication skills make a difference

By analysing real consulting situations, moderated by experienced coaches, physicians and assistants learn that their communication skills make a real difference—whether they are convincing or not, whether they are seen to be self-confident or insecure. They realise that patients who have been addressed adequately are more willing to speak frankly about their fears, hopes, personal motives or constraints regarding vaccination. And with this information in mind, physicians and assistants can achieve better and quicker results by finding the suitable set of arguments to address patients' needs and gain patient acceptance for the procedure. ➤

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> Development, implementation and validation process

Once the ideas for a training programme (CME certified, target group specific) or informational tool have been developed, we start looking for a sponsor making the service material available nationwide to the target group through their sales force or sponsoring physicians who want to participate in the programme. Only if we succeed in convincing third parties (pharmaceutical manufacturers, sick funds, public institutions) of our activities and if we can prove, based on direct demand, that the target group does in fact show an interest in our programmes can we implement them across Germany.

As a general rule, we first assess the level of acceptance of the programme we have developed. With the Vaccination Watch, for example, we initially had only 15 000 watches produced, later 30 000 and then 60 000. The Prevention Workshops started out as a pilot project (10 events). In view of the positive feedback (high demand, evaluations by workshop participants), the number of workshops was, in subsequent years, increased to 20, 40 and 60 per year.

This process differs fundamentally from the development of patient information folders or decision aids made available by universities or state-run organisations. These institutions develop materials on behalf of a government agency, they receive government funding to provide scientific advice through the development and validation process and produce the materials with public monies. Whether or not the physicians themselves consider the materials of any use in their daily practice is not one of their main concerns, and acceptance testing is based mostly on random sampling.

For example, we directly asked physicians for their feedback about the usefulness of the Prevention Watch displayed in their waiting room. On a questionnaire, they were asked to rate (using grades from 1 to 6) how well the watch was able to catch their patients' attention, how often their patients asked them about the watch, how they rated the medical information and how much time the watch actually saved them. Overall, 98% of physicians commended the Vaccination and Prevention Watch.

Medical education is one component of system 'treatment'

So is medical education an ideal remedy to cure our health care systems? It's like with every chronic disease that shows a complex set of symptoms—you need combination therapy! Successful medical education is just one component of treatment. Ignoring preventive medicine and neglecting the impact of patient adherence to treatment outcomes and quality of life has caused a lot of gaping wounds. If the 'remedy' of medical education is administered to farsighted and keen players, and is fostered by competitive pressure and social responsibility, the prospects are good to stop the bleeding. So to avoid future pain due to unfair rationing of resources, it would be better for all of us to take the proposed remedy.

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The best quality journal is the one with a 100% rejection rate!

In their thought-provoking paper, Macdonald and Kam [1] are concerned with the definition of a 'quality journal' because publication in flagship journals is a major indicator of research performance in UK universities (I would say almost everywhere in the world and in about any discipline). The article investigates the notion of 'quality journal' and finds dizzying circularity in its definitions. Actually, what a quality journal is does not really matter. What matters is that there is agreement that quality journals do exist. As so often happens with indicators of performance, the indicator has become the target. The challenge is thus to publish in quality journals, and the challenge rewards gamesmanship. Vested interests have become particularly skilful at the game, and at exercising the winners' prerogative of changing the rules. All but forgotten in the desperation to win the game is publication as a means of communicating research findings for the public benefit. The paper examines the situation in management studies, but the problem is more widespread. It concludes that laughter is both the appropriate reaction to such a farce, and also, perhaps, the stimulus to reform.

Macdonald and Kam also refer to the well-known fact that rejection rates are often seen as telling indicators of quality journals: the higher the rejection rate, the higher the quality of the journal to the point that we are now perilously close to the **ultimate in quality journals: a journal with a rejection rate of 100% that publishes nothing at all!**

The authors also report that, in management research at least, a) of the papers cited, the half more cited is actually 10 times more cited than the rest; b) between 10 and 30% of citation is self-citation; c) more than half of academic papers are never cited at all, and d) the majority of academics never receive as many as three citations in a lifetime. I wonder what the situation is other fields. Anybody know?

Macdonald and Kam reckon that reminiscing about a golden age when academics published to improve the lot of mankind is as pleasant as it is deluding. They indeed posit that there never was such a golden age. Academic publishing, they assert, has always been ridden with self-interest, and academics have always schemed to promote themselves. (What about Newton? Boyle? I ask). They also assert that papers published in quality journals are money rather than wealth in the sense that they are meant to be counted rather than read.

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Reference:

1. Macdonald S, Kam J, Aardvark et al.: quality journals and gamesmanship in management studies. *Journal of Information Science*. 2007;33(6):702-717.