Involving patients in clinical education

The interdependent relationship between the clinical teacher, the learner and the patient is a vital part of clinical education. Changing health services and patient expectations have stimulated the need for teachers to consider patients' rights and needs as active participants and partners in clinical teaching.

This article introduces the scope, principles and practice of patient involvement in clinical education and considers the application of best practice in patient involvement to the education and training of health professionals. It also examines ethical and practical questions about using real patients and balancing the needs of students and patients in teaching situations.

What is meant by patient involvement?

Involving people in health care has been an important aspect of successive UK government policies since the late 20th century, and it is now an underlying principle of the 'patient-led NHS'. It is a statutory requirement that 'patient and public involvement should be part of everyday practice in the NHS' (Department of Health, 2009); this inevitably includes the training and education of health professionals (General Medical Council, 2009; Morgan and Jones, 2009).

Patient involvement in health care generally clusters around two areas:

1. Active involvement in the health care being given, rather than being a passive recipient of expert advice and treatment
2. Involvement in the development of health-care services representing their own or the general patient view in decision-making structures.

The patient has always been at the core of medical learning but often as convenient 'teaching material'. There is a need to move the relationship between doctor, learner and patient towards patient-centred learning, where patients are partners in the education process (British Medical Association, 2008). Gordon et al (2000) suggest that patient involvement in clinical teaching can occur in many forms and throughout the whole curriculum cycle: taking an active role in bedside teaching, planning and development of teaching and workplace-based learning sessions and activities.

Professor Judy McKimm *is Associate Professor and Pro Dean, Health and Social Practice, Unitec, New Zealand, Visiting Professor in Medical Education at the University of Bedfordshire and Honorary Professor in Medical Education, Swansea University*

Why involve patients in clinical teaching?

'For the junior student in medicine and surgery, it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself' (Osler, 1905).

There are many advantages to involving patients in teaching which Doshi and Brown (2005) list as:

- Learning in context
- Opportunities for role modeling
- Teaching transferable skills
- Increased learner motivation
- Increased professional thinking
- Integration of clinical skills, communication skills, problem solving, decision making and ethical challenges.

However, disadvantages include:

- Its ad-hoc nature
- The decline in availability of patients or clinical cases
- It cannot cover the whole curriculum
- Variations in supervision and delivery
- Conflicting pressures between teaching and service delivery.

Students and trainees express significant benefits of learning with and from patients. Although simulation and other learning methods offer opportunities to practice procedures they only prepare learners for working with patients and are no substitute for learning to practice medicine independently with patients. Learners value working with patients in the context of structured learning events, supported and supervised by more senior clinicians. To develop effective clinical reasoning, learners need to see a wide range of cases in varying contexts (Eva, 2005) but they also need support in making sense of what they see, through discussion with and challenge from clinical teachers.

Which patients should be involved, where and how?

Spencer et al (2000) reviewed the role of the patient in teaching and learning and devised a framework to assist clinical educators in working with patients in any given context. The 'Cambridge framework' is based around checklists identifying Who? How? What? and Where?

Who?

Which patients to involve depends on a number of interconnected factors. These include:

- Presenting clinical problems
- Socioeconomic status, ethnicity, background, culture, experience and expectations of each patient, his/her family and carers
- Age, gender, sexual orientation
- Emotional and intellectual capacity.

While research suggests that the majority of patients benefit from being involved in teaching (Haffling and Håkansson, 2008; Lefroy, 2008), clinical teachers need to decide on the appropriateness of involving patients in teaching after consultation with patients and carers.

How?

Considering 'the how' enables teachers to select the type of interactions that may be most relevant to achieve different learning outcomes for learners (*Figure 1*).

Where?

The 'where' includes a choice of settings and professional contexts such as:

- 'Real environment' and 'simulated environment' – as training wards and simulation centres are increasingly being used in training health professionals

- 'Uni-professional' or 'multiprofessional' settings – clinical situations in which doctors alone are learning with patients or where a range of professionals are learning and working (*Figure 2*).

The location of the encounter (e.g. patients' homes, GP practice, intensive care unit) has a huge impact on the patients' and learners' experiences and the learning opportunities available. The location affects the learning that can take place while the patient is present, the preparatory and follow-up learning, and the roles and expectations of teacher, patient and learner (Spencer and McKimm, 2010).

What?

Considering the sort of learning (the content) or clinical problems that the trainee might encounter when working with different patients can help to tease out what specifically the learner is gaining from listening to and examining the patient (*Figure 3*).

This also helps clinical teachers assess what can be expected of the learning situation with different patients and in different contexts and what the likely impact on or value is, both for patients and learners, of involving the patient in a given situation.

Figure 1. The 'how' of clinical teaching with patients. Adapted from Spencer et al (2000).

Brief contact or prolonged contact
Passive role or active role
Time limited or time committed
Trained or untrained
Inexperienced ('novice') or experienced ('expert')
Planned encounter or unplanned encounter
Simulated situation or real situation
'Questioning' or 'informing'
Known patient or unknown patient
Focused learning or holistic learning
Tutor involved or tutor not involved

Figure 2. The 'where' of clinical teaching with patients. Adapted from Spencer et al (2000).

'Our place' or 'your place'
Community or hospital
'My culture' or 'your culture'
'My clothes' or 'your clothes'
Service setting or educational setting

What sort of patient?

Real patients in real clinical areas

One of the real benefits to learners in working with real patients in the clinical context is that they can consolidate and synthesize their learning from a range of sources.

Whenever clinical teaching occurs with real patients, patients are usually the most vulnerable of the three parties involved. Most patients still find clinical teaching extremely rewarding, often commenting that they feel students 'have to learn'. The patient's contribution to teaching should always be respected and he/she should know that, should he/she wish to withdraw, it will not affect treatment and care. Patients must be made explicitly aware that they are in a teaching environment, that learners may be present and sometimes helping to provide their care. This allows the patient to raise any anxieties. The patient needs to be kept informed, mutual agreement needs to be reached about every session, and patient privacy and dignity must always be maintained. Explain to the patient the number and level of the learners who may be present, what the patient might be expected to do and clarify the patient's proposed role. Verbal agreement should be obtained and documented.

While involving real patients in teaching in clinical areas is often opportunistic (based on who is on the ward or attending the clinic or surgery), the same steps must be taken in all cases.

Expert patients

These are real patients who are trained to deliver teaching sessions acting as both patient and teacher. The idea of the expert patient is part of the wider patient involvement agenda: it was targeted at patients with chronic conditions to help them 'become key decision-makers in their own care' (Hardy, 2004). In medical education, the expert patient role is that of a patient who agrees to participate in teaching and learning. He/she is seen as an 'expert' in his/her own condition and is often briefed or trained so as to facilitate student or trainee learning.

Patient educators have the benefits of being:

- Motivated individuals with an interest in medical training
- Real patients with real clinical histories and signs
- Able to give structured feedback to learners and teachers from the patient's perspective, such as the pressure of the hands or the way in which a history was taken.

Expert patients can help overcome educational challenges involving intimate examinations. For example female patient educators are commonly used to teach gynaecological and breast examination. They can also help to free up clinical tutors as, once trained, patient educators need little assistance in running sessions and can also be used in clinical assessments (standardized and objective). Expert patients or patient educators can be drawn from many settings, even those where concerns might be expressed about the potential risk to patients, such as those who are terminally ill or with mental health problems.

Figure 3. The 'what' of clinical teaching with patients. Adapted from Spencer et al (2000).

Undifferentiated problem or defined problem
Straightforward or challenging
High impact or low impact
General or specific
Clinical science or basic science
Minor or major
Simple skills or complex skills
'Revealed' attitudes or 'hidden' attitudes
Particular focus or generic approach

Using video and audio

Although clearly not the 'traditional' doctor–patient–student triad, the 'patient voice' can be incorporated into clinical teaching using a whole range of resources including video, case scenarios, sound recordings and e-learning resources. Many of these resources are freely available, including interactive computerized tutorials on topics such as epileptic seizure classification (Farrar et al, 2008) or breaking bad news (Cleland et al, 2007). These resources are helpful when it is inappropriate or difficult for learners to work with real patients, for example tropical medicine, child protection or terminal illness, and enable a more standardized approach to assessment of clinical skills or knowledge.

What do patients think?

Most research into patient views on involvement in teaching emphasizes the positive nature of the encounter, 'even unprepared patients see themselves as contributors to teaching' (Haffling and Håkasson, 2008). Patients often see themselves as experts on their condition and facilitators of learning, particularly in professional skills and attitudes (Stacey and Spencer, 1999). Empowering patients includes providing 'opportunities for communication and input, being asked for their consent; having their feedback valued' (Howe and Anderson, 2003).

Benefits cited by patients include:

- Feelings of altruism and helpfulness
- 'Repaying the system'
- Learning more about their clinical condition or problem
- Being given more time and attention by clinicians – a better service
- Being valued and enhancing self-esteem
- Reassurance of wellbeing ('a good going over') (O'Flynn et al, 1997; Coleman and Murray, 2002; Howe and Anderson, 2003).

Factors that cause patients to feel reluctant to participate in clinical teaching include:

- Embarrassment about emotional problems or intimate examinations
- Gender or cultural factors, for example male students practising gynaecological procedures (O'Flynn and Rymer, 2002)
- Previous poor experiences with learners
- Relatively large numbers or less experienced learners
- When the consultation or encounter is 'high stakes' (such as birth, being given bad news, a difficult, painful or sensitive examination or procedure)
- Repeated contact with doctors and learners can also reinforce feelings of ill-health, emphasizing the medicalization of health issues (Coleman and Murray, 2002).

Benson et al (2005) also identified that patients perceive differences between what they might accept as the norm in hospital and in general practice, which is seen more as the 'patient's territory'. The Postgraduate Medical Education and Training Board (2008) suggested that medical colleges should involve a greater diversity of patients in education and training, expectations of patients must be clearly indicated, interviews could be filmed to take the pressure off less confident patients and a national bank of case studies could be developed to reflect the UK's diverse population.

Ethical issues

It is not acceptable to simply assume it is okay to involve patients in teaching and learning. Key ethical issues to be considered when involving patients can be summarized as the 'three Cs': consent, choice and confidentiality.

Consent

'A mindset shift needs to occur within the medical profession to enable informed partnership rather than informed consent (patient)' (Postgraduate Medical Education and Training Board, 2008). Medical law and ethics enshrine the principle of informed (patient) consent, particularly relating to medical procedures. However, in teaching and learning, this is often tacit and assumed. Teachers need to remember to inform patients (ideally in writing in advance) that students may be involved in their care. Howe and Anderson (2003) suggest that obtaining consent is 'a continuous process that begins with the first contact the service has with the patient'.

Choice

Trainees need to learn from patients and practice procedures within the 'turbulent here and now of care delivery' (Hardy and Stanton, 2007). Clinical teachers can ensure patient choice through seeking agreement without the learner being present, confirming choice in the presence of learners (Howe and Anderson, 2003) and building in opportunities for patients to say no to specific tasks. Note also that patients may have less personal power and space in an acute setting (Benson et al, 2005).

Confidentiality

Practical steps that help to maintain confidentiality include:

- Providing information so patients understand the boundaries of confidentiality
- Reassuring the patient, involving him/her in discussions
- Finding private spaces to discuss intimate issues
- Remembering that curtains around a bed do not provide privacy
- Discussing confidentiality actively with trainees
- Obtaining permission for the use of any recorded media.

Optimizing the opportunities

'The bedside is the perfect venue for unrehearsed and unexpected triangular interactions between teacher, trainees and patient' (Ramani, 2003). Paradoxically, unrehearsed and unexpected 'moments' work best when prepared for. Before the session involving patients, think about:

- What preparatory work the trainee needs (e.g. reading, skills laboratory)
- Where the teaching will occur
- Which parts of the session require direct patient contact
- Whether you will be present when the trainee is with the patient
- What role you will take (observer, instructor, demonstrator, questioner)
- Where discussions will take place (do they have to be round the bedside?)
- How to build in opportunities for patient feedback
- How to build in debriefs for learner and patient
- What follow-up learning or reading should be carried out.

Janicik and Fletcher (2003) suggest that clinical teachers need to attend to aspects in three domains:

1. Attending to the patient's comfort
2. Focusing on the microskills of teaching, modified for the bedside
3. Attending to group dynamics and giving feedback.

Spencer and McKimm (2010) also suggest that if teachers attend to the ongoing dialogue between learner, teacher and patient (the 'trialogue') the development of both therapeutic and learning alliances between all parties is facilitated. Another structured model for teaching involving patients is shown in *Table 1*.

Conclusions

Involving patients in teaching and learning is a vital element of equipping doctors with the skills, knowledge and behaviours that will enable them to become effective, caring and compassionate practitioners.

Table 1. A model for patient-based teaching

Shadowing (role modeling)	Trainee shadows a more senior clinician and learns by observation *Tip – before the session identify active observation focus or questions that the trainee will specifically look for*
Patient-centred	Trainee is allocated patients and follows their progress from start to end of episode of illness *Tip – useful to help trainees actively learn patient management and problem solving, needs support through guided reading and discussion from teachers*
Reporting back	Trainee assesses the patients and reports back to the trainer *Tip – teacher needs to build in identified briefing and debriefing time with a structure and purpose to the feedback*
Direct observation	The trainer observes the trainee's performance directly *Tip – follow rules of feedback, good for learning clinical skills, take care not to leave the patient as a passive participant in the process, think of how the patient might feed back to the trainee*
Videoing interviews	The trainee's interview with a patients is recorded and later viewed with the trainer *Tip – needs consent from patient re images, good for learning consultation and communication skills, can be done with a group or single trainee. Take care that the trainee does not over-dwell on minor issues*
Case conference	A case is presented by the trainee and discussed by a wider audience *Tip – useful for multi-professional learning and inputs, teacher supports trainee re the type of questions that might come up and how to present a case*

From Doshi and Brown (2005)

Effective involvement of patients in teaching is founded on good clinical care, which can help support or diminish patients' capacity for self-care and autonomy. Real involvement of patients (and carers) in teaching and learning means that they share in the learning process. This can range from active involvement in lesson planning, assessment or leading teaching sessions, to a less active role, but one that nevertheless includes the patient in the learning process as a partner, thus reflecting the shift highlighted by the Postgraduate Medical Education and Training Board (2008): 'every patient should be considered a teacher as well as a patient'. **BJHM**

Conflict of interest: Professor J McKimm was commissioned by the London Deanery to lead on the development of the suite of e-learning modules from which these articles have been derived.

Benson J, Quince T, Hibble A, Fanshawe T, Emery J (2005) Impact on patients of expanded, general practice based, student teaching: observational and qualitative study. *BMJ* **331**(7508): 89 (doi: 10.1136/bmj.38492.599606.8F)

British Medical Association (2008) *The role of the patient in medical education.* www.bma.org.uk/careers/medical_education/roleofthepatient.jsp (accessed 5 July 2010)

Cleland J, Ford R, Hamilton NM, Nabavian S, Walker K (2007) Breaking bad news: an interactive web-based e-learning package. *Clin Teach* **4**(2): 94–9

Coleman K, Murray E (2002) Patients views and feelings on the community-based teaching of undergraduate medical students: a qualitative study. *Family Practice* **19**(2): 183–8

Department of Health (2009) *Creating a Patient-led NHS. Delivering the NHS Improvement Plan.* Department of Health, London (icn.csip.org.uk/_library/Creating_a_patient-led_NHS.pdf accessed 28 June 2010)

Doshi M, Brown N (2005) Whys and hows of patient-based teaching. *Advances in Psychiatric Treatment* **11:** 223–31

Eva K (2005) What every teacher needs to know about clinical reasoning. *Med Educ* **39:** 98–106

Farrar M, Connolly AM, Lawson J, Burgess A, Lonergan A, Bye AME (2008) Teaching doctors how to diagnose paroxysmal events: a comparison of two educational methods. *Med Educ* **42:** 909–14

General Medical Council (2009) *Tomorrow's Doctors.* General Medical Council, London

Gordon J, Hazlett C, Ten Cate O et al (2000) Strategic planning in medical education: enhancing the learning environment for students in clinical settings. *Med Educ* **34:** 841–50

Haffling A, Håkansson A (2008) Patients consulting with students in general practice: survey of patient's satisfaction and their role in teaching. *Med Teach* **30:** 622–9

Hardy P, Stanton P (2007) Cultivating compassion: seeing Patient Voices. *BMJ* **335:** 184–7

Hardy P (2004) The expert patient programme: a critical review. MSc Lifelong learning, policy and research. www.pilgrimprojects.co.uk/papers/epp_msc.pdf (accessed 27 June 2010)

Howe A, Anderson J (2003) Involving patients in medical education. *BMJ* **327**: 326–8

Janicik RW, Fletcher KE (2003) Teaching at the bedside: a new model. *Med Teach* **25:** 127–30

Lefroy J (2008) Should I ask my patient with cancer to teach students? *Clin Teach* **5:** 138–42

Morgan A, Jones D (2009) Perceptions of service user and carer involvement in healthcare education and impact on students' knowledge and practice: a literature review. *Med Teach* **31:** 82–95

O'Flynn N, Rymer J (2002) Women's attitude to the sex of medical students in a gynaecology clinic: cross-sectional survey. *BMJ* **325:** 683–84

O'Flynn N, Spencer J, Jones R (1997) Consent and confidentiality in teaching general practice: survey of patients' views on presence of students. *BMJ* **315:** 1142

Osler W (1905) The hospital as a college. In: *Aequanimatus and Other Addresses.* HK Lewis, London

Postgraduate Medical Education and Training Board (2008) *Training in Partnership: The Patient Perspective: Shaping the future of postgraduate medical education and training in the UK – the patient perspective.* PMETB, London (www.gmc-uk.org/9_May_2008_Patient_Perspective_Seminar_Report_.pdf_30426823.pdf accessed 22 July 2010)

Ramani S (2003) Twelve tips to improve bedside teaching. *Med Teach* **25**(2): 112–15

Spencer J, McKimm J (2010) Involving patients in clinical education. In: Swanwick T, ed. *Understanding Medical Education.* Wiley Blackwell, London

Spencer J, Blackmore P, Heard S et al (2000) Patient-oriented learning: a review of the role of the patient in the education of medical students. *Med Educ* **34:** 851–7

Stacey R, Spencer J (1999) Patients as teachers: a qualitative study of patients' views on their role in a community based undergraduate project. *Med Educ* **33:** 688–94

KEY POINTS

- Consider whether learning objectives can best be achieved involving patients, is it in the patients' best interests or can they be achieved using some other method?
- Consent is about involvement and partnership.
- Introduce questioning before and after the encounter to stimulate learners' awareness of how they can learn from and appreciate the patient's input.
- Plan the session to encourage patient (and carer) participation.
- Actively consider your own involvement in the learning session with patients, in the light of the trainee's experience and competence and the patient's place on his/her health journey.
- Clinical teachers are role models to learners both as a clinician and as a teacher.