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FEATURE

The patients who decide what makes a good doctor

Patient involvement in medical education is moving to the next level, finds **Emma Wilkinson**: they now design and mark assessments, develop curriculums, and inform admissions

Emma Wilkinson *freelance journalist, Sheffield, UK*

"These marks count," says Nicki Cohen, deputy dean for assessments and admissions at King's College London. She is talking about objective structured clinical examinations (OSCEs). However, the marks in question are not awarded by the senior doctor overseeing the stations, but by patients.

About 10% of OSCE marks at the medical school are awarded by real or simulated patients, with the weight dependent on the skill being tested. It is higher for communication, for example, because the best person to assess that is the person being communicated with, says Cohen.

"The most important thing," she says, "is that the students are aware that assessment isn't just what the senior doctor thinks. They have to really think about maintaining that patient focus."

This is just one example of how UK universities are taking patient involvement in training future doctors to the next level, getting patients involved in designing and marking assessments, developing curriculums, and even admissions.

At the University of Sheffield, a typical OSCE will feature around 70 patients alongside 50 actors. The proportion of patients has increased over the years because it gives the student "a more realistic experience," says programme lead, Martin Hague.

The university began its patients as educators programme in 2004, when just seven patients with acute kidney injury took part in simulated ward scenarios. Now 800 patient educators—unpaid volunteers with a range of conditions—also take part in teaching and assessment that contributes 1.5% of students' marks.

"They do contribute to the [student's] overall mark," says Hague, "and we give [the patient educators] training on how to do that. We use them to consider [students'] consultation skills and language and empathy."

New marking criteria

For Jane Moore, course organiser for the undergraduate teaching course in obstetrics and gynaecology at the University of Oxford, having patients assess OSCEs was not enough.

Around six years ago, Oxford started to recruit women who had experienced miscarriage to speak to the students. This led to a study on patient perception that informed a new marking guide for an OSCE scenario based on delivering bad news.

The patient tutors, who are paid and have contracts, worked in collaboration with clinical staff to develop the curriculum and final assessment.

As a result they changed the marking sheet, adding "eye contact, giving accurate information, empathy, and, something which I would never have thought of, 'Please don't ignore my partner,'" explains Moore.

Together, the clinicians and patient tutors decided that an actor would play the part of the patient, with the patient tutor as their partner. The resulting mark is a 50/50 combination of the clinician and patient tutor.

Patient tutors are included in three of the eight OSCE stations—one of which assesses email conversation and is marked solely by the patient—meaning that 30% of the overall grade for the eight week rotation is awarded by patients.

Moore says that putting patients' assessment into the exam makes students take it seriously. "Also, it is about giving patients power," she says. "If you give them a voice you give them power and you can't objectify them anymore. That is something we should be learning right from the start."

Mostly, using the jointly developed marking guide, clinician and patient assessors agree, but occasionally they pick up on different aspects. Ingrid Granne, lead for recurrent miscarriage and early pregnancy at Oxford University Hospitals NHS Trust, says she would have thought herself a good judge of how a patient was feeling about a consultation. Having the patient tutors involved in the assessment has made her realise she is often quite wrong.

"You quickly realise that how you interpret something is based on yourself. It doesn't really matter if I think the student has been sympathetic or communicated well if the patient doesn't think that," Granne says.

Patient tutor Emily Gray, a law researcher, gives this example: "The doctor had ticked all the boxes, but the student had a grin on his face the whole time and looked like he was going to laugh. The clinician present hadn't noticed it until I pointed it out."

The patient tutors have also influenced how care is provided in Oxford through a redesign of the early pregnancy service, which is being relocated to the community so that women having a

emmalwilkinson@gmail.com

miscarriage do not have to be seen in the same place as heavily pregnant women.

Responsibility and accountability

Robina Shah runs the University of Manchester's Doubleday Centre for Patient Experience and, with her codirector, Paul O'Neill, has recruited 23 medical education partners (MEPs) since 2014. The partners are patients, carers, or interested members of the public from all walks of life and participate in the design, delivery, and governance of medical education.

MEPs, who are paid and work between three and 14 hours a month depending on their role, sit on all the relevant committees. They have a say in curriculum design and content and assessment as well as being members of student health and conduct panels.

"Our medical education partners are not simulated patients or 'expert patients,'" says Shah, to make the distinction from people who teach about their health conditions. "They are valued and core members of the team and have responsibility and accountability."

They also contribute to the admission of medical students: each year the lead partner for admissions prepares several OSCE scenarios about NHS values and professionalism to test ethics, probity, openness, and honesty.

"The feedback from [clinical] colleagues has been positive: we have been told that [the MEP admissions] station has provided great sensitivity in finding those students who demonstrate strong values," says Shah.

Colin Lumsden says the MEP on the curriculum committee, which he chairs, provides a "unique insight on the patient perspective."

"Our MEP often asks us to explain and expand on our rationale for what we do and why," he says. "She has frequently challenged the status quo by ensuring that our practices are transparent and fully justified."

Karim Lajee, an MEP who sits on the programme committee, says the programme has been a real eye opener. "The importance placed on the patient and public perspective is very refreshing."

The Doubleday Centre has 15 national affiliates who support its work, including NHS England's former medical director Bruce Keogh and Keith Pearson, chair of Health Education England. The MEPs programme has already been recognised by several organisations, including the Institute for Healthcare Improvement, for the work it has done on making medical training more patient centred.

"[The MEPs] are certainly making a positive difference to how we engage and involve the public as partners in medical education," says Shah, who is hoping to find some funding for a PhD student to evaluate the effect.

Clinician resistance

Not everyone recognises the value of involving patients in medical education to this extent, says Oxford's Moore, who has heard fellow clinicians claim, for example, that patients cannot contribute to assessment because they have only one perspective. "The solution is the proper criteria to mark against and then quality assurance as for any other examiner," she counters.

Other clinicians have claimed that "patients tend to get things out of perspective," which Moore says is: "a typical 'calm down, dear' type response, in my view— the resort of people with power who know they are in the wrong, perhaps."

Despite such pockets of resistance, Moore believes her approach will slowly take hold in other areas of medical teaching and is planning to harness feedback for trainee doctors from patients attending routine NHS appointments. "Once you start to think about who the healthcare system is for, it is obvious that it is the patients who should be deciding what the standard for doctors should be," she says.

"The patients are not claiming or trying to judge whether doctors have the correct information, but when it comes to communication skills, of course it should be the patients judging that."

Patient view: Peter Johnson

"I only offer suggestions that I think worthy of busy clinicians' time"

It is important to increase patient involvement in medical training because the relationship between clinicians and patient needs to be a mutually beneficial working partnership.

I am an active member of the patient and carer group in the faculty of health sciences at the University of Southampton; we are involved in developing curriculums, student selection, and employability, and we are working towards participating in assessments.

Several of the examples in this article refer to the importance of communication and empathy. I am pleased to see mentions of body language but disappointed that the importance of active listening is not mentioned. When I facilitate a communication session for healthcare students or clinicians, I invariably include the old saying: "We have two ears and one mouth—use them proportionately." Clinicians can only help patients get better if they find out what the patient's concerns and hopes are by asking open ended questions and listening with interest to how the patient responds.

One of the ways I can tell how useful my contribution has been in medical training is the feedback I get from academic and clinical colleagues, particularly when a suggestion I made is implemented. We, as patients, have to be aware how busy clinical and academic colleagues are, often having to work under pressure to tight deadlines. I only offer suggestions if I think they will improve some aspect of a programme or project and are worth colleagues taking time to consider them.

One of my projects is the implementation of next year's postgraduate courses. It is working well, which leads me to believe that patients should also contribute after qualification, such as coaching clinicians in communication skills as part of continuous professional development.

Patient involvement in medical training will be particularly beneficial, and help overcome clinician resistance, if we each play to our strengths. Whenever appropriate, it is better to have more than one patient involved in any project or programme. At Southampton, there are two of us on one project and we meet up just before a meeting to swap notes.

The one thing patients have in common is experience of the healthcare system. However, each of us has life and work experience that can add a different perspective for students and clinicians.

Involving child patients in postgraduate medical training and assessment

December 2017 saw the General Medical Council sign off the Royal College of Paediatrics and Child Health's (RCPCH's) new curriculum—the first created with the help of 170 children and young people plus 30 parents and carers, who shared their views on what would make the "best doctor" for them.

This is the work of the college's children and young people's engagement team, which runs its &Us network for children, young people, parents, and carers, and helps use their views to influence and shape policy and practice—increasingly, in the training and assessing of paediatricians.

As well as supporting curriculum development, the team has been developing child patients' involvement in the college's Start assessments for trainees who are near to becoming consultants. Scenarios based on young people's narratives were included in the scenario bank for the first time in the autumn, and the team is working on creating more so that eventually each assessment will include at least one of these. And that's just phase one, says the college's children and young people's engagement manager, Emma Sparrow.

"Phase two will look at having RCPCH &Us members in the assessment, providing joint assessment feedback with an examiner," she explains. "Phase three will see them running their own station—writing the scenario, delivering the assessment, and providing feedback—all supported by an RCPCH assessor."

Now her team is also exploring involving children and young people in the clinical membership exam. "We have started to do some pilot work on how they feel in clinical exams; they could be involved in assessing," says Sparrow.

"We want to bring the examiners and the young people together so [the examiners] can understand things from the young person's view."

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