

Learning in practice

Involving patients in medical education

Amanda Howe, Janie Anderson

School of Medicine,
Health Policy and
Practice, University
of East Anglia,
Norwich NR4 7TJ
Amanda Howe
*professor of primary
care*

Janie Anderson
*specific skills
academic general
practice registrar,
Eastern Deanery*

Correspondence to:
A Howe
amanda.howe@uea.ac.uk

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Patients have always been part of medical education, but we can no longer assume that they will choose to participate. The drive towards informed consent and a more equal partnership in shared decision making in clinical practice implies a need for different approaches to involving patients.¹ In addition, recent reforms of medical education now use more structured and extensive patient contact,^{2,3} and this cannot be achieved solely through opportunistic patient contact in clinics and on wards. Using original data and background literature, we examine what is known about involving patients in medical education and suggest ways to improve learning and patient satisfaction.

Methods

This article is based on a search of Medline and references from primary sources, using the keywords consent, patient involvement, patient participation, empowerment, medical, and clinical education and the findings of a workshop at the University of East Anglia examining best practice for involving patients in student learning. The university took its first MBBS students in October 2002. We used purposive sampling to draw participants from groups likely to have a role in involving patients in medical education. Invitations to key organisations resulted in 49 delegates, with about one third clinical staff, one third key educationalists (tutors, faculty members, etc), and one third patients or their advocates. We used focus groups to discuss the following questions:

- What can we do to make the public feel positive about participating in student learning while respecting people's autonomy?
- What issues must be covered as good practice when giving information about patient involvement in educational settings and when gaining consent?
- How can my organisational or personal setting contribute effectively to student learning and what are the barriers to this?

We compiled data from flipcharts, transcribed tape recordings, and individual comments on the evaluation forms using NVIVO software for the analysis and iterative review of findings between the authors.⁴

What do we know about patients' views?

Few studies have examined what patients think about taking part in medical education or whether their views coincide with those of medical educators.⁵⁻⁷ However, most papers suggest that patients feel positive about participating in medical education.⁸⁻¹³ One study of community based learning showed that patients saw their role as experts in their condition, exemplars of their disease, and as facilitators for the students' development of appropriate professional skills and attitudes.⁹ They perceived gains from talking about their problem; learning more about their condition because of being part of a learning encounter; personal satisfaction from helping; and receiving "gifts" such as personal gratitude.

Patients' views may be influenced by the circumstances. Although giving increased information at the time of booking a clinic appointment in gynaecology outpatients did not alter the number of people agreeing to participate, it did increase their satisfaction with the experience.¹⁴ Satisfaction was also increased by giving specific written information to patients participating in exams¹⁵ and by allowing them to see the doctor alone as well as with students present.¹⁶

Barriers to participation

The nature of the patient's problem may influence consent,^{11 12 17} as may a previous bad experience.^{13 18} Negative preconceptions about what might be involved influence patients' decisions,¹⁰ and lack of choice also produced negative reactions. Lynoe et al found that 80% of patients would "feel negative" if their consent to trainee involvement had not been actively obtained before the start of the learning experience.¹³



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Consent must be obtained from all patients before they are involved in teaching

Another concern was confidentiality.^{19 20} O'Flynn et al found that 40% of patients felt that students should not see their records. This study did not, however, offer a rationale for learning from records review and so may be an overestimate of public concern.¹² The participants in our workshop also identified confidentiality as a major concern, seeing this as a potential barrier to patients wanting to take part in medical teaching and learning experiences. Participants were unclear about information that students might retain, with whom this would be shared, and what patients had a right to know.

We also found a lack of awareness of current practices in medical education and clinical training. Many lay participants were unclear about how qualified students might be, what they might be expected or allowed to do, and the nature of a teaching hospital or practice. Expectations of student and patient behaviour varied widely.

Need for consent

We found a widespread consensus that specific consent must be obtained for student contact. Although the Department of Health has issued guidance on consent,²¹ it does not include student participation in clinical practice. The General Medical Council guidance on consent and confidentiality is not specific to learners in clinical settings. A survey of US medical schools about informed consent²² concluded that only a minority implemented national guidance and that medical students varied their frankness around consent if the procedure they had to perform was seen as invasive (such as intimate examination or techniques with more risks of injury).²³

At our workshop, informed consent was seen as "a continuous process that begins with the first contact the service has with the patient." Whether a patient gives consent is partly determined by how staff behave: those who are respectful and give full information empower patients to make a real choice.

Participants felt that express verbal consent was adequate in many situations. Written consent was more appropriate for situations involving physical contact and any risk or discomfort. A signature was also recommended when staff are consenting patients in advance or may not be present at the learning encounter. The professional status of the person consenting was expected to vary and could be a nurse, doctor, student, advocate, or administrator.

People should be given enough time to think about whether they wish to take part. This may mean contacting them before their appointment, or allowing a pause between giving them the information and asking for their consent. The consensus was that this should be done without the student(s) being present and confirmed in the presence of the students.

Changes to improve patients' experience

The workshop identified communication as an important part of improving patients' experiences: "What I've learned from the experience of consenting patients and teaching medical students is the importance of communication." The information required could be about the nature of a teaching hospital or about a specific teaching and learning experience. The aim is to

inform the patient, make the interaction more positive, and facilitate informed consent. Special needs must be considered—for example, how best to communicate with those who speak different languages, have limited ability to communicate, or have learning disabilities. People's capacity to understand may be more limited when they are unwell, and this should be allowed for.

There was considerable discussion about the cultural changes in the NHS that should ensure good practice in involving patients in medical education (box). Guidelines need to be drawn up for everyone in the teaching process. The guidelines would need to be compatible with existing procedures for consent in research and clinical care and consider any potential medicolegal issues. Many doctors, particularly in secondary care, perceived a tension between the need to provide a clinical service and the time required to obtain fully informed consent for learners. Training and support for staff to recruit patients before the clinic or consultation would give patients more time to consider consent and could improve the learning experience. Obtaining feedback about their experiences from patients (as well as staff and students) was seen as a core commitment to a high quality process and as an important component of communication.

Improving the learning experience

Participants thought that empowered patients would be more likely to be effective in learning encounters because they would be participating without hidden concerns. They identified several factors that would lead to such empowerment:

- Enough information in a form that can be understood
- Opportunity to communicate
- Being asked for their consent
- Having their feedback valued
- An open approachable attitude from the person in power, usually the named tutor.

Another approach to overcoming some of the difficulties of opportunistic learning in clinical settings is to train patients to lead education. For example, one programme used volunteer parents in the community to teach residents about their child's illness.¹⁹ Student learning outcomes in an Australian study were found to be equally well met when teaching sessions were led by patients or consultants.²⁴

Conclusions

The evidence suggests that patients remain willing to take part in medical education provided that they are

Cultural changes required to improve patient participation

- Develop guidelines for patients, teachers, and students
- Manage implications for staff time and training
- Recruit and prepare patients before the learning encounter
- Advice to students—including appropriate dress and behaviour, how to implement good practice, how to deal with problems and difficult situations
- Get feedback on the effect of patients' participation

Summary points

Patients participating in clinical education need to be empowered by a more positive partnership with staff and students

Patients require enough information to assess what is involved and understand the boundaries of confidentiality

Consent should be sought before the start of the learning encounter

Feedback from participants and teachers should be given to patients in a way that rewards them for their involvement

Cultural change will be needed to implement these changes within the NHS

treated with respect. Our workshop identified good communication and informed advance consent as important parts of good practice. Although the high level of consensus suggests that the conclusions of the workshop are valid, a different set of participants or group structure might have developed different emphases, particularly if the proportion of lay participants had been higher.

The ideas expressed at the workshop need to be tested for their acceptability and feasibility in the clinical setting. The organisational changes that could facilitate implementation of the recommendations also need examining. It will be important to see whether informed choice increases or reduces patients' willingness to be involved. Unless we ensure that patients view participation in medical education positively, we will not be able to increase the opportunities for experiential learning.

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