Patients in partnership with educators: use of design thinking to improve patient involvement in undergraduate medical education

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ABSTRACT

**Background:** Design thinking involves taking a designer’s approach to problem solving, using empathy and experimentation to arrive at innovative solutions (ideou.com, 2019). It can be especially useful for solving 'wicked problems', and consists of 5 stages: empathise, define, ideate, prototype and test. With the UK General Medical Council guidance actively encouraging the role of patients in development of curricula and assessments, we hypothesised that design thinking could be used to facilitate this.

**Summary of Work:** We report two experiences of using design-thinking methodology to generate ideas to promote patient involvement in undergraduate medical education. One involved groups of patients, students and educators exploring the theme of incorporating more of the patient perspective into the curriculum. The other asked patients and educators to explore how to involve patients in curriculum design, assessments and student selection.

**Summary of Results:** Multiple ideas generated by patients in the first workshop have been taken forward. A fellow has been appointed to write new case based learning scenarios with the assistance of patients with the conditions in question, and a student selected module in simulation is being developed to allow students and patients to work together to create role play scenarios based on real experiences. To promote student insight into the patient experience, a research study where students accompany patients whilst travelling to and from a hospital appointment, observing the appointment purely from the patient’s point of view is currently underway. Ideas generated from the second workshop included establishing a physical presence for patient groups in the medical school promoting further collaboration in curriculum development. Other suggestions that are currently being explored are using real patients in exams including training them to provide feedback, and a lay panel at student selection centres with autonomy to decide their own questions.

**Discussion and Conclusions:** Design thinking is a useful tool to unlock creativity and promote collaborative practice between patients and educators. It provides a democratic forum in which patients and educators can work as a team to generate innovative strategies to increase patient involvement in medical education.

**Take-home Messages:** Collaborating with patients, and using design thinking to facilitate this, can help generate new ideas for medical curricula.
The patient, student and professional as equal educators and learners in the concept of Welearn in Human Embryology

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ABSTRACT

Background: Welearn in Human Embryology is part of a 20-weeks minor program in the combined third year bachelor program medicine and biomedical science. The central learning objective is to be able to place a specific birth defect and its treatment in the context of the patient and/or the parents. In Welearn, students (n=29) meet (parents of) patients in the field of birth defects (n=10), a scientific researcher and a pediatrician. The goals are to improve person-centered care, to learn from each other, and to develop a research proposal initiated by the patients. Two to three students are coupled to a patient. There are three group sessions (Introduction, Communication and research, Experiences) and individual meetings with the patient at home and, when appropriate, in the out-patient clinic.

Summary of Work: The sessions were observed by a medical educator. The program was evaluated with evaluation forms for all participants after each session and three focus group interviews.

Summary of Results: The group session 'Introduction' was rated with an 8 on a 10-point Likert scale, 'Communication and research' with 7.3 by patients and students and 8.5 by professionals, and 'Experiences' with 6.8 by parents, 7.1 by students and 8.3 by professionals. In general, Welearn was rated 4.0 or more by all groups an a 5-point Likert scale. Positive points mentioned by all groups were: exchange of perspectives, equivalence, and person-centeredness. Points to improve were: management of expectations, more concrete framework, and support by literature.

Discussion and Conclusions: The targeted learning values of Welearn were person-centeredness, exchange of perspectives, equity, learning together by doing together, self-directed learning environment, transfer to practice and inter-professional learning. Most of these values were encountered, but students had difficulties in operating in the self-directed learning environment. They asked for more structure and instructions. Also the parents would be happy with a more concrete framework. Conclusion: Welearn as a program has proven to be valuable for patients, students and professionals.

Take-home Messages: By bringing patients, students and professionals together in a safe, role less and self-directed learning environment, a unique exchange of attitude, knowledge and experiences takes place.
The patient’s voice in a pre-clinical curriculum

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ABSTRACT

Background: Early intensive contact between students and patients is increasingly recognized as beneficial for learning. However collaboration between students and real patients to improve medical professionalism is uncommon. Participation of patients, learning in collaboration and self-directed learning are the core of our newly designed curriculum (bio-) medical sciences. Within the ultimate framework of the study, patients will inspire students to learn and students will encourage patients to talk and participate in the education of future doctors and scientists. Learning takes place in a meaningful environment, practically orientated.

Summary of Work: In 2015 we co-created two educational activities with patient representatives for bachelor students: 1. Students meet Patient (SMP): a program in which every student frequently meets different patients, each with a unique medical problem and context. 2. ‘Bring your own patient’ (BYOP): a 1-2 years longitudinal program for every student to study one patient in his context, being an expert of his medical journey. Both programs are supported with learning goals. Students also formulate personal learning goals e.g. on professional development. Students report about their experiences in written essays and during group meetings.

Summary of Results: Qualitative analysis of written essays shows that students are inspired by these contacts with patients and show professional development, improvement of interpersonal skills and increase in knowledge. There is diversity in lessons learned by students. Feedback of patients shows that they feel empowered to stress the impact of disease and the importance of shared decision making, contributing to patient-centered care.

Discussion and Conclusions: Exchange of unique experiences and thereby increasing learning output, is stimulated when individual patient contacts are embedded in the pre-clinical curriculum. Therefore we created discussions in small groups in the study-program ‘professionalism’ to maximize learning output. Patients also have a contact to share their experiences with if they would like to. Both longitudinal follow up (BYOP) and incidental individual patient-student contacts (SMP) are powerful to motivate the bachelor students in their study process, enhance patient-centeredness and professionalism and stimulate patient-empowerment in practice.

Take-home Messages: Active patient involvement in a pre-clinical curriculum is a successful method to learn in reciprocity.
Aboriginal patients as educators: ‘clinical yarning’ in healthcare settings

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ABSTRACT

Background: Aboriginal Australians are custodians for the longest continuing culture in the world, which has a strong oral tradition. The effects of colonisation continue after 200 years resulting in disparities in health status despite many Commonwealth programs to ‘close the gap’. A community meeting was held in a major rural city to discuss the findings of a local diabetes study. Effective interactions with healthcare professionals were highlighted as a means to influence the understanding and management of diabetes. 'Yarning' is a traditional communication framework which can re-orientate communications to privilege an Aboriginal worldview. Aboriginal Elders attending the meeting requested that the local University of Sydney campus 'teach doctors how to 'yarn''.

Summary of Work: In response to this invitation, our University asked Aboriginal patients and community members to help us better define the communication problem from their perspective and to teach us about yarning. Consultation with Aboriginal people across three communities was guided by these questions 1) What are the major challenges in communicating with doctors and nurses? 2) What is yarning? What makes a good yarn with a doctor or nurse? 3) How do we go about teaching yarning to health students?

Summary of Results: An online course consisting of five modules was prepared for healthcare students from across the University. Starting with hearing patient stories, students learn about differences in cultural perspectives, see examples of yarning in healthcare and develop reflective practice skills to guide lifetime learning about yarning. The final module focusses on reciprocity. On completion, students have a foundation for improved communication with Aboriginal patients in both clinical attachments and in the workforce.

Discussion and Conclusions: Differences in conceptual cultural frames between western and Aboriginal approaches and the interdependence of language and culture amplify the communication gap which exists between non-Aboriginal health professionals and Aboriginal patients.

Take-home Messages: Healthcare professionals hold one type of respected knowledge. Our Aboriginal patients also hold valuable knowledge. When patients are invited to contribute as educators these knowledges are brought together. This approach could be extended to other First Nations people to improve communication and close the gap.
Patient safety on the agenda, a co-creation

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ABSTRACT

Background: Our topclass ‘innovation in care’, designed for residents, is a multidisciplinary skills training program to improve patient-care and patient-safety. Residents increase their knowledge, perform a quality improvement project (QIP) to practice skills and show leadership development (LSD). Every resident is connected with a patient (‘buddy’) to stimulate reflection on personal progress. In this report we focus on patient-involvement in our topclass.

Summary of Work: Patient platforms of the academic hospital are approached to recruit potential buddies. Buddies have authentic, relevant and valid expertise in illness and its consequences. Based on CV and a QIP-plan buddies link themselves to a resident. The resident informs the buddy about QIP and LSD in 3 personal contacts. To facilitate the learning process the buddy is trained how to stimulate reflection and give feedback on both topics. In between the buddy-resident contacts, buddies meet to reflect on their experiences.

Summary of Results: Qualitative analysis of feedback and review reports shows that the majority of couples learn in reciprocity, although they start insecure. Buddies learn about the daily practice of a resident, stress patient-centered care in LSD and notice the barriers in a QIP. Buddies and residents notice the enhancement of the patient perspective and participation in a QIP. In their review reports at the end of the topclass, residents describe the influence of a new perspective on their professional performance. They are not used to ask feedback from patients on their personal professional development. Not only the patient perspective but also the professional background of the buddy can be useful in the learning process. Couples that perceived a ‘mis-match’ were coached to overcome the barrier.

Discussion and Conclusions: The patient seems to be the natural partner in a QIP in patient care, although in reality this is not common. A topclass to provide knowledge and skills to enhance patient participation can be helpful. Developing the topclass in collaboration with residents and patients facilitates more customization.

Take-home Messages: The patient as a buddy in a topclass for residents induces mutuality in learning and is therefore a strong and new instrument for professional development of these residents and patient-empowerment.
Patient voices in physician validation - a qualitative study

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ABSTRACT

Background: Despite increasing calls for patient and public involvement in healthcare quality improvement, the question of how patient evaluations can contribute to physicians’ learning and performance assessment has received scant attention. This study aims at adding to the conceptualisation of patient involvement in quality of care and medical education through exploring patients’ perspectives on their role in physicians’ lifelong learning and re-validation processes.

Summary of Work: We used a qualitative approach and semi-structured interviews to explore patients’ take on physician re-validation. We purposively sampled 25 patients from two Dutch hospitals, and through the Dutch Lung Foundation. Data was analysed according to the principles of template analysis. We started coding using a set of a priori themes developed from the literature on patient empowerment, performance feedback and assessment. We iteratively modified themes and refined templates throughout data analysis. The final template included themes around doctor-patient relationships, doctor-patient communication, feedback, patient empowerment, patient identity and power dynamics.

Summary of Results: Results show that patients differed with respect to the role they envisage for themselves in physicians’ learning and re-validation. Three patient voices were discerned: the pro-active patient, the complacent patient, and the outsider. The voices differ in patients’ willingness and perceived capability of providing feedback and evaluating physicians’ performance. Patients’ personal experiences and anticipated consequences of evaluating their physician appear to influence patients’ readiness to play a role in feedback and validation processes. That is, the extent to which patients experienced a power balance within the doctor-patient relationship seemed to have a direct impact on their voicing behaviour.

Discussion and Conclusions: Reflecting on the challenges inherent in patient and public involvement, our results underline that no ‘collective’ patient voice exists, but that a multitude of experiences and patient perspectives must be considered in performance evaluation of physicians.

Take-home Messages: As not all patients are equally suitable or wish to play a role in physicians’ learning and re-validation, it is crucial to maintain the right balance between empowering patients and respecting their uniqueness. To involve patients successfully in physicians’ learning, it is imperative to ensure a safe environment for feedback and to foster patient awareness.