Multiprofessional Faculty Development - Involving Patients in Clinical
Background and context

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’s statement of 1905 is as true today as it was then, but medicine has come a long way since the days of patients being used just as ‘teaching material’. Caring for the patient and working through interesting clinical cases are still the core reasons why doctors practise medicine, but a recent BMA discussion paper (BMA, 2008) highlights the need for a shift in the relationship between doctor, learner and patient towards patient-centered learning, a more active role for patients and involving patients as partners in the education process.

One of the main challenges for clinical teachers is to achieve a balance between ensuring good patient care and enabling the learner to acquire the skills, understanding and behaviours of an effective professional practitioner. A number of recent trends in healthcare are important in this regard:

- shifts in clinical care, such as less in-patient care with shorter stays in hospital: patients who are in hospital may be very ill or frail
- increased student and trainee numbers leading to reduced opportunities to learn from large numbers of patients
- patients more assertive about being ‘used’ as ‘teaching material’, especially by large numbers of students/trainees
- introduction of patient pathways and integrated care leading to reduced opportunities for learners to take histories and clerk patients
- changing roles of healthcare professionals have reduced learning opportunities in practice.

(Spencer, 2003; Ker & Bradley, 2007)

In the next sections we will explore how clinical teachers can meet some of these challenges through using alternative teaching and learning approaches while still ensuring the needs of both learners and patients can be met.
Patient involvement in healthcare

One of the drivers for increased patient involvement in medical education is the increasing acknowledgement of the ‘patient voice’ in healthcare. This in turn reflects a wider involvement of service users and carers, and the ‘personalisation’ of care at all levels in public services (Carr and Dittrich, 2008, p. 4). This shift towards a partnership and personalised care agenda, enshrining choice and located around local services, is set out in the NHS Next Stage Review (DH, 2008, p. 14), which emphasises the role of clinicians, not only as practitioners and leaders, but also as partners in care.

Two streams of lay involvement in healthcare services have emerged. Patient involvement as the contribution of individuals to clinical decisions about their own healthcare and that of others in similar circumstances, and public involvement via the participation of individuals or groups in the development, planning and provision of services. Clinical and non-clinical decision making are different; however, areas of overlap exist in clinical governance, medical education and research.

Patient involvement can be seen as a product of particular interpersonal relations typified within the doctor–patient relationship and the importance of appropriate communication training has long been recognised. However, as the BMA Patient Liaison Group (2007) stated: ‘PPI is not about people wanting to make the clinical decisions. It is, in part, about facilitating patient autonomy.’ They suggest that patients want to be treated as partners by health professionals, and would like to be offered a choice of treatment and to be informed to enable choice. Involvement in care improves outcomes through greater compliance with medication and treatment.

There has been little research into the effectiveness of user involvement in the evaluation and development of services, although a positive effect on the patient experience has been reported. For example, the Macmillan/DH Cancer Partnership Project Evaluation report (2004) summarises:

- partnership groups show effective achievements including improvements in information, communication of bad news, transportation, parking, waiting times and the design of new buildings
- strong leadership is crucial to the effectiveness of groups
- the commitment of health professionals, cancer networks and cancer service users is key to sustainability of patient involvement in cancer services
- health professionals may experience emotional and interpersonal challenges when working with patient/carer members in the groups.
The learners perspective

Students and trainees also express huge benefits in learning with and from patients. Learners value working with patients immensely 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 many cases in different contexts (Eva, 2005), but they also need support in making sense of what they see through discussion with and challenge from clinical teachers.

Doshi and Brown (2005, p. 224) identify the advantages of patient-based teaching as:

- learning in context
- opportunity for role modelling
- teaches transferable skills
- increased learner motivation
- increased professional thinking
- integration of clinical skills, communication skills, problem solving, decision making and ethical challenges.

And the disadvantages as:

- its ad hoc nature
- decline in availability of patients/clinical cases
- cannot cover the whole curriculum
- poorly supervised and variable delivery
- conflicting pressures of teaching and service delivery.

Guidance for learners who are working with patients should include ‘advice on appropriate dress and behaviour, how to implement good practice and how to deal with problems and difficult situations’ (Howe and Anderson, 2003).
Involving patients in clinical teaching

Patients can be involved in clinical teaching in many ways throughout the whole curriculum cycle: planning, design/development, teaching and workplace-based learning sessions and activities, assessment strategies and methods, and evaluation (Gordon et al., 2000).

See other e-learning modules and ‘Other resources’ papers for specific ideas around these aspects. In this module, we focus specifically on where patients are directly or indirectly involved in teaching and learning.

Spencer et al. (2000) reviewed the role of the patient in clinical teaching and learning and suggested a framework for discussing the involvement of patients in medical education. The model is based around identifying Who? How? What? Where? and provides checklists against which patient involvement can be measured in a curriculum or in individual settings. These have been reproduced below.

Who

Patients vary immensely in terms of the clinical problems with which they present, and also in their age, gender, ethnicity, sexual orientation, emotional and intellectual capacity and socio-economic status. Patients may be ‘real’ patients, simulated patients (or actors), ‘expert’ patients or simulators such as models or manikins (discussed in more detail later in the module). Decisions need to be made by clinical teachers in consultation with patients and carers as to the appropriateness of involving patients in teaching. However, research into patient involvement highlights that the majority of patients benefit from being involved in teaching (Lefroy, 2008; Haffling and Håkansson, 2008).

How

Trainees and students working on a ward, in an outpatient clinic, GP consultation or emergency department will have very different opportunities for encounters with patients. This will affect 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.

The list below provides a useful summary of the types of interaction that may be most relevant to achieve different learning outcomes for learners. Most attributes apply to all patients, but some (such as the novice or expert patient) will need to be planned with specific patients in mind.

How?

<table>
<thead>
<tr>
<th>Brief contact</th>
<th>Prolonged contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive role</td>
<td>Active role</td>
</tr>
<tr>
<td>Time limited</td>
<td>Time committed</td>
</tr>
<tr>
<td>Trained</td>
<td>Untrained</td>
</tr>
<tr>
<td>Inexperienced (‘novice’)</td>
<td>Experienced (‘expert’)</td>
</tr>
<tr>
<td>Planned encounter</td>
<td>Unplanned encounter</td>
</tr>
<tr>
<td>Simulated situation</td>
<td>Real situation</td>
</tr>
<tr>
<td>‘Questioning’</td>
<td>‘Informing’</td>
</tr>
<tr>
<td>Known patient</td>
<td>Unknown patient</td>
</tr>
<tr>
<td>Focused learning</td>
<td>Holistic learning</td>
</tr>
<tr>
<td>Tutor involved</td>
<td>Tutor not involved</td>
</tr>
</tbody>
</table>
Where

The location of the encounter (patients’ homes, GP practice, intensive care unit or oncology outpatient chemotherapy unit) has a huge impact on the patients’ and learners’ experiences, and the learning opportunities available. Settings may be very different, but equally valuable for facilitating the achievement of different learning outcomes.

Where?

<table>
<thead>
<tr>
<th>‘Our place’</th>
<th>‘Your place’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Hospital</td>
</tr>
<tr>
<td>‘My culture’</td>
<td>‘Your culture’</td>
</tr>
<tr>
<td>‘My clothes’</td>
<td>‘Your clothes’</td>
</tr>
<tr>
<td>Service setting</td>
<td>Educational setting</td>
</tr>
</tbody>
</table>

The ‘where’ also includes:

- ‘real environment’ and ‘simulated environment’ – as training wards and simulation centres are increasingly being used in training health professionals
- ‘uni-professional’ or ‘multiprofessional’ settings – to distinguish between clinical situations in which doctors alone are learning with patients and those in which a range of health and social care professionals are learning and working.

See the module Facilitating learning in the workplace for ideas about planning learning opportunities in different settings and the ‘Other resources’ papers for ideas in the operating theatre, outpatient clinic, community, consultation and bedside teaching contexts.

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 hearing from and examining the patient.

What?

<table>
<thead>
<tr>
<th>Undifferentiated problem</th>
<th>Defined problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Challenging</td>
</tr>
<tr>
<td>High impact</td>
<td>Low impact</td>
</tr>
<tr>
<td>General</td>
<td>Specific</td>
</tr>
<tr>
<td>Clinical science</td>
<td>Basic science</td>
</tr>
<tr>
<td>Minor</td>
<td>Major</td>
</tr>
<tr>
<td>Simple skills</td>
<td>Complex skills</td>
</tr>
<tr>
<td>‘Revealed’ attitudes</td>
<td>‘Hidden’ attitudes</td>
</tr>
<tr>
<td>Particular focus</td>
<td>Generic approach</td>
</tr>
</tbody>
</table>
What sort of patient? Real patients in real clinical areas

Patients can be actively involved in teaching in various ways, from real encounters in real-life situations to simulations and videoed patient ‘stories’. In the next six pages we describe some of the commonly used methods.

Real patients in real clinical area

Thinking point

- List the advantages and disadvantages of using ‘real patients’ in teaching and training; how does your experience of using simulated patients or other scenarios compare?

One of the real benefits to learners in working with real patients in the clinical context is for learners to consolidate and synthesise their learning from a range of sources.

Whenever and wherever clinical teaching occurs, real patients are usually the most vulnerable of the three parties involved. Most patients find clinical teaching extremely rewarding, often commenting that they feel students ‘have to learn’, but the patient’s attitude towards being involved in teaching should always be respected and it should be reinforced that, whatever their decision, it will not affect their treatment and care. Within any teaching centre, patients must be made explicitly aware that the facility is a teaching environment and that learners may be present and in some cases helping to provide the care. This allows the patient to prepare for the initial encounter and to raise any anxieties they may have. At all times, the patient needs to be kept informed, mutual agreement needs to be reached about the session and, most importantly, patient privacy and dignity must be maintained.

While using real patients for teaching in clinical areas is often opportunistic (based on who is on the ward or attending the clinic or surgery), newer developments employing simulated patients and trained real patients, such as lay clinical educators or patient educators, are being increasingly used within undergraduate and postgraduate training.
What sort of patient? Lay clinical educators and expert patients

In terms of clinical education, these terms refer to ‘real patients’ who are trained to deliver teaching sessions, acting as both patient and teacher. The idea of the expert patient is also enshrined in the wider patient involvement agenda: the ‘expert patient initiative was… part of the government’s commitment to place patients at the heart of healthcare which is… part of the transformational focus of the clinical governance agenda’ (Hardy, 2004, p. 2). It was primarily targeted at patients with chronic conditions to help them ‘become key decision-makers in their own care’ (Hardy, 2004, p. 2), but in medical education, the expert patient role is that of a patient (usually with a chronic condition with stable signs and symptoms) who agrees to participate in teaching and learning. They are seen as ‘experts’ in their own condition and are often briefed or trained so as to facilitate student or trainee learning.

There are a number of advantages in not involving patients who are primarily being treated in the clinical setting for clinical care in teaching. Patient educators have the benefits of being:

- motivated individuals with an interest in medical training – patients are commonly recruited from local populations
- 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 are also helpful in overcoming 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. If they are well trained they can also be used in clinical assessments (standardised and objective). In North America for example, patient educators are commonly used in Objective Structured Clinical Examinations (OCSEs) with no other examiner.

Expert patients or patient educators can be drawn from many settings, even where concerns might be expressed about the potential risk to patients, such as those who are terminally ill or with mental health problems. Lefroy (2008, p. 14) describes how she worked with Ken (a patient educator), who was terminally ill, and identifies the following ‘hints’ for clinical teachers,

- Suitable patients are those whose eyes light up when you ask them to talk to medical students.
- Do some lesson planning with the patient (so that they own the session).
- Prepare the patient to feel challenged.
- Prepare the students to meet a person with cancer (something like: ‘be open but be sensitive’).
- Be ready to deal with student reactions – this can be a powerful experience.
- Debrief your patient to see whether there is anything that he or she needs to discuss.

Sometimes, however, it is neither possible nor appropriate to involve real patients in learning. Next we describe some alternative strategies.
What sort of patient? Simulated patients

Simulation is increasingly used at all levels of medical education and training to complement learning and assessment using real patients. Although simulation can never replace the authentic learning experiences of the clinic or bedside, it can prepare clinicians for the real world, providing an environment for the practice of technical and non-technical skills, clinical reasoning and professional judgement.

Simulation replicates an environment or situation through the use of technologies, interaction with people, computers or models. It can range from low-fidelity activities such as paper-based exercises, case studies, problem-based learning or role play; to medium-fidelity teambuilding exercises; through to the use of manikins and complex high-fidelity integrated simulators.

Simulated patients (SPs) were first used in the 1960s, with their use in medical undergraduate and postgraduate education expanding rapidly since the 1980s (Barrows, 1993). Simulated patients are role players (often actors) who are trained to work with healthcare professionals in communication and diagnostic skills. They are used in clinical simulation, particularly in the teaching of communication skills and OSCE-style assessments.

Training is essential to making simulated encounters as real and as standardised as possible, particularly in high-stakes summative assessments. There is wide international experience of using simulated patients in most clinical specialties, although children, the very elderly and some mental health problems are difficult to simulate in this medium and are therefore perhaps under-represented in assessment and training. Alternatives such as videoing clinical encounters for teaching and assessment are described shortly.
What sort of patient? The 'well volunteer'

The past 20 years have seen a dramatic change in the demographics of the UK medical population. In most UK medical schools it is still common practice for students to examine one another as ‘well volunteers’, such as for surface anatomy or heart sounds, and in some cases to peer-assess one another. Gender and cultural issues mean that sympathetic approaches to learners undressing in front of one another during skills sessions need to be adopted, and ‘healthy volunteers’ (such as PhD students) are recruited and paid to act as patients for clinical skills sessions and examinations. This allows all learners to participate fully in the sessions, and teaching is more predictable and productive. The ‘patients’ can be trained to give feedback similar to that of a lay clinical educator.
What sort of patient? Manikins and other simulators

Another alternative is to use models and simulators such as ‘Harvey’© the cardiac simulator, anaesthetic simulators or computer-based technology which allows virtual surgery and other techniques.

Ker and Bradley (2007, p. 5) summarise the potential applications of such simulation as follows:

- routine learning and rehearsal of clinical and communication skills at all levels
- routine basic training of individuals and teams
- practice of complex clinical situations
- training of teams in crisis resource management
- rehearsal of serious and/or rare events
- rehearsal of planned, novel or infrequent interventions
- induction into new clinical environments and use of equipment
- design and testing of new clinical equipment
- performance assessment of staff at all levels
- refresher training of staff at all levels.

The development and availability of clinical skills laboratories, training wards, virtual reality, synthetic simulators and multimedia learning technologies have enabled doctors at all levels to develop clinical skills and techniques. This not only helps to overcome the moral and ethical issues concerned with practising on real patients, cadavers or animals, but also has practical benefits in enabling learners to practise, learn from mistakes and have access to clinical situations where there are service pressures to optimise time, such as in operating theatres. Ultimately, learning using simulation helps to reduce clinical error and risk by enhancing doctors’ competence and confidence (Brigden and Dangerfield, 2008; Ker & Bradley, 2007).
The patients perspective

‘Patients should be involved at all stages of training to explain and portray the patient journey (patient)’ (PMETB, 2008, p. 7).

Most research into patient views on being involved in clinical teaching emphasises the positive nature of the encounter and ‘even unprepared patients see themselves as contributors to teaching’ (Haffling and Håkasson, 2008, p. 622). Patients see themselves as experts in and examplars of their condition and as 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 and an open and approachable attitude from the person in power (usually the tutor)’ (Howe and Anderson, 2003, p. 327).

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
- companionship and relief for social isolation (e.g. community visits to elderly patients living alone)
- reassurance of wellbeing (‘a good going over’)

(Coleman and Murray, 2002; Howe and Anderson, 2003; O’Flynn et al., 1997)

However, patients feel that participation in teaching has to be considered carefully and sensitively. Factors that cause patients to feel reluctant to participate in clinical teaching include the following.

- Feeling embarrassment or anxiety about emotional problems or intimate examinations.
- Learners’ gender or other cultural factors, for example male students being involved in gynaecological or obstetric procedures and consultations (O’Flynn and Rymer, 2002).
- Previous poor experiences with learners.
- When there are 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 and emphasise the medicalisation of health issues (Coleman and Murray, 2002).

Benson et al. also identified that patients perceive differences between what they might accept as the norm in hospital (where things might have to be accepted as the ‘norm’) and in general practice, which is seen more as the ‘patients’ territory’ (2005, p. 4).

Thinking points

- Benson et al.’s point raises issues around the assumptions teachers, clinicians and patients might make around hospital-based care: is the patient seen more as ‘teaching fodder’, depersonalised and objectified in some localities than others?
- What can you as a teacher do to compensate for this within intense service pressures and large numbers of trainees and students?
What sort of patient? Video and audio

The ‘patient voice’ can be incorporated into clinical teaching using a range of resources, including video, case scenarios, sound recordings and e-learning resources. Many of these resources are freely available (such as the ‘Patient Voices’ programme available on the internet) or through shareware, others can be purchased or they can be developed by teachers and learning technologists to suit specific purposes. Examples include interactive computerised tutorials on various topics, such as epileptic seizure classification (Farrar et al., 2008) or breaking bad news (Cleland et al., 2007). The Wellcome Trust and WHO have produced a set of electronic and printed resources on many aspects of international medicine. The References and Further reading sections include links and information on examples of such resources.

Resources can be included in lectures (for example, embedded in PowerPoint presentations), seminars or tutorials to provide illustrative material or trigger scenarios about different clinical conditions or situations, and can be particularly helpful when it is inappropriate or difficult for learners to work with real patients. For example, the Royal College of Paediatrics and Child Health has developed an assessment of clinical skills using videos of very ill children. The Royal College of Ophthalmologists also uses video assessments in examinations, and personal digital assistants (PDA, a handheld or palmtop computer) have been used as an assessment tool (Van Schoor et al., 2006).
Ethical issues

Ethical issues to be considered when involving patients in teaching can be summarised as the ‘three Cs’: consent, choice and confidentiality. The main message emerging from policy documents, good practice and the literature is that simply assuming that patients will be involved in teaching and learning without making this explicit through systems, conversations and practice is no longer enough.

Consent

’A mindset shift needs to occur within the medical profession to enable informed partnership rather than informed consent (patient)’ (PMETB, 2008, p. 7).

Medical law and ethics enshrines the principle of informed consent. This aims to protect those involved in clinical care, particularly when invasive procedures are involved. The lines are more blurred around patients ‘consenting’ to involvement in teaching and learning. It is good practice to inform patients (ideally through written information sent in advance) that students or trainees may be involved in their clinical care, obtaining consent should be: ‘a continuous process that begins with the first contact the service has with the patient’ (Howe and Anderson, 2003, p. 327).

Choice

How can clinical teachers facilitate patient choice in participating in teaching and learning when trainees need to learn from patients and practise procedures within the ‘turbulent here and now of care delivery’ (Hardy and Stanton, 2007)?

Informing patients and seeking agreement should be done without the learner being present, then confirmed in the presence of learners (Howe and Anderson, 2003, p. 327). Building in ‘moment-to-moment’ opportunities for patients to ‘say no’ to specific tasks that might be carried out by learners is another way of empowering patients and acknowledging their needs. Lack of personal power and space and the more urgent need for treatment means that the type of attention that needs to be paid in the hospital context is different to that needed in primary care, where there is a more intimate relationship, more privacy and a more personal setting (Benson et al., 2005, p. 4).

Confidentiality

Practical steps that help to maintain confidentiality include:

- providing enough information to patients so they can assess and understand the boundaries of confidentiality
- reassuring the patient and involving them in discussions
- remembering that curtains around a bed or cubicle do not ensure silence
- finding more private spaces to discuss intimate or distressing issues
- discussing issues of confidentiality actively with trainees as part of the preparation and debrief
- obtaining permission for the use of images, sound recordings and extracts from case notes, particularly around anything that might identify a patient.

Clinical teachers are key role models for their learners: keeping the ‘three Cs’ in mind for both you and your learners ensures that these are seen as fundamental pillars of good medical practice, not as options.
Models and approaches

It is important to plan and prepare for sessions that involve patients. Before the session, think about:

- what preparatory work the trainee needs to do (e.g. reading, skills laboratory)
- where the teaching will take place
- which parts of the teaching session require direct patient contact
- whether you will be present or absent when the trainee is with the patient
- what role you will take (observer, instructor, demonstrator, questioner)
- where discussions will take place and with whom (do discussions always have to be round the patient’s bedside, for example?)
- how you will build in opportunities for patient feedback
- how you will build in debriefs for learner and patient
- what follow-up learning or reading should be carried out.

‘The bedside is the perfect venue for unrehearsed and unexpected triangular interactions between teacher, trainees and patient… physician teachers should be vigilant about grabbing teachable moments’ (Ramani, 2003, p. 114).

Below is a selection of models that might help you to think about and structure learning encounters involving patients.

Janicik and Fletcher (2003, p. 128)

This model groups clinical teachers’ skills into three domains, identifying some of the key aspects that need to be attended to in each domain.

<table>
<thead>
<tr>
<th>Domain I</th>
<th>Domain II</th>
<th>Domain III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend to patient’s comfort</td>
<td>Microskills of teaching – modified for the bedside</td>
<td>Group dynamics</td>
</tr>
<tr>
<td>Ask ahead of time</td>
<td>Diagnose the patient</td>
<td>Limit time and goals for the session</td>
</tr>
<tr>
<td>Introduce everyone to the patient</td>
<td>Diagnose the learner</td>
<td>Include everyone in teaching and feedback</td>
</tr>
<tr>
<td>Brief overview from primary person caring for patient</td>
<td>o observe</td>
<td></td>
</tr>
<tr>
<td>Explanations to patient throughout, avoiding technical language</td>
<td>o question</td>
<td></td>
</tr>
<tr>
<td>Base teaching on data about that patient</td>
<td>Targeted teaching</td>
<td></td>
</tr>
<tr>
<td>Genuine, encouraging closure</td>
<td>o role model</td>
<td></td>
</tr>
<tr>
<td>Return visit by a team member to clarify misunderstandings</td>
<td>o practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o teach general concepts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o give feedback</td>
<td></td>
</tr>
</tbody>
</table>
Doshi and Brown (2005, pp. 224–6)

| Shadowing (role modelling) | Trainee shadows a more senior clinician and learns by observation  
|                           | Tip – prior to 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 feedback to the trainee |
| Videoconferencing interviews | The trainee’s interview with a patient 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 |
| Wave scheduling (Ferenchick et al.) | This is a technique for including teaching time into an outpatient clinic or GP surgery in which the trainee sees Patient 1 while the trainer sees Patient 2, then the trainer joins the trainee to see Patient 1 and there is a gap in the appointments. This is repeated so that alternate patients (i.e. 1, 3, 5) are seen by both trainer and trainee, and patients 2, 4, 6, etc., are seen by the trainer alone  
|                           | Tip – this is a useful way of optimising busy outpatient clinics but needs careful scheduling, timekeeping and allocation of appropriate patients to the trainee’s ‘list’ |

McKimm (2008)

A Trialogue is a discussion between three groups with different principles, backgrounds and expectations: a structured three-way conversation (myDictionary.com).

- The ‘Trialogue’ focuses on relations and interactions. The relationship and interactions between clinician (as teacher), learner and patient help to explain and structure complex clinical teaching and learning activities.
- The Trialogue provides a model for analysing complex interactions between the three ‘players’ in clinical teaching settings through the metaphor of a continually shifting dialogue.
- It provides clinical teachers with a framework for:
  - scaffolding learning
  - facilitating learner and patient active engagement in the learning process
  - ‘reflecting in action’ (Schön, 1991) to promote student learning whilst simultaneously attending to the needs of the patient
  - helping clinical teachers to pay conscious attention – ‘mindfulness’ (Epstein, 1999) – to the relationship
and emerging dialogue between players.

The Trialogue reflects concepts of the ‘parallel dialogue’ (Gergen et al., 1996) and the ‘inner consultation’ (Neighbour, 2004) suggesting that ‘expert’ clinical teachers (Proctor, 2001) operate within two sets of parallel processes: one attending to the patient (the inner clinical consultation) and one attending to the learner (the inner teaching dialogue).

The modules in this series Facilitating learning in the workplace and Workplace-based assessment provide more ideas relating to specific learning interventions.
To sum up

Involving patients in teaching and learning is an essential and powerful way of facilitating doctors to acquire the skills, knowledge, behaviours and approaches that will enable them to become effective, caring and compassionate practitioners.

This module has introduced some of the key principles and ideas around involving patients in clinical teaching and learning, exploring some of the advantages and benefits for both learners and patients, some of the issues to take into consideration and some alternatives to enabling learning without involving ‘real’ patients in ‘real’ clinical contexts. Real involvement of patients (and carers) in teaching and learning means just that, involving patients in sharing in the learning process. We have seen that 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 PMETB consultation: ‘every patient should be considered a teacher as well as a patient’ (2008, p. 7).

Perhaps one way of keeping this in mind is that effective involvement of patients in teaching is centred around good clinical practice. We could reframe Tomkins and Collins’ statement on medical treatment to say that clinical teaching ‘and the way in which it is delivered can either support or erode the capacity for self-care’ (Wilson, 2007).

Finally, here are some points to keep in mind when planning teaching or learning with patients.

- Always consider whether the learning objectives can be best achieved involving patients, whether this is in the patients’ best interests or whether the objectives can be achieved using some other method.
- Think about consent in terms of involvement and partnership.
- Introduce questioning before and after the encounter to stimulate awareness of your trainees about how they might learn from or appreciate the patient’s input and involvement.
- Plan the session carefully so as to encourage patient (and carer) participation.
- Actively consider your own involvement in the learning session with patients, in light of the trainee’s experience and competence and the patient’s place on their health journey.
- Remember that you are a role model to your trainees as both a clinician and as a teacher.

Congratulations

You have now reached the end of the module. Provided you have entered something into your log you can now print your certificate. To generate your certificate please go to ‘my area’ and click on ‘complete’ in the course status column. Please note, you will not be able to print your certificate unless you have entered something in your ‘reflections area’.

Please now take a moment to evaluate the course and enter your comments below.
Further Information

This module was written by Judy McKimm, Visiting Professor of Healthcare Education and Leadership, University of Bedfordshire. The module relates to areas 1, 2 and 3 of the Professional Development Framework for Supervisors in the London Deanery.

References


Further reading and online resources

www.patientvoices.org.uk/ provides over 100 digital stories from patients, carers and health workers on a range of topics.

www.dipex.org/DesktopDefault.aspx - has a wide variety of personal experiences of health and illness. You can watch, listen to or read their interviews, find reliable information on treatment choices and where to find support. The site covers cancers, heart disease, mental health, neurological conditions, screening programmes, pregnancy, teenage health, chronic illnesses and many others.

www.who.int/tdr/profiles/partners/wellcome.htm - WHO and the Wellcome Trust have produced a range of resources such as interactive CD-ROMs available for purchase on international health topics. Free access resources include an image library and video and multimedia resources on a range of tropical medicine conditions and health strategies.

www.simulatedpatients.co.uk this site provides a one-stop resource for users of simulated patients throughout the UK.

www.aspeducators.org US based organisation; website provides good ideas around the use of simulated patients.

www.asme.org.uk/conf_courses/2006/docs_pix/03_07_report.pdf - an extensive review of the employment of LCE in the UK.


Self-Assessment Activities

Select one or more of the activities below to develop your teaching clinical skills.

If you are registered on the site, you can do this in the reflections area. Click on the my area link at the top of the page to access your personal pages. Please note that you must be logged in to do this. Please also note that you will need to contribute to the reflections area during the course of the module in order to complete and print out your certificate.

Activity 1

Ker and Bradley summarise the potential applications of simulation. Taking each of these areas of clinical teaching/learning in turn, identify how you currently achieve these in your own teaching context and how might this be achieved more effectively and ethically.

<table>
<thead>
<tr>
<th>Potential applications</th>
<th>How do you achieve this now?</th>
<th>How might this be achieved more effectively and ethically?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine learning and rehearsal of clinical and communication skills at all levels</td>
<td></td>
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<tr>
<td>Routine basic training of individuals and teams</td>
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<tr>
<td>Practise of complex clinical situations</td>
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<tr>
<td>Training of teams in crisis resource management</td>
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<tr>
<td>Rehearsal of serious and/or rare events</td>
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<tr>
<td>Rehearsal of planned, novel or infrequent interventions</td>
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<tr>
<td>Induction into new clinical environments and use of equipment</td>
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<tr>
<td>Design and testing of new clinical equipment</td>
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<tr>
<td>Performance assessment of staff at all levels</td>
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<tr>
<td>Refresher training of staff at all levels</td>
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</tbody>
</table>

Activity 2

Taking one of the models or approaches described in the module, and plan a teaching session involving patients and learners. Identify specifically what role and contribution each of the actors in the session will take and how learners will learn from, about and with the patient.

Once you have carried out the session, think carefully about what worked well and what you might improve.

Activity 3

Considering the patient involvement and empowerment agenda, and the ethical issues of choice, consent and confidentiality, reflect on a recent clinical teaching session involving real patients and identify the positive aspects of the encounter. If carers or other professionals were involved, how did you ensure their input and involvement? Then list some of the aspects that could be improved, identifying who is responsible, what needs to be done and how this could be taken forward.