

are underestimates and suggests considering individuals in whom fatigue has persisted for only six weeks as incipient cases of chronic fatigue syndrome. Even more remarkable is the proposal to accommodate within the rubric of chronic fatigue syndrome children in whom "fatigue may not be a presenting problem."<sup>1</sup>

Three types of treatment modalities are highlighted, with each given equal weight on which to build the therapeutic approach to chronic fatigue syndrome: graded exercise, cognitive behavioural therapy, and pacing. How these disparate methods emerged from the menu of options is symptomatic of irreconcilable perspectives within the group. The seminal studies that established the utility of graded exercise and cognitive behavioural therapy were proofs of concept, confirming that one can apply standard metrics of illness and document clinically meaningful improvement in chronic fatigue syndrome.<sup>7-9</sup> Yet they are specialised modalities and too limited now in their availability for the typical patient. Pacing, based on the sensible notion that a patient with limited physical and cognitive resources should expend them cautiously, however, emerges as a key recommendation without any formal proof, perhaps because anyone can advise it and undertake it. While pacing may prove beneficial, one must be concerned that encouraging patients to avoid incremental increases in activity for fear that their symptoms will be aggravated may condemn them to stay ill longer.

As to the capacity of medical institutions to afford full service needs for people with chronic fatigue syndrome, the limitations are predictably the same as for those with other chronic diseases. Resource use needs to be based on competing public health needs, and above all on evidence as to what is most effective. In the United Kingdom, the National Institute of Clinical Excellence is one body to which this and related reports could be referred for further opinion.

The report does not articulate a detailed research plan. Emphases are placed on epidemiological studies and more clinical trials. There is certainly a need to understand better the range of chronic fatigue syndrome in children and adolescents and to determine whether severe neurological problems can be documented, as claimed, to represent features of chronic fatigue syndrome.

What the report expresses well is that core issues for chronic fatigue syndrome are those of belief and

trust, in that patients are not believed and that medical institutions are not trusted to serve them adequately. One senses the need to testify repeatedly in the report that chronic fatigue syndrome "is a genuine illness." While there will always be those who doubt the evidence, as there are those who doubt HIV is the cause of AIDS, the time has come to move on. Whatever one presumes chronic fatigue syndrome to be, people suffer with it and because of it. A report of a joint working group of the royal colleges made that point abundantly clear in 1996.<sup>10</sup>

Too often we fail to appreciate that despite our inclinations or abilities to comfort patients, they will seek other solutions in the healthcare marketplace. This underlies the enormous popularity of complementary and alternative medicine. While there is little evidence that these approaches benefit people with chronic fatigue syndrome,<sup>2</sup> they are accessible and are best addressed, like the patients who seek them, through serious investigation.<sup>11</sup>

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## Learning in practice: a new section in the *BMJ*

*A place where educationalists and clinicians can exchange ideas*

See *Learning in practice* pp 153, 156, Editorial p 126

William Butler Yeats said that education should be "not the filling of a pail but the lighting of a fire." But how far does this aspiration tally with our own experience of medical education? We all remember good teachers who inspired and motivated us; delivered useful content in an assimilable manner; harnessed our emotional as well as cognitive energies as learners. Unfortunately, most of us also remember too many bad teachers and

poor educational experiences—dull lectures, irrelevant content, assessment of rote learning in preference to comprehension, and presentation driven more by the convenience of teachers than our learning needs. The kind of dispiriting experience which erodes motivation, and turns us into "have to" rather than "want to" learners.

This week the *BMJ* launches a new section called "Learning in Practice." We like the word learning

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because its focuses on the outcome, which really matters to patients—clinicians who know what they need to know to practise good medicine. Learning and education—the process by which we hope to achieve it—are everyone’s business in medicine today. Yet learning remains one of the most unexamined parts of clinical practice. All doctors are teachers and learners throughout their careers, and lifelong learning is something we aspire to. Yet most of us know little about how to do it well.

Beacons of excellence in medical education exist, but much of the landscape is murky. The common picture is of ad hoc policies and initiatives, poorly informed by evidence. In the darkest corners things have moved little beyond the rhetoric of “see one, do one, teach one.” Meanwhile, a cycle of educational abuse continues to play its part in doctors’ underperforming or even leaving the profession.

If clinicians are relatively uninformed about best educational practice it is not because no evidence exists. True, much educational research is conducted using methods unfamiliar to doctors. Its quality is mixed, with a greater focus on observational research and inductive reasoning and fewer experimental data than is the case with clinical research. Much of it is published in medical education journals, which clinicians tend not to read. So the evidence that exists seems inaccessible and easy to dismiss. Yet this is unacceptable where the alternative is evidence free medical education at the public expense. Allowing educational knowledge, expertise, and inspiration to accumulate, unused and undervalued, in ivory towers marked “medical education department,” while clinicians battle on in ignorance, is profligacy with resources no health-care system can afford.

What can a general medical journal do? Clearly not provide all the answers, or even a significant proportion of the content needed to address this gap between educational evidence and practice. What we can do is encourage a wider debate. In our new section we hope to publish original research and review articles which highlight good teaching and learning practices of use to a wide range of clinicians. If we can-



not fill the gap, we might draw attention to it. Learning in Practice will appear each month and will be the place where educationalists and clinicians can exchange ideas aimed at delivering better educated doctors capable of better patient care.

Tomorrow’s doctors need more than ever to be life-long learners. Rather than mere pails full of educational content they must be adept at accessing “just in time” knowledge, driven by professionalism, responsible for their own learning, and enthusiastic to learn how to manage patients better. Please send us articles that might help point in this direction.

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## Researching the outcomes of educational interventions: a matter of design

*RCTs have important limitations in evaluating educational interventions*

**P**roblem based learning, an educational intervention characterised by small group and self directed learning, is one of medical education’s more recent success stories, at least in terms of its ubiquity. From its beginnings in McMaster University in the 1960s it has been adopted in undergraduate medical courses worldwide. It is also being used in postgraduate and continuing medical education.

Problem based learning has been the subject of at least four much quoted reviews, three published in the early 1990s and one more recently.<sup>1-4</sup> Such attention is not surprising. What might be surprising is that the

effects of such a popular educational approach are seemingly small, except in the area of student satisfaction. According to the reviews the extent of knowledge gained by such measures as performance in licensing examinations is at best unclear. Participants in problem based learning, however, can expect small gains in clinical reasoning.

The paper by Smits and colleagues in this issue provides a review of problem based learning in postgraduate and continuing education (p 153).<sup>5</sup> It is, however, based on only six studies which met the authors’ inclusion criteria for controlled study designs.

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