Cite this as: *BMJ* 2024;387:q2163
http://dx.doi.org/10.1136/bmj.q2163
Published: 03 October 2024

Medicine is difficult—there are no shortcuts

Delivering high quality, patient centred care requires medical training that is long enough, broad enough, and deep enough, writes Andrew Elder

Andrew Elder,

A senior medical leader recently gave me a piece of advice.

"Even when you are bored stiff saying the same thing again and again, say it again. Even when you think everybody will be fed up hearing it, say it again. Because the politicians may not yet have heard you."

So, I will say it again. Medicine is difficult.

Yes, we have fabulous imaging and more laboratory investigations than any of us can name. And yes, we can interrogate our patients' genomes, and the genomes of the organisms and cancers that infect and affect them. But, despite all this wonderful technology, diagnosis remains difficult. Every patient is a unique individual in a unique context, a product of both their biology and their biography. Making accurate and timely diagnoses requires more than just technology—it requires listening, observation, careful thought, judgment, and time. Uncertainty often prevails—and the ability to manage that is not learnt from any textbook.

The treatment, management, and care decisions that follow diagnosis are also difficult. Multiple minds, meeting in multiprofessional teams, seek consensus on the best that can be offered. Complex options lead to complex explanations and discussions with a patient and their family. What could be done may be relatively straightforward, but what should be done requires studied listening, enquiry, exploration, and judgment. Discussing, deciding, and agreeing "to do or not to do" takes time, thought, and commitment. There are no algorithms and no shortcuts for patient centred care.

Medicine is difficult even though we recruit the brightest and best from our schools and colleges. It is difficult even though we teach and train them over intense undergraduate courses of up to six years, sometimes with intercalated higher degrees, using curricula that demand the acquisition of much knowledge, and many skills, behaviours, and attitudes. Medicine remains difficult despite postgraduate training lasting up to 10 further years to consultant level, and five further years to the level of the general practitioner. The learning does not end there—continuing professional development, documented and monitored by appraisal, is a mandatory feature of a doctor's professional commitment to lifelong learning.

And despite all this education and training, doctors can still get things wrong. Errors in diagnosis, treatment, and care can still be made. Medicine is difficult.

Medical knowledge, as measured by published research and guidelines, is now said to double every 60 days. One might think this would provoke calls for longer, even more intense teaching, training, and learning for those who aspire to be doctors. But it is now suggested that we can "make" our doctors in shorter timeframes—for example, in a four year undergraduate degree course. Even shorter training, with entirely different entry criteria, is also promoted. Medical associate professionals, with a pre-degree in a wide range of subjects, are judged ready for clinical practice after only two years of training in "the medical model."

But the "medical model" of education and training is defined by much more than a structured approach to history taking, physical examination, diagnostic reasoning, and care planning. It is defined by the breadth and depth of knowledge and skills that the doctor must acquire. It is defined by the intensity of mandatory assessments of knowledge and skills that the doctor must undergo in the workplace and examination hall. And the "medical model" is also defined by its duration. Clinical experience—by the bedside, in the consulting room, and in the operating theatre—and all that comes with it, is a time-based commodity. Competency based medical education may not see experience, or "time served," as of any relevance—yet few clinicians would deny its central importance in high quality and safe patient care.

The visions of future healthcare that have produced this mission to generate more doctors or more "associate professionals" in shorter and shorter timeframes do not come from the minds of those who see medicine on its front lines. These are remotely conceived, industrial visions of care—and of the workforce that might provide that care—based on a political concept of "productivity" that is alien to those who walk the wards, talk to patients, and see the quality of care, rather than its quantity, as paramount.

Medicine is difficult, has become more difficult over my 40 year career, and will continue to become more difficult. We need to continue to attract the brightest and best to train as doctors. We need to ensure that their training is long enough, broad enough, and deep enough to make them feel *and be* equipped to do the difficult daily work of the doctor, to innovate and to research, and to design and deliver care for people in the way that they—as highly trained professionals—feel their patients need. And not in the way that others speculate may be just about good enough.

Our patients should demand no less.