Global Trends in Patient-centred Healthcare and Medical Education: From traditional to progressive

Insights from Elsevier-hosted round tables at three key Medical Education conferences.

The Association for Medical Education in Europe Conference (AMEE): August 2019 in Vienna, Austria

The Asia Pacific Medical Education Conference (APMEC): January 2020 in Singapore

The Ottawa Conference on the Assessment of Competence in Medicine and the Healthcare Professions: March 2020 in Kuala Lumpur, Malaysia

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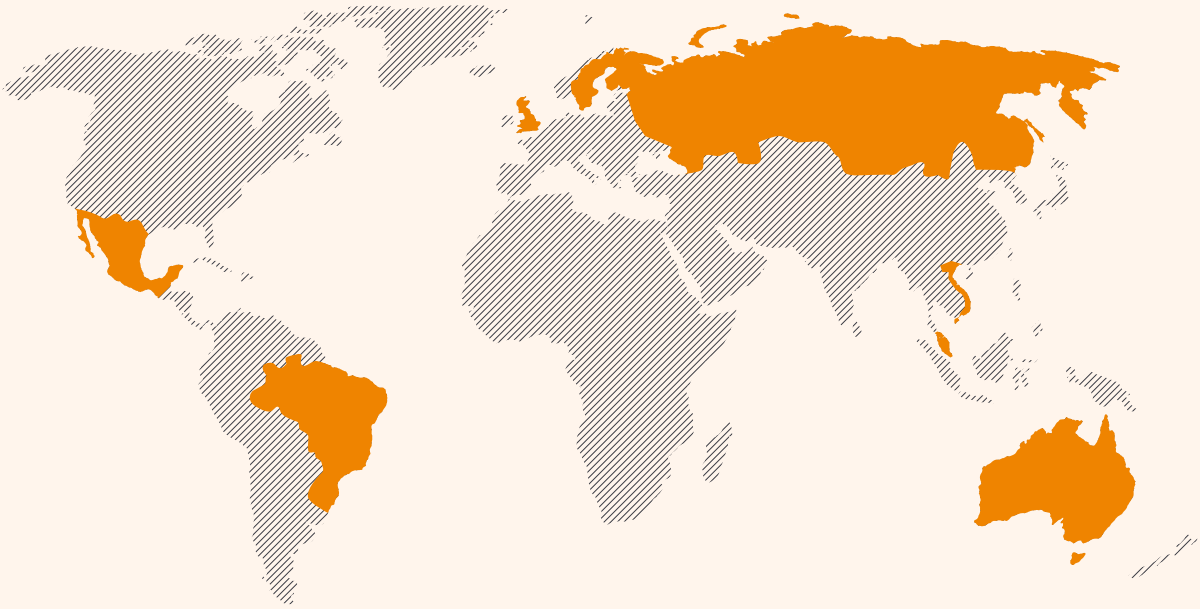
Countries Represented



- Australia
- Brazil
- Finland
- Malaysia
- Mexico
- Russia
- Sweden
- United Kingdom
- Vietnam

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Please note: This paper includes different perspectives and personal real-life examples shared by medical faculty and students from around the world. This icon will be used to represent when these individual viewpoints have been summarised from the original discussion.

Overview

Preparing new doctors for a changing, patient-centred world

Healthcare is evolving constantly. Over the last 20 years, the patient has shifted from being an object to an active partner in medical practice. Yet technological and cultural changes are happening at different speeds in different countries and within different institutional settings. As clinicians, how can we accommodate these differences? As educators, how can we get students up to speed?

The changing landscape presents other challenges: As more patients shift from being passive to proactive participants in their own healthcare, they will be expected to make informed decisions and generate more of their own data. Do patients have the skills to do this? Are young doctors prepared to teach them how?

At three recent medical education conferences, Elsevier led round tables with representatives from around the world to discuss challenges, solutions, innovations and questions like these. Participants included medical students, medical school faculty and clinical professionals from nine different countries, providing a well-rounded range of perspectives.

Discussion points centred around these key questions:

How does clinical practice differ in different countries? How do doctors and patients interact differently in different places?

How are medical schools preparing students for the world of the empowered patient? And how are they gauging success? How do educational approaches reflect this?

Are new doctors well prepared? If not, what are the gaps?

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Executive summary

Patient-Centred Healthcare and Medical Education: A range of approaches – from traditional to progressive

A. Differences Between Round tables

With participants from nine representative countries, the three round table discussions presented a variety of insights into current practices and mindsets in different parts of the world.

On one end of the spectrum, an academic working in **Russia** stressed the country has a long way to go from its highly traditional system to a more patient-centred one. He said the round table leader's description of the old-school "the doctor in the white coat is God" approach is still the norm in clinical settings. Medical students from **Spain** and **Brazil** shared their frustrations about lack of student-patient interaction, inadequate clinical training, and poor preparation for the professional world.

Professors and medical professionals from **Mexico**, **Australia** and the **United Kingdom** explained that, despite having a good amount of patient exposure integrated into their programs, students still lack the confidence to communicate effectively with patients. One of them asked, "It makes me wonder: Did we miss something along the way?"

On the progressive end, attendees from **Finland**, **Sweden**, **Vietnam** and **Malaysia** spoke of early student-patient exposure (as early as the first week of the first year), the choice of smaller primary practices over larger clinical settings, and the importance of teaching patient-centredness as part of the curriculum.

> *"The older, more traditional type of approach – 'the doctor in the white coat is God'– required a different type of training. What type of training is required now?"*

B. Similarities Between Round tables

Definition of the 'empowered patient'

Across the three round tables, attendees agreed on the importance of empowering patients and on the general definition of the term. They emphasised the focus on patient teams and on teaching information literacy skills rather than just feeding information during patient contacts. Although not all attendees used the term "empowered patient" in their institutions, all said that "patient-centred" was commonly used and understood.

They described the 'empowered patient' as being:

- aware of their condition and what they need to do
- empowered with the skills to look for information themselves when they need it
- part of a team and involved in decision-making about their own health

Jan Herzhoff, the President of Global Healthcare at Elsevier, described major changes and developments in medical education, noting the shift from a more narrow academic focus to a more well-rounded professional preparation and soft skills (like empathy and communications). Students are training with virtual apps ("anytime, anywhere") and in multiple settings (like community clinics), not just in hospitals, to gain relevant skills. Medical schools are using a more student-centred approach and personalised learning, reflecting the changing ways that students access and consume information.

> *"Medical students themselves have changed," he stressed. "How they learn has changed. This combined with what they need to learn is seen as part of a paradigm shift."*

Other areas of agreement: Skills training and optimal settings

Regardless of the different approaches used in their own countries and institutions, all attendees agreed on the need for more student-patient exposure and better tools and training to prepare students for the changing world of medicine. Shared views include:

- Students need to spend more time with patients. Longer engagement is necessary (we must increase quantity, not just quality).
- Communication skills are critical. We must teach students how to interact with patients who come in all shapes and sizes!
- Medical students lack confidence in clinical settings. How do we help change this?
- Large clinical settings are not optimal for training; smaller family clinics or primary care practices provide more and better quality engagement with patients.
- Although some countries are moving faster than others, the world of healthcare is changing – so we will have to teach patients skills to use these resources themselves.

Challenges

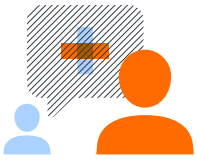
All participants agreed that students need more patient exposure. They also all agreed that modeling was important to outline how to train students to work in a patient-centred environment. However, one attendee asked, “How do you model interaction when you’re not allowed to speak to patients in the clinical setting?”

Patient Exposure

Spain: Students are more focused on books and exams than on patients; they are afraid to make mistakes; they are often asked to leave the patients’ rooms; patient exposure in a clinical setting comes in the final year (which is thought to be too little, too late).

Communication Skills

United Kingdom: We can only help empower patients if we have the communication skills to do this. We need communication skills to help patients contextualize the information they find on the internet.

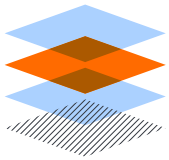


Feedback and Assessment

Australia: Our problem is not assessment, it’s our failure to give effective feedback to students. They need more than just 'good job'. We’re very poor at giving feedback from clinical settings (hospitals) because we’re so busy and short-staffed.

Faculty Development

Australia: We need more professional development opportunities for faculty.



Consistent Approaches / Common Definitions

- Sweden: How do we apply patient-centredness the same everywhere?
- Brazil: These things [‘empowered patient’ and ‘patient-centred’ approach] are not discussed at all in medical school.
- Russia: Basic, widespread education is needed. Could the humanities be integrated into medical education to teach skills required for patient-centred healthcare?

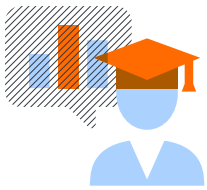
Local insights

Reviewing insights from across the three round tables, five key takeaways rose to the top. These were the most frequently and widely cited needs and were agreed upon in principle. While implementation of solutions might take different forms and follow a different pace in different countries and institutions, identification of top needs is a useful first step.

Top needs identified:

1. Communication Skills for Students
2. Formative Assessment / Better Feedback
3. Professional Education for Faculty
4. Technology to "Fill the Gaps"
5. Rethinking Clinical Settings / Patient Exposure

A range of interesting ideas and innovations were discussed as possible solutions to common challenges. See sample insights below:



1. Communication Skills for Students

To equip them with the skills and confidence to succeed in the world of the 'empowered patient'

Example: Teaching the Skills (Malaysia) – When talking about professionalism, we give students hypothetical situations and ask questions like: 'What was the conflict?' and 'How did you deal with it?' You have to teach the students how to interact with the patients.

Example: Teaching Teamwork (Mexico) – We teach our students to work with the patients and their families as a team. It's not that we are on one side and they are on the other. [We focus on] the communication skills and subskills we need to build in the students and in the patients.

2. Formative Assessment

To generate richer, more constructive feedback, measuring soft skills and key factors like relational empathy and verbal/nonverbal communication skills

Example: 360 Assessment (Vietnam)

We are exploring ways to use 360 assessment with a rubric that allows one to ask an open-ended question — and to let the patient answer. We plan to improve consistency by having each assessor assess the same student the same way at he same stage of learning.

Example: Systematic Training and Reflection (Sweden)

We sit down together and discuss [their experiences] — that's the difficult part. We need to give them experience and then give them something to reflect upon and then repeat that and increase the level of complexity. It needs to be run throughout medical school. There needs to be a focus and there needs to be a plan for it. It doesn't just happen; it's systematic training.

3. Professional Education for Faculty

Teaching "how to model" to illustrate best practices, provide consistency, address faculty shortages and time constraints

Example: Faculty Modeling and Mindset (Sweden)

I believe we're setting expectations by the way we as teachers behave with the patients. For instance, we get a much different reaction from Swedish patients based on how we ask the patient: 'This is a future colleague of mine who's joining me' vs 'Would you mind if I bring a student? Are you sure? Is that okay with you?' You get a different reaction based on how you ask the question; so it's about the mindset of the faculty.

4. Technology to "Fill the Gaps"

Use of technology (such as video-based feedback and virtual simulations) to fill in the gaps. For instance, to show examples of faculty modeling or student-patient interaction.

Example: Virtual Hospital App (Australia)

Used by students at home or in class as part of an integrated curriculum. The app-based platform includes a variety of case studies complete with medical history and symptoms, allowing students to simulate patient care by providing a virtual diagnosis and treatment plan, as part of a treating clinical team. The technology is complemented by real-life simulations, which include actors in a hospital environment who present with symptoms that students must diagnose and then treat.

Example: Technology for Patient Empowerment (Vietnam)

A participant described his experience as a medical student, traveling around lower socio-economic communities with his laptop computer. By bringing technology into people's homes he was able to show them how to access information — and was able to share this with their families.

5. Rethinking Clinical Settings / Patient Exposure

Moving clinical training from hospitals to community-based and primary care practices to improve the level of experiential learning and supervision

Example: Primary Care vs Hospitals (UK) – There's a national study each year that shows preparedness of medical students to start Foundation year 1 and our school always places in the top. It is because we do so much of our training in primary care. Patients in hospital are really sick, so you don't have much time to talk to them. Also, they aren't in hospitals very long!

Example: Early Exposure Pays Off (Finland) – I think the strength of our curriculum is the number of [student-patient] contacts. We start from year 1 and continue to see more and more each year. After 4 years of clinical studies they're licensed to work as a doctor (supervised) during their summer holidays, getting a full salary. Interaction with the patients is their strength.

Example: Training in Family Clinics (Vietnam) – Most of the time we send a student to a very small family medical clinic once a week to work with patients in very early years. We want to prepare them step by step so that then in the clinical years — years 4, 5 and 6 — they're applying what they've learned.

Example: "Near-Peer Support" Pilot Project (Australia) – We employed our own post-graduate doctors — teaching fellows, just a few years older than the students — to provide near-peer support. They would take students in groups of 2 or 3 for bedside teaching. They had clinical privileges but no clinical duties — so were able to get the most out of the environment without taking away from the work to be done. This is helpful during the first year and then again later in the students' final year.

Conclusion

Confidence and communication skills go hand in hand. In order to build confidence in a clinical environment, students need more patient exposure (in either real-life or virtual settings) and better communication skills (gained through integrated curriculum, patient exposure, faculty modeling and formative assessment). They need to learn in an environment that allows errors and room for growth.

> *"The way to improve students' communication skills is to teach them how to communicate with patients!"*

Formative assessment can generate productive, meaningful feedback to drive learning and improve confidence. As 'soft skills' like empathy become more and more important, we must find ways to innovate with more flexible assessment tools to measure and gauge these factors. In the same way that we seek to empower patients to actively manage their own health, formative assessment allows students to actively manage their own learning — and to set goals to improve key skills.

Professional development can teach faculty how to model behavior to students. With staff shortages, time constraints and cultural differences in patient-doctor relations, this type of training and development would be welcome, according to our round table participants.

Decentralizing clinical training from hospitals to smaller community-based and primary care clinics gives students more patient exposure, more opportunities to practice communication skills, and better feedback from supervisors.

To fill the gaps, technology continues to provide creative ways to simulate real-world settings and scenarios and to allow for better quality feedback than is feasible in busy hospitals. Tools to facilitate communication and teamwork could be used to boost critical skills, preparing new doctors for the changing demands of the patient-centred world.

Acknowledgements

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AMEE 2019 Round table attendees consisted of faculty members and students from the below universities:

- Anáhuac University, Mexico
- University of Eastern Finland
- University of Exeter, UK
- First Moscow State Medical University, Russia
- Umeå University, Sweden
- The University of Córdoba, Spain
- The Federal University of Pelotas (UFPel), Brazil

Ottawa 2020 Round table attendees consisted of faculty members from the below universities:

- Universiti of Malaya
- Universiti Sains Malaysia
- Universiti Kebangsaan Malaysia
- Taylor's University
- IMU Centre for Education
- Melaka Manipal Medical College
- Management & Science University
- Universiti Putra Malaysia
- Perdana University

APMEC 2020 Round table attendees consisted of faculty members from the below universities:

- Bond University, Australia
- Health Advancement in Vietnam (HAIVN)
- Nanyang Technological University Lee Kong Chian School of Medicine, Singapore