"How to deal with clinical decision making as time goes by"

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Family Medicine Teaching Unit Head in Malaga. Spain

Good morning to all the colleagues in this room, and thank you for your attention and your participation too. I want to recognize **WONCA, semFYC and SAMFYC** too for giving us this opportunity to show you our experience. (And I hope not to give too much work to the translators because of my English).

I'm going to introduce myself:

My name is Daniel Prados Torres, I am the Family Medicine Teaching Unit-Head in Malaga, and the responsible of this educational experience here based in promoting different strategies to develop the *mindful* learning in uncertainty management.

It's for me an excellent opportunity to share with you a formative experience with young doctors who are specialising themselves in family medicine in Malaga Teaching Unit, based on working with residents in clinical reasoning and uncertainty management for a long time, using several educational strategies which are going to be clearly explained by my colleagues.

Speakers:

1. **Francisca Leiva-Fernández, MD PhD.:** ***the teaching uncertainty management to young doctors.***
2. **Raquel Garófano Gordo, MD.:** ***resident's experience in the uncertainty management Learning.***
3. **Agustín Gómez de la Cámara, MD PhD.:** ***Evidence-Based Medicine as a tool for the clinical decision making.***

<u>I'm accompanied in this meeting by:</u>

1. **Francisca Leiva-Fernández, MD PhD.:**

   She's a Family doctor assigned to the Teaching Unit of Family Medicine in Málaga. She's co responsible with me in the organization of the journal clubs (based in EBM) and she's collaborating in the research "Utility of a complex educational model to enhance in young doctor the skills development to apply new knowledge and make evidence-based interventions in their daily practices."

   She's going to talk about: the teaching uncertainty management by the young doctors.

2. **Raquel Garófano Gordo, MD.:**

   She's a Family resident assigned to the Teaching Units of Family Medicine in Axarquía (in Malaga) and she has been participating in the Axarquía journal club for the last two years (the whole activity).

   She's also collaborating with us in the Teaching Unit of Malaga in the research of "this complex educational model utility"

   She's going to talk about: resident's experience in the uncertainty management Learning.

3. **Agustín Gómez de la Cámara, MD PhD.:**

   He's a Family doctor and Coordinator of the Research Unit Hospital "Doce de Octubre" and Sanitary Area 11 of Madrid and he's a coordinator of the Thematic Network Investigation in Evidence-Based Medicine and Member of the CIBER epidemiology and Public Health too.

   He's going to talk about: Evidence-Based Medicine as a tool for the clinical decision making.

INTRODUCTION

European Core Curriculum for Medicine. The Students' Perspective

The core curriculum is structured in nine domains with 76 learning outcomes which are listed in alphabetical order:

- Clinical Skills,
- Communication,
- Critical Thinking,
- Health in Society,
- Life Long Learning,
- Professionalism - Attitudes, Responsibilities, and Self Development,
- Teaching,
- Teamwork,
- Theoretical knowledge.

European Core Curriculum
The Students' Perspective

I would like to do a little introduction about this topic.

It would be interesting to think in two starting questions: **what's a good doctor? And, what's a good family Doctor?**

On one hand, in the 5th International Follow-Up Conference on the Bologna Process in Medical Education in July two-thousand-and-six 2006 in Bristol (UK), the European Medical Students' Association (EMSA) and the International Federation of Medical Students' Associations (IFMSA), representatives from 15 European countries discussing a **"European Core Curriculum for Medicine - the Students' Perspective"**.

All stakeholders in medical education should increase the *Critical thinking* (consisting in the systematic evaluation of information preceding any professional decision and action). *We emphasise that this skill is integral to all aspects of the doctor's role*, as a consequence :

Critical Thinking

Graduates:

•Able to question medical procedures and treatment protocols before their application.

•Able to find the evidence base for clinical decisions.

•Stay up-to-date with recent scientific developments and implement evidence based medicine in daily practice.

Include:

1. The ability to **evaluate relevant scientific texts** and learning resources.
2. To be conscious of the **limitations of current medical knowledge**.
3. Should be able to **apply quality assurance methods** in professional practice.
4. Should be able to **effectively and critically use resources** in professional practice.

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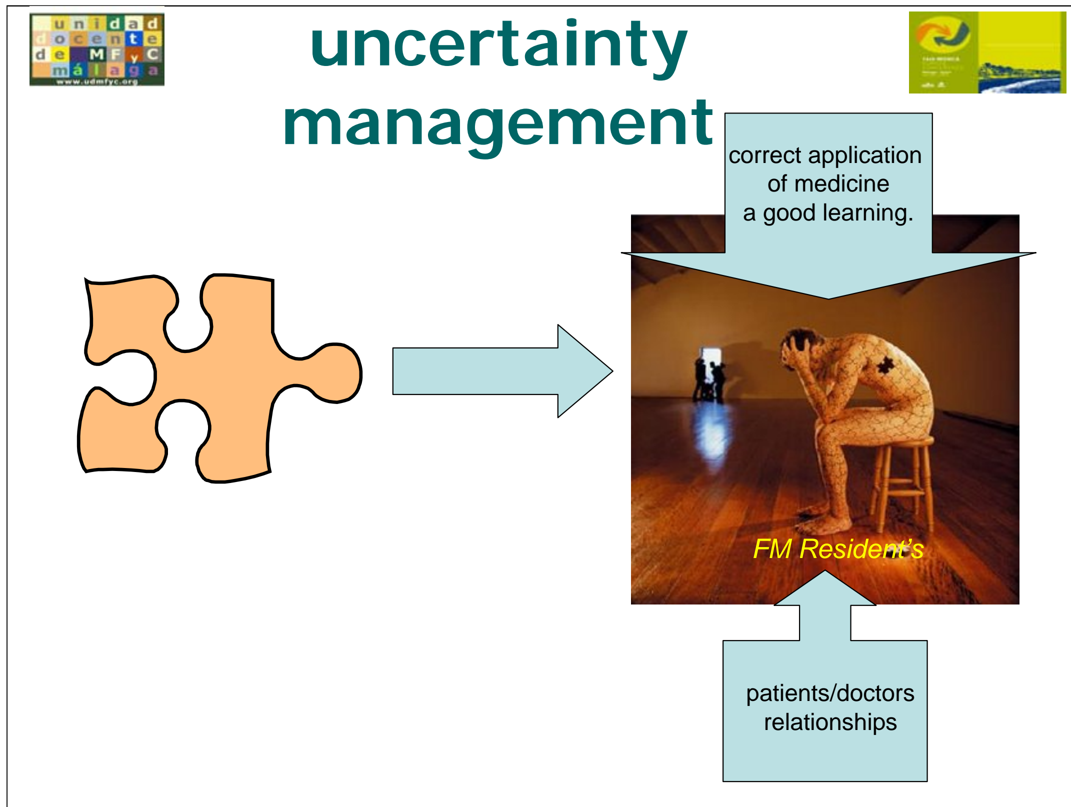
Neighbour R. *"The Inner Consultation"*
Epstein R. *"The Mindful Learning"…*

"Two Heads"

"Logistikon and Nous" (Platón)

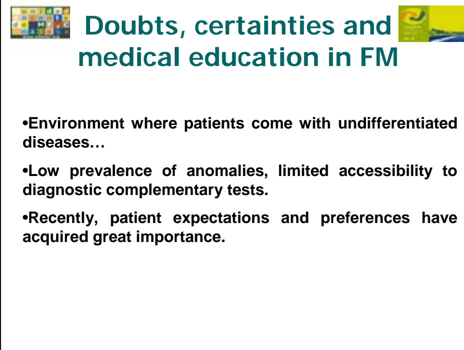
On the other hand, for **professor Neighbour, in his book "the Inner Consultation",** a good family doctor is a doctor with two heads, one of them is responsible of the self observation of oneself.

Talking about learning, the one which makes us being conscious of the way we learn. Remember *"Logistickon and Nous"* from Platon.



We are going to highlight **uncertainty management** because it has an influence in **patients/doctors relationships**, in several learning among specialising education and it is **necessary for the correct application of medicine and a good learning.**

(Good clinical practice and learning process in doctors along their professional life are influenced by adequate uncertainty management. Many patients and some doctors still think that professional knowledge is characterized by certainty, but actually, it is a question of doing choices with the best probabilistic election).



Doubts, certainties and clinical effective intervention

Family medicine is an environment where patients come with **undifferentiated diseases**, in their first stages and/or with a lack of organization in their presentation.

Family doctors activity takes place with the following characteristics: **low prevalence of anomalies** (or high frequency of normality), **limited accessibility to diagnostic complementary tests**, concerning to different choices of action (diagnosis included) and the potential benefits that they represent for each patient (included cost and iatrogenic). Recently, **patient expectations** and preferences have acquired great importance.

Clinical effective intervention is based on two criteria:

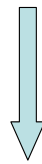
1. Reasonable (sufficient) **certainty** in the benefits degree and make sure that risks, disadvantages and costs are balanced.
2. **Absence of another alternative** intervention with a better balance between benefits, risks, disadvantages and costs.

Advances in clinical research help doctors to take better decisions increasing their accuracy. Nevertheless, not all the clinical choices obtain the same research support, even with therapeutic interventions, so, doctors use many treatments that have not been studied by randomized clinical trials. The task of studying all the medical interventions is almost impossible though, it is necessary to promote the best clinical investigation, centred in priorities, needs of knowledge for clinical decisions, with mechanisms to assess its innovative contribution and performance in order to reduce the current lack of evidences.

Finally, it’s necessary to remember that, often, **clinical variability comes from the insufficient knowledge** about the best alternatives. If we develop a feasible and continuous medical education practice (CME) for all the doctors, variability will decrease.

Educational benefits of this model

STEP TO ACQUIRED SIGNIFICANT LEARNING:



1. **Unconscious Incompetence**
2. Conscious Incompetence
3. Conscious Competence
4. **Unconscious Competence**

Benefits:

- **Promotes this intellectual evolution in residents and**
- **Helps them to develop the self-learning along their life**

(Piaget: *each time we teach something to someone we prevent him to discover it by himself*)

Under the educational point of view, it's necessary for the adults' education that resident doctors evolve from an ***unconscious incompetence to an unconscious competence in medical knowledge*** (going through conscious incompetence and conscious competence). All of the levels are necessary for the significant learning.

We think the model which is going to be presented promotes this intellectual evolution in residents and helps them to develop the self-learning along their life.

Moreover it is important not to be given the answers directly if we really want to learn something and interiorize it. It's better to discover it by oneself so that we make sure we won't ever forget it.

(Piaget said once: "each time we teach something to someone we prevent him to discover it by himself"), just like this model searches.

What does this activity add?

1. Formative strategies for small groups of professionals and for individuals
2. A new approach to reinforce continuous medical education activities in clinical settings
3. A time for listening to new and old ideas about EBM
4. A time for self-reflections: "a bit of time for thinking"

What does this activity add?

Formative strategies for small groups of professionals and for individuals to reach a significant learning in medicine.

A new approach to **reinforce continuous medical education** activities in clinical settings (hospitals, health centres and teaching units)

A time for listening to new and old ideas about Evidence-Based Medicine and for self-reflections; *"a bit of time for thinking"* ***(from a critical approach about maintaining medical competence as time goes by)***

¡Thank you very much!