

○ Education for partnership

DEVELOPMENTS IN MEDICAL EDUCATION

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Executive summary

- Many patients expect to play an active role in managing their own health care. A growing body of evidence shows that people who are actively involved in protecting their health and managing their healthcare have better health outcomes. In order to be fully engaged, patients require help from clinicians who recognise and actively support their contribution and are willing to work with them as healthcare partners. However, evidence from patient surveys suggests that appropriate support from clinicians is not always forthcoming, particularly in the UK.
- Relevant competences for doctors include: knowing how to guide patients to appropriate sources of information on health and healthcare; providing effective education on health protection and disease prevention; being able to communicate information on risk and probability in a clear, comprehensible manner; determining patients' role preferences and, where appropriate, involving them in treatment decisions; providing support for self-care and self-management of chronic conditions.
- The study outlined here looked at the extent to which doctors are being trained to work in partnership with patients and explored gaps in both evidence and practice.
- Patient partnership is now on the agenda in medical education. Its importance is emphasised in codes and statements of principle, it appears in some of the new curricula, and methods of assessing the relevant competences have begun to be developed. Despite promising developments in some medical schools and certain postgraduate training programmes, particularly in general practice, we found a general lack of awareness of needs and skill gaps and few examples of good practice.
- Research evidence suggests that the relevant skills and competences can be taught, but evidence on how best to teach them is sparse. Few studies have looked at the impact of educational initiatives on clinical practice and health outcomes in the longer term.
- Barriers to change include a medical culture that prioritises the 'hard' sciences over what is seen as 'soft' evidence; a lack of interest in the topic on the part of the medical establishment that is transmitted to students; curricular and service pressures; insufficient knowledge of how best to teach the relevant skills; and lack of an effective mechanism to spread good practice.
- There is a need to develop and test new, creative educational initiatives designed specifically to teach the core competences required for supporting patient engagement in healthcare.
- Greater use should be made of patients as teachers. Both real and simulated patients have a potentially useful part to play in medical education and there is considerable scope for extending and developing their role.

- Explicit assessment criteria and the validity and reliability of methods for assessing the relevant competences need to be established. Methods for obtaining and using systematic patient feedback should be developed and implemented.
- Greater attention should be paid to the role models encountered by doctors in training (the hidden curriculum), and trainees should be given help to deal with unacceptable attitudes and behaviours observed among colleagues and seniors.
- Selection procedures should aim to identify desirable and undesirable attitudes towards patients and these should be taken into account when selecting entrants to medical schools or postgraduate programmes.
- Managers should ensure that sufficient priority is given to medical education and that educationalists receive adequate support to provide high quality training in patient-centred approaches. They should aim to promote respect for patients throughout their institutions.
- More funding and support is required for research and development in medical education to ensure that innovative developments are properly evaluated.
- The organisations responsible for medical education should work together to promote and disseminate good practice wherever it is identified, with a view to strengthening the move towards the sort of medical practice that effectively supports and engages patients.

1 Introduction

What patients and the public expect from doctors is changing. It has always been expected that medical education will teach clinical knowledge and practical skills, as well as schooling students and trainees in a professional culture that emphasises their responsibility to be trustworthy and act in the interest of their patients. In recent years however, many people have come to expect more. Nowadays patients expect clinicians to respect their autonomy, to listen to them, to inform them, to take account of their preferences, to involve them in treatment decisions and to support their efforts in self-care.¹ This includes taking action to prevent the occurrence or recurrence of disease, understanding the causes of illness and the treatment options, being involved in treatment decisions, monitoring symptoms and treatment effects, and learning to manage the symptoms of chronic disease. If they are to fulfil this role effectively, they require help from clinicians who recognise and actively support their contribution and are willing to engage with them as healthcare partners.

But these aspirations are sometimes frustrated by an unresponsive profession used to a dominant role in their encounters with patients rather than seeing them as active participants in their own health care.² Although research evidence has long shown the complexity and negotiated nature of many doctor-patient relationships – especially in the case of chronic conditions^{3,4} – medical education has not always reflected this sufficiently, nor adequately prepared doctors for the more fully engaged patient of today.

Evidence from patient surveys

The manner in which health care is delivered can serve to undermine the patient's role. A number of recent surveys have provided evidence that patients' role as active partners in their healthcare is insufficiently recognised and supported by health professionals.⁵ In England, the national NHS patient surveys consistently reveal gaps between patients' desire for involvement and their experience. For example, 47% of the 85,773 respondents to the 2004 inpatient survey indicated that they would have liked more involvement in decisions about their treatment and care, as did 31% of 102,383 primary care patients.⁶ Of those prescribed medicines in primary care, 41% of patients said they would have liked more involvement in the choice of medication and 39% would have liked more information about medication side-effects.

A recent UK population survey of people aged 45 and over found strong support for the notion that patients have an important role in managing their own health care, but more than half of those with chronic conditions were not effectively engaged in self-management.⁷ A significant minority had not been shown how to monitor their condition, with those in the older age-groups and those with lower socio-economic status being least likely to have received effective help.

This lack of support for an active patient role is not confined to the UK. In population surveys carried out in 2004 and 2005 in Australia, Canada, Germany, New Zealand, the UK and the USA, less than two thirds of patients said their doctor involved them in

treatment choices, gave them preventive advice, or gave them a plan for managing chronic conditions at home.^{8,9} However, the proportion from the UK saying they had received such help was even lower than this. In particular, British patients were significantly less likely to receive opportunistic advice from doctors on disease prevention and lifestyle modification than those in the other countries, less likely to be involved in treatment decisions, and less likely to have been given help with self-management of long-term conditions.⁵ For example, among British people with specific health problems, only 45% said their doctor had given them advice on diet or exercise, only 43% said their doctor had involved them in treatment choices, only 51% had been told about possible side-effects of their medication, and only 45% had been given a plan for managing their care at home.

It appears that healthcare delivery is still characterised by paternalistic attitudes in which the patient's role in protecting and promoting their own health is not properly recognised and supported. A number of factors may have contributed to the slower rate of development in the UK, including professional socialisation reinforcing conservative attitudes and low expectations on the part of clinicians, reticence on the part of patients, time and resource pressures, and perhaps also shortcomings in professional education and training.

Medical education has a key role to play in shaping the attitudes and practice of future doctors. If the situation is to improve, students and trainees will need to be taught how to engage with patients as healthcare partners. In this paper we look at how medical education in the UK is responding to the challenge and suggest ways in which these efforts could be strengthened.

The report addresses two main questions:

- To what extent are doctors currently being trained to work in partnership with patients?
- What else could be done to ensure that doctors help patients play a more active role in their healthcare?

Our report focuses on medical education in the UK, but we believe its conclusions may have some relevance in other countries also. The paper draws on a literature review and a series of interviews with experts in medical education and training, to identify key issues and scope opinion amongst those responsible for future developments in the area.

The challenge facing health professionals

Patients' expectations are changing and clinicians have sometimes been slow to recognise and respond to these new expectations. It is in doctors' interests to take account of these trends, not just because that is what patients would want them to do, but also because it is likely to lead to better health outcomes.¹⁰⁻¹⁴ Studies have shown that involving patients more actively in the management of their own health care improves their experience and often results in more effective and efficient utilisation of services with consequent improvements in health status.^{15,16}

Public perceptions of medical authority are in transition. Various political efforts to introduce market forces in health care have shifted the focus onto patients as active consumers rather than as passive (and grateful) recipients of health care. Consumers expect to receive information about the competence of the professionals they consult and the pros and cons of their treatment options to enable them to make informed choices. High profile cases involving negligent or under-performing doctors may also have made patients less inclined to consign responsibility for their care and treatment entirely to the doctor. Most patients want to be able to trust the clinicians they consult, and indeed most still do, but trust does not equate to blind faith. Nowadays people expect to see evidence that their trust is justified.

New technologies, such as ready access to health information via the internet, tools for self-diagnosis and self-monitoring, genetic profiling, and treatments for previously untreatable conditions (e.g. 'lifestyle' drugs) are beginning to impact on clinical practice and on patients' expectations. The public is becoming more aware of the possibilities, but they are often ill-equipped to evaluate them critically, leading to higher expectations and sometimes misplaced demands.

These trends raise practical and ethical questions about how health professionals should respond. If clinicians are ignorant of patients' values and preferences, they may prescribe treatment that is inappropriate to their needs. On the other hand, if they simply accede to all demands they risk distorting priorities and undermining effective care. If they concede too much responsibility, they risk patients feeling unsupported and even abandoned. Health professionals must learn how to respond to these changes, by providing information and education where appropriate, and by adapting their practice styles accordingly.

This requires a new relationship between clinicians and patients. Instead of the clinician being the primary decision-maker and care organizer, the patient's role in promoting health and managing their own health care needs to be explicitly recognised and supported. Clinicians must learn to treat patients as important participants in the process of treating and managing disease. This involves understanding patients' role preferences, offering them appropriate information or guiding them to relevant information sources, and providing education and support in self-care, self-management and shared decision-making. Patients should be encouraged to express their views and, if they wish, to participate in identifying treatment goals, choosing between options, monitoring their condition and managing their care. But this exchange must be informed by balanced, independent, evidence-based information. This requires the clinician to play the roles of facilitator, educator, negotiator and navigator, in addition to the traditional roles of

diagnostician, prescriber and technical expert.¹⁷ In this report we refer to these as the competences for patient partnership.

The role of medical education

While many health professionals appreciate the need to see patients as active players in theory, it is proving difficult to achieve change in the real world of medical practice. Many clinicians feel ill-equipped to deal with the new demands.¹⁸ Some feel threatened by informed, articulate patients and others are unsure how to engage those who are less willing or able to ask questions and share their preferences. There is confusion among professional leaders and educators about how to respond to these needs.¹⁹ Evidence suggests that well-designed training programmes can lead to improvements in patient-centred care, but good examples are relatively scarce.²⁰

While much important work has been done to encourage understanding of the patient's perspective, especially in general practice training,^{21:22} there is still a tendency to encourage trainees to focus on the disease rather than the person, downplaying both the complexity of the doctor-patient encounter and the importance of patients' values, preferences and self-knowledge.²³⁻²⁵ An over-emphasis on the technical aspects of care negates the importance of emotional and psychological responses, which are an important part of patients' experience. Most patients want to understand what is happening when they are ill and they need information so they can understand the choices they face, but they often complain that doctors do not explain the details in a comprehensible fashion. Risk information is sometimes poorly expressed, leaving patients unable to assess the likely impact of different treatments and unable to participate in decisions about their care.²⁶⁻²⁸

Education is vital to the development of the attitudes, knowledge and skills that are essential if doctors are to involve patients more proactively in their health care. Medical education and training has a key role in preparing doctors for the new era of patient engagement. This paper considers the extent to which current practice in undergraduate and postgraduate education for doctors helps them to meet these new needs. We identify various gaps and barriers to change and we conclude with a number of recommendations aimed at ensuring that the doctors of the future are fully equipped with the necessary competences for delivering health care in partnership with their patients.

2 What is patient partnership?

Fostering a culture of partnership between doctors and their patients requires doctors to develop a specific set of skills and attributes. In order to engage patients more fully in their care, they must learn about the theory and practice of developing health literacy, enabling shared decision-making, and supporting self-care, all of which demand excellent communication skills. In this study we refer to these as the competences for patient partnership (see Box 1):

Box 1: Competences for patient partnership

Medical students and trainees need to learn how to:

- Guide patients to appropriate sources of information on health and healthcare
- Educate patients on how to protect their health and prevent occurrence or recurrence of disease
- Elicit and understand patients' preferences
- Communicate information on risk and probability
- Share treatment decisions
- Provide support for self-care and self-management.

Willingness to exchange information and share understanding of health problems and possible solutions are crucial elements in partnering with patients. Clinicians need to develop expertise in communicating health information in a comprehensible manner. This involves judging what information patients will find helpful, how much to give and the best way to give it, including the appropriate use of language. In order to do this effectively clinicians must encourage patients to tell them about their circumstances, beliefs and preferences, and they must be very good listeners. They must also be good teachers, with the skill to build health literacy (i.e. ability to obtain, process and understand health information) in their patients, and they must understand and take account of cultural differences. This involves eliciting, understanding and responding to patients' role preferences, which may vary considerably between and within different cultural groups.

The need for good communication skills is obvious. While most patients give positive reports of their interactions with doctors most of the time, complaints about insensitive communication or failure to provide relevant information are still relatively common.⁶ Up

to eighty percent of patient complaints to disciplinary bodies are attributable to a breakdown of communication between patients and doctors.²⁹

Giving and receiving information from patients in the consultation is necessary but not sufficient. Many patients seek additional information, not necessarily because they don't trust what the doctor or nurse tells them, but because they want a deeper understanding than can be obtained during a single short consultation. Clinicians need to be able to guide their patients to reliable information sources and help them assess the quality of the information they find on the internet and elsewhere. They also need to understand what outcomes are of importance to patients and what role they prefer to play in decisions about their treatment and care. Most patients need help to understand risk and outcome probabilities and to deal with the uncertainties inherent in most treatment regimes. This requires skilled and sensitive communication, tailored to the individual patient and delivered with empathy and understanding.

In many cases patients, together with their family carers, expect to look after their own healthcare needs, so health professionals need to know how to access relevant self-care resources and how to help their patients make use of them. Modern medical education and training must enable doctors to support patients in the technical aspects of self-care, as well as building patient confidence and self-assurance when doing so. Clinicians must also learn what can and cannot be left to patients and how to monitor patients who are providing care and treatment for themselves.

The social sciences have much to contribute to the education of doctors in this field. There is an extensive body of published research evidence on patients' attitudes and expectations, their experiences of being ill and receiving treatment, and their values and preferences. As well as contributing empirical data, psychologists, sociologists and anthropologists have developed a variety of theoretical approaches to assist in understanding doctor-patient interactions, some of which have considerable relevance to pedagogical developments in medical education.

But most medical education does not take place in the class room or lecture hall. Doctors and other clinicians must develop and practise their skills in the real world of hospital or general practice, and much of their expertise is developed through observing experienced health professionals working with patients. This informal learning – the hidden curriculum – is crucial in shaping attitudes. The term refers to the set of cultural influences on the learning environment, for example, implicit rules, customs, and rituals.³⁰ The hidden curriculum has been described and analysed in relation to the education and training of house officers,³¹ general practitioners,³²⁻³⁴ dentists³⁵ and nurses,³⁶ and can be seen to facilitate six distinct learning processes: loss of idealism, adoption of a 'ritualised' professional identity, emotional neutralisation,³⁷ change of ethical integrity,³⁸ acceptance of hierarchy,³³ and the learning of less formal aspects of what it means to be a doctor.³⁹

Young doctors may be influenced by their observations of the behaviour and attitudes of nurses and other health professionals, as well as by that of senior medical colleagues, and what students and trainees learn from their peers or fellow students can also be influential. In particular, the hidden curriculum can have an important influence on doctor-patient interactions. For example, if trainee doctors observe patients being treated in a paternalistic fashion, they are very likely to adopt similar attitudes. This in turn will perpetuate a system in which patient partnership has little chance of flourishing.

Patient partnership should be reinforced at all levels of education – undergraduate, postgraduate and continuing professional development – and in the attitudes of tutors, mentors and role models, if a more balanced relationship is to be achieved between doctors and patients. The challenge for medical education is to integrate a truly patient-centred approach into a diversity of clinical scenarios, so that all trainees learn how to apply the relevant competences in practice.

3 Is patient partnership on the agenda in medical education?

The interviews conducted for this study and the review of the literature pointed to four principal areas in which progress has been made recently. These areas are:

- Statements of principle
- New curricula
- Teaching and learning methods
- Assessment methods

We look at each of these in turn below.

Statements of principle

The development and agreement of a set of overarching standards or principles has played a major role in the transformation of medical education and training in recent years. These articulations of fundamental values have helped to clarify the objectives of medical education, providing a strategic direction on which to build. The primary example in the UK is *Good Medical Practice* – a document produced by the General Medical Council (GMC) to inform doctors and the public of the standards and values expected of a 'good' doctor.⁴⁰ The document provides a framework to guide curriculum development and training programmes in both undergraduate and postgraduate education. All medical schools are expected to ensure that medical students graduate with a clear understanding of the principles set out in the document and each of the medical Royal Colleges has formally adopted them as a guide to developments in postgraduate and continuing education.

The significance of *Good Medical Practice* lies in its explicitness about the nature of the interactions expected between patients and doctors.⁴¹ For example, under the heading of 'Relationships with patients' the document establishes that doctors must respect the right of patients to be fully involved in decisions relating to their care and give their consent to any treatment before it is instigated. This section also details the content and nature of good communication between patients and doctors. Doctors are obliged to listen to patients, to respect their views and beliefs, and to share information whenever this is needed or patients ask for it.

In *Tomorrow's Doctors*, first published in 1993 and revised in 2002, the GMC set out how the principles outlined in *Good Medical Practice* should be operationalised in an educational context.⁴² This signalled a significant change in the guidance to medical schools: the focus moved from an emphasis on absorbing facts to a learning process that includes critical appraisal skills and competence in interacting with patients and

colleagues. Students were required, for example, to adopt appropriate attitudes and behaviour in respect of the patients' rights to be fully involved in decisions and to recognise their obligation to understand and deal with patients' healthcare needs by consulting them about their views and preferences.

In *The New Doctor*, the GMC turned the focus onto postgraduate education, setting out the qualities and competences expected of a doctor at the point of full registration (for a UK-trained doctor, at the end of the pre-registration house officer year).⁴³ A number of the core competences outlined in *The New Doctor* are directly aimed at engaging patients. It states, for example, that trainees must consider the range of factors that influence the information and treatment needs of the individual patient, such as the patient's health beliefs, attitudes and lifestyle; understand and respect the patient's point of view; encourage patients to share in decisions about their treatment; and help them to access relevant information.

Statements of principle of this type are important because they establish the importance of a patient-centred approach, emphasising the point that obtaining the skills to engage patients as active partners in their care is a key aim in the education and training of doctors. However, intentions and statements must translate into actual initiatives in education and training if they are to affect medical practice.

New curricula

Recent years have seen a shift towards competency-based curricula, which specify the knowledge, skills and attitudes required of medical students and trainees at different stages of their training. This includes specification of the competences required for patient engagement.

In postgraduate medical education, stated curricula are a relatively recent development. In the past, trainees were supervised within the 'firm' structure, a strictly hierarchical system based on a group of doctors with different tiers (consultant, senior registrar, registrar, senior house officer and pre registration house officer). This was essentially an apprenticeship programme, relying on observation of role models, with close supervision and team support. Since the early 1990s, the move to reduce junior doctors' working hours has led to the gradual abolition of the firm structure. In its place has emerged an educational system which offers trainees less supervised learning time and less consistency in who supervises them. In this context, the adoption of clearly specified curricula with defined learning objectives and assessment criteria has been seen as a means of ensuring consistency in what the trainees learn.⁴⁴

Initially, the curriculum was simply a list of skills, which were to be observed and practised, together with specification of the relevant areas of basic science that students were expected to absorb. Attitudes were not usually a stated part of the curriculum. More recently, however, efforts have been made to develop outcome or competency-based models, which specify what is required in terms of knowledge, skills and attitudes.⁴⁵ In this context all medical schools and Royal Colleges have introduced competences in communication as a central component of the syllabus for their entry examination and curricula for specialist training, although communication skills programmes still take up relatively little curricular time, especially in postgraduate education.⁴⁶

A number of bodies responsible for specialist medical education and training have introduced, or are piloting, curricula that make explicit the required competences for patient engagement. In 2002 the Joint Committee for Higher Medical Training (JCHMT) – an umbrella body for higher education for the medical Royal Colleges in the UK – set out learning objectives for trainees, including effective communication and involving patients in decision-making.^{47:48} This was an important step in the right direction, but the relevant competences were expressed in fairly general and non-specific terms. For example, the learning outcomes for communication skills stated that trainees should learn how to structure patient interviews, but omitted to mention other types of knowledge and skills pertinent to effective communication, such as how to convey complex information about risk and uncertainty, or knowledge of patient information resources.

The syllabus for the Royal College of General Practitioners' membership exam (MRCGP), developed in 2002, was much more specific in this regard. It made a firm commitment to patient engagement, stating that doctors must show that they are attentive to patients' needs, demonstrate an interest in their problems, listen to them, and share decisions with them; examinees must be able to demonstrate an ability to engage patients through effective information exchange, enhancing their knowledge, and respecting them as partners in their care. However, the syllabus stops short of setting out a role for doctors in identifying appropriate sources of information which patients can themselves explore, and does not specify the competences required for educating patients in self-care or supporting them to self-manage chronic conditions.

In 2005 the GMC and the Department of Health launched *Modernising Medical Careers* (MMC), presaging a major overhaul of postgraduate medical education.⁴⁹ A significant change to the existing system was the introduction of the Foundation Programme, a two-year programme of general training lying between medical school and specialist training. Consisting of a series of supervised placements in a variety of specialties and health care settings, it will be guided by a detailed curriculum specifying the learning objectives and competences to be gained at each stage.

The MMC curriculum for the foundation years goes further than any previous curriculum in specifying the competences required to support greater involvement of patients in their treatment and care. The requisite knowledge, skills and attitudes are clearly specified and integrated into almost all sections of the syllabus. For example, a section entitled 'Good Clinical Care' makes explicit the need for knowledge about appropriate use of open and closed questions to ensure effective listening and communication skills. Trainee doctors must be able to demonstrate the ability to involve patients, to provide information clearly, to seek and obtain fully informed consent, to encourage questions and negotiate individual treatment plans, to recognise patients' anxieties and concerns and, where necessary, communicate these to other health professionals, and to give patients a sense of ownership of their treatment or management plans.

Trainees are also expected to develop the skills needed to identify poor performance and unsatisfactory conduct in fellow professionals and to act to ensure that patient safety is protected at all times. They must develop patient-centred attitudes, including showing consideration and respect for patients' dignity and autonomy, willingness to involve patients in decisions and to respect their preferences and those of their family or carers, and to welcome feedback from patients. They must learn how to access appropriate written information for patients, and they must develop attitudes of empathy and

openness, offering choices and respecting patients' decisions. Finally, the 'Professional Behaviour' section specifies that doctors must place patients' needs above their own convenience and behave with honesty and probity at all times.

There are persisting concerns, however, over the extent to which competences required for patient engagement can be meaningfully specified, and whether a competency-based model for curriculum development will actually deliver desired outcomes. Some have argued that a competency-based approach could result in demotivated learners, with reduced educational content and an undue focus on minimum standards, leading to an increased administrative burden on tutors.^{50;51} However, most of the people interviewed for this review had confidence in a competency-based approach and felt it had significant advantages, but they acknowledged that there are difficulties in defining and assessing competences that are not strictly technical or clinical. This underlines the need to develop precise definitions, standards and assessment criteria for the skills involved in engaging and partnering with patients.

Teaching and learning methods

The development of curricula specifying what should be taught must be accompanied by development and testing of methods for teaching the relevant attitudes and competences. Detailed work has been carried out to describe and categorise the processes. For example, a substantial body of research has described the components of shared decision-making with a view to articulating the relevant competences. The theory of shared decision-making, together with careful observation of the process suggests it involves a number of steps, (Box 2).^{52;53}

For these skills to be practised effectively, trainees need to know how to tackle each of the steps, how to assess patients' reactions and modify the process accordingly, and how to handle any deviations from the norm. They need to observe the process as practised by skilled clinicians and they need opportunities to practise the skills with patients in clinical settings. Their progress must be assessed by trained observers, including patients, and fed back to them. We identified some published reports of successful attempts to teach these skills to general practitioners, but found little evidence that they have been widely adopted outside a research setting or in other specialties as yet.^{53;54}

Box 2: Competences for shared decision-making

- Recognise and clarify the medical problem and its consequences for the patient
- Identify potential solutions
- Discuss the natural history of the problem (i.e. what would happen without treatment), and the treatment options, including clear communication of the benefits, harms and uncertainties inherent in each
- Tailor the information to the individual patient's needs and circumstances
- Check the patient's understanding and reactions
- Determine the patient's decision-making role preference
- Explore the patient's views on the treatment options
- Together discuss, negotiate and agree a course of action
- Implement the chosen course of action
- Arrange follow-up
- Evaluate the outcome.

Despite a long tradition of involving patients in medical education, the potential teaching resource available through their more active involvement is growing but has not yet been fully exploited in all educational settings.⁵⁵ Educational activities have traditionally involved patients as relatively passive participants, for example to illustrate symptoms or procedures, but there are clear benefits when patients are given a much more active role.⁵⁶ Direct contact with patients can help to develop students' and trainees' communication skills, professional attitudes, empathy and clinical reasoning.^{57:58}

Patient involvement in education can be achieved using either actors as simulated patients or real patients as teachers, talking about their own experiences. A 'simulated' or 'standardised' patient is usually an actor who has been trained to portray the characteristics of a real patient, in order to give students and trainees an opportunity to learn, or be evaluated on, clinical skills.⁵⁹ The simulated patient is trained to mimic the signs and symptoms of the real patient, but unlike real patients, who may be unable or unwilling to undergo repeated examinations and assessments, simulated patients can consistently reproduce specific clinical histories, behaviours and symptoms over and over again.⁶⁰ Simulated patients can provide constructive feedback and they may be less reluctant than real patients to express concerns or difficulties experienced with a student or trainee.

Research has shown advantages of involving patient teachers in a variety of educational activities (including physical examination skills, diagnostic skills and communication

skills training), with the role of the patient teacher typically involving presentations, facilitating seminars, demonstrating to small groups, and giving feedback on individual doctors' performance.⁶¹ Videos of patients talking about the experience of being ill and receiving treatment can also be helpful for training purposes. The Database of Individual Patients' Experience of illness (DIPEX), for example, is an internet website which aims to inform patients and educate healthcare professionals by offering access to video interviews with a broad range of patients accounting for their experience.⁶² Interacting with patient teachers, either simulated or real, as an integral component of their training might prove to be the best way to build a sustainable culture of patient partnership.

Assessment methods

Appropriate means of assessment can focus and motivate learners, and only if skills, knowledge and attitudes are tested against explicit standards and criteria can educational objectives be shown to have been met. The crucial question that concerns us here is whether criteria for assessment can be defined that reliably reflect a student's or trainee's competence in areas that are relevant to patient engagement. Assessment in medicine has traditionally taken a number of forms:

- Knowledge tests, including oral and written examination
- Direct observations of actual patient consultations, including workplace-based assessments
- Role-plays with simulated patients
- Videos of consultations

Direct interaction with patients is believed to play a crucial role in developing students' and trainees' competence in engaging and partnering with patients.⁵⁷ Successfully supporting their active involvement is primarily about behaviour rather than knowledge, so oral and written examinations are not an ideal method for evaluating learning in this area. Instead various structured observations can be used, including Objective Structured Clinical Examinations (OSCE), mini-Clinical Examination Exercises (mini-CEX), and Direct Observation of the Procedural Skills (DOPS).

Defining standards and measurable criteria for assessing performance in engaging and supporting patients is an inherently complex task, but a number of recent initiatives show that it is possible. For example, the Royal College of General Practitioners has specified a set of standards, criteria and evidence enabling more precise assessment of the relevant skills, and scales have been developed to measure performance of specific tasks in general practice.^{63;64}

The examination for membership of the Royal College of General Practitioners (MRCGP) consists of four modules. One of these modules - on consultation skills - is assessed by video examination. The prospective member submits a videotape of seven patient consultations which is used as the basis for assessment of competence against 15 performance criteria, five of which reflect aspects of "patient-centredness" ('cues not ignored', 'social and psychological context explored', 'health understanding explored', 'explanation takes account of patient's beliefs', patient's understanding (of explanation)

confirmed', 'management options shared').⁶⁵ Each candidate is assessed by seven examiners, who provide ratings on each of the 15 criteria.⁶⁶

We found no other examples of Royal Colleges introducing video assessment as a component of the examination for membership, although other colleges are working to develop and improve their approach to assessment. The Royal College of Physicians is, for example, investigating the validity, reliability and feasibility of various methods of assessment including direct observation of the clinical encounter, direct observation of the performance of practical procedures (DOPS), and the doctor's ability to perform effectively as part of a team using 360 degree assessment.⁴⁸ The Royal College of Psychiatrists introduced an OSCE as part of their membership exam in 2003, which focuses, among other things, on specialist doctors' ability to apply communication skills with patients and carers, and negotiate with and engage patients.⁶⁷

The strength of most of these methods of assessment is that they involve direct observation of patient encounters in a workplace setting. However, performance under observation is not always a reliable indicator of actual practice. To overcome this it has been suggested that assessments should be repeated on multiple occasions with different patients in different clinical environments,⁴⁸ but this could be prohibitively labour-intensive. It might also place too great an assessment burden on trainees. There is no such thing as an ideal assessment tool and much work is needed to further develop and refine the instruments and to test them for validity, reliability and impact.⁶⁸

A further weakness of current approaches is that they do not integrate feedback from patients into the assessment of competence. There is ample evidence that professionals' assessments do not correlate well with patients' assessments. A plausible explanation for the discrepancy, which is evident as a difference in the scoring of clinicians' overall attainment on assessment of communication skills, is that patients ascribe high importance to competences that only they can have experience of – such as, for example "a level of intimacy".⁶⁹⁻⁷¹ Notwithstanding the difficulties inherent in designing appropriate assessments, there does seem to be scope for increased use of patient feedback in the assessment of trainees' behaviour.

4 Can education make a difference?

As we have seen, much progress has been made in specifying clear professional standards and developing innovative curricula, teaching and assessment methods, but it is striking how much of this appears to be confined to undergraduate education in a few medical schools, or for postgraduates in general practice settings only. Apart from isolated examples in other specialties, we found little evidence that these new developments were diffusing across the medical spectrum, for example into the surgical specialties. The question also remains of whether these educational developments will lead to real changes in patients' experience.

What has been shown to work?

In order to establish what actually works in building competence for patient engagement we examined research evidence on specific educational initiatives. As in other areas of medicine, the most reliable evidence comes from well conducted controlled trials, the value of which is enhanced when several trials can be compared through systematic review of their combined results. Our literature search identified six systematic reviews relevant to this topic.

- Hulsman et al. reviewed 14 studies evaluating undergraduate and postgraduate communication skills programmes.⁴⁶ The most significant improvements were found in students' and trainees' self-ratings of their communication behaviours, but only modest improvements were found in observed communication skills and in patient outcomes.
- Lewin et al. reviewed 17 studies evaluating the impact of interventions that aimed to promote patient-centred care in clinical consultations.²⁰ All these studies evaluated taught courses that aimed to give trainees the skills needed to discuss therapeutic decisions, to detect psychological stress, to elicit patients' views, to negotiate behaviour change, and to guide patients in searches for relevant information. The review found fairly strong evidence that 'patient-centredness' can be promoted through training programmes. The authors also found some evidence that the programmes had a positive impact on patient satisfaction, but they were unable to draw conclusions about their effect on health status or clinical outcomes.
- Van Dam and colleagues reviewed eight RCTs of training programmes designed to enhance the ability of patients with diabetes to participate in their care.⁷² They found that teaching GPs how to help their patients set realistic goals, coupled with prompts, guidelines and feedback improved the quality of diabetes care, but there was no evidence that training on its own resulted in better health outcomes or improved self-care. The authors concluded that a combination of approaches (i.e. active involvement of patients together with a targeted attempt to change clinicians' behaviour) is likely to be the most effective approach.

- Stevenson et al carried out a review of studies on concordance in medicine-taking, including four studies that evaluated training sessions for doctors designed to enhance communication skills and information giving.²⁴ The training programmes were found to lead to improvements in doctors' general communication with patients, and these in turn led to improvements in patients' knowledge and understanding of their medications.
- Fellowes et al undertook a systematic review focusing on communication skills training for health professionals working in cancer care.⁷³ Health professionals who had been through communication skills training were found to use more open and fewer leading questions, express emotion and empathy more frequently and be more in control of follow-up patient interviews. However, there were no significant differences between those in the intervention groups and those who had received no training in relation to other aspects of patient-doctor communication, such as summarising, interrupting patients and checking whether they understood and agreed to decisions.
- Gysels and colleagues came to a similar conclusion in a systematic review of sixteen evaluative studies carried out for the National Institute of Clinical Excellence (NICE).⁷⁴ They found modest improvement in outcomes such as use of open questions, expressions of empathy and self-reporting, ability to discuss bad news, doctors' regard and concern for the patient, and whether the doctor assessed the impact of symptoms on the patient's life. Learner-centred programmes that combined a didactic component with small group work, time to practise and constructive feedback produced the most impressive results.

So the evidence from the systematic reviews of different educational approaches suggests that communication skills can be taught, but that a combination of training and other interventions is the most effective way forward. For example, Coulter and Ellins reviewed the evidence on a wide range of strategies to engage patients in their care, including decision aids used in clinical consultations to help patients make treatment choices and training for clinicians in the principles of shared decision-making.⁷⁵ Training coupled with information support can promote significant improvements in doctor-patient interactions. Furthermore, better communication coupled with other practical interventions, such as providing written self-care plans, can lead to improved health outcomes.

The relevant skills can be taught. However, most of the studies have focused on general communication skills, rather than the specific competences outlined at the beginning of this study, namely information provision, education about prevention, risk communication, shared decision-making, self-care and self-management. We found only a few studies that evaluated attempts to teach the competences involved in shared decision-making, and fewer still that focused on supporting patients in self-care and self-management. More creative approaches need to be developed and evaluated.

Improvements in clinicians' communication skills are clearly necessary, but they may not be sufficient to ensure that patients become more engaged in their own care. Understanding the principles of good communication is one thing, but ensuring that this makes a difference in practice is quite another. Achieving such a change will also require investment in patient information, support for health literacy development, education for

patients and encouragement to seek a more active role, together with a cultural change in both doctors' and patients' attitudes to sharing responsibility for medical care.

Barriers to change

There was a consensus amongst the people we interviewed that education has an essential part to play in ensuring that medical care is truly patient-centred, but there appears to be a general lack of awareness of the skill gaps as far as partnering with patients is concerned. There is a prevalent belief that most medical practice is already patient-centred, with only a small minority of doctors performing less than optimally. Engaging patients as partners requires more demanding skills and attributes than those currently taught in many communication skills courses in medical schools, yet except for general practice training, there is little emphasis on these skills in postgraduate medical education.

For example, we found very few examples of effective teaching about patients' information needs and how to help them find relevant information resources. Most medical students receive training in how to break bad news and how to help patients make end-of-life decisions, but we found little evidence that trainees were taught about how to handle the consequences of medical errors and what to tell patients. Most medical schools teach students about the requirement for informed consent in courses on medical ethics or medical law, but this does not appear to be integrated with training on how to educate patients about risk and probability to ensure that their consent is truly informed. There is interest in teaching about shared decision-making, but low awareness of the complexity of the skills required. We found no instances of trainees being explicitly taught how to help patients take control of their own health care. Furthermore, none of our informants was aware of any systematic approach to the teaching of self-management skills, a significant gap in current training courses.

Our interviewees pointed to a number of problems or barriers that inhibit attempts to introduce further change into the medical curricula:

- **Medical culture:** Role modelling is still an important component of education and training in medicine, but many experienced doctors have been slow to accept the need for any development of the professional role to incorporate partnership with patients. The dominance of the 'hard' sciences in medical education creates a lack of understanding of, and sympathy for, what is seen as 'soft' evidence. This may be compounded by selection procedures that reward knowledge of basic science, but do not probe for empathy or interpersonal skills. The focus on interpersonal relations, which draws on the social sciences for its evidence base, is seen by some as not truly 'scientific', and not a high priority. Certain segments of the medical establishment place much greater priority on basic science than on the type of applied research and development that is required to understand patients' priorities and to develop educational initiatives that address these.
- **Lack of interest in the topic:** Antipathy to the topic of interpersonal skills on the part of the medical establishment is often shared by medical students, most of whom gain entry to medical school on the basis of their abilities in the natural sciences rather than the social sciences. While communication skills are now accepted as a core part

of the undergraduate curriculum, many postgraduate trainees see little need for further learning on this topic. Yet postgraduate deans told us that they regularly have to deal with trainees with communication problems. These problems often have their roots in a failure to respect patients. Several interviewees argued that the best way to change such attitudes is to expose students to patients who have the confidence to challenge outmoded views. This might involve greater use of patients as teachers in simulated and real settings.

- **Curricular pressures:** There are fears among some sections of the educational community that increased emphasis on interpersonal skills might displace what are perceived to be more important traditional components from the medical curriculum. Medical educators often feel under-valued and under-resourced, inhibiting their capacity or willingness to develop and implement new educational initiatives. Faced with many competing priorities and little encouragement to develop and test new programmes, it is often easier to carry on with the old ones rather than risk experimentation.
- **Service pressures:** Many NHS organisations rely on doctors in training for service provision. It can be difficult to find extra time and support required to introduce new teaching methods and to enable trainees to study and practise their skills.
- **Insufficient evidence of effectiveness:** Inadequate data supporting the effectiveness of new educational initiatives, making evidence-based changes to curricula difficult. With ever-increasing pressures on undergraduate and postgraduate curricula, it is hard to argue the case for more space and time to be devoted to a topic when there is little hard evidence on the most effective way of teaching it and few people who have experience of doing so.
- **Lack of an effective mechanism to spread good practice:** Innovative ideas in education have been slow to bridge the gap from an academic research setting into actual teaching. The relatively underdeveloped nature of educational research and the low priority accorded to medical education by NHS organisations may be partly to blame, but our findings suggest that there is also a lack of effective leadership in this area. Various bodies have responsibilities for medical education in the UK, including the GMC, the Academy of Royal Colleges, the Postgraduate Medical Education and Training Board (PMETB), and the Department of Health. While these organisations have been active in setting out basic principles and drafting curricula, as far as we could determine, none has taken the next step of developing and promoting practical methods for teaching and assessing the relevant knowledge, skills and competences.

5 What needs to be done?

Recent years have seen important progress in the development of professional standards and medical curricula which recognise the need for doctors to work in partnership with patients. However, there is still a gap between the aspirations for a new medical culture which will encourage patients to become more engaged, and the realities of current practice.

Key stakeholders interviewed for this study acknowledged the importance of doctors being able to support patients in a more active role, and most of them agreed that this should be achieved through changes to the way medicine is taught and learned in the UK. However, the evidence on what can be done in practice to facilitate this development is still rather sparse. We know what needs to be done, but not how best to do it.

Much medical training appropriately takes place in the workplace. If trainee doctors are frequently presented with role models whose consulting styles and interactions with patients are stuck in a paternalistic or directive mode, there is a strong likelihood they will forget what they have been taught and instead adopt these observed behaviours. This type of interaction tends to undermine patients' sense of self-efficacy and ability to cope. The risk is that, despite the best intentions of educators, inappropriate role models promote an enculturation, or socialization, of students and trainees, which develops practitioners who are likely to focus more on their own interests than on those of their patients.³⁰ If these attitudes are to be challenged, trainees will need help to deal with any discrepancies between what they have been taught and what they observe in practice.

Another key factor which may limit the impact of patient-centred initiatives in medical education is a shortage of time and resources available for training and learning. In the UK, service provision is dependent on the labour of trainee doctors and tutors are often struggling to teach new skills in a highly-pressured environment. Hospital boards of management must be persuaded to give much higher priority to medical education and to ensure that tutors and trainees receive all the support necessary to ensure that patient-centred approaches are well taught.

An insufficient evidence base could also be a reason why leaders in education have found it difficult to drive forward innovations in medical education and assessment. Even in those areas where systematic evidence on effectiveness is available, it is hard to draw firm conclusions about the most effective teaching and learning methods.

Recently researchers in the field have acknowledged that the evidence base is insufficient and have instigated new initiatives to alleviate the problem. For example, the Best Evidence Medical Education (BEME) collaboration, a network of academic researchers, has been established with the aim of conducting and disseminating appropriate systematic reviews of the effectiveness of educational initiatives that will better meet the needs of users.⁷⁶

Our review indicated that in order to inform educational reforms in medicine, research should build the evidence base in three ways:

- Assess the relative effectiveness of existing programmes in bringing about desired changes in doctors' knowledge, skills, attitudes and behaviour
- Establish whether innovative educational programmes actually target those aspects of medical practice which really matter to patients and which lead them to become more engaged
- Focus on patient-centred outcomes, harnessing evidence, for example, on changes in patient experiences that result from innovation in education.

More creative experimentation and better studies are required, but this will require adequate funding streams for educational research, the development of a cadre of appropriately skilled researchers and willingness among both funders and educationalists to take risks. Future studies should examine the impact of new teaching methods on patients' expectations and experiences.

There is also a pressing need to study the validity and reliability of the different ways in which doctors' knowledge, attitudes and skills can be measured. The establishment of sound, evidence-based assessment methods that can reliably test adherence to explicit professional standards and which could be used for revalidation as well as for educational purposes, would go a long way towards tackling the cultural barriers inherent in the hidden curriculum.

Changing the face of medical education and building a new sense of professionalism that treats patients as true partners is not simple. Laudable aspirations will clearly no longer suffice. The medical community must face up to the educational challenge of promoting effective patient partnership. This will, no doubt, require time, commitment and substantial resources. But everybody stands to gain from reforms in medical education: patients will find it easier to play an active role in their own health care, and doctors will find it easier to remain in touch with their patients and to respond to their needs. There is much to be gained from international collaborations of the type fostered by the Best Evidence Medical Education Collaboration, since pooling experience from different countries would seem to offer the best chance of strengthening knowledge in this underdeveloped area.

Promoting partnerships with patients is on the policy agenda; it is emphasised in professional guidance and codes; and it is beginning to appear explicitly in medical curricula. It now needs to be taken to the next stage, i.e. developing practical methods for teaching and assessing the necessary skills and providing an effective challenge to inappropriate role models.

Recommendations

There are no simple solutions to the problems we have identified, but we hope the bodies responsible for medical education, i.e. the GMC, the PMETB, the medical schools, the Royal Colleges and the specialist societies, will give consideration to the following points:

1. There is a need to develop and test new, creative educational initiatives designed specifically to teach the core competences required for supporting patient

engagement in healthcare, namely information provision, education in prevention and health promotion, risk communication, shared decision-making, self-care and self-management.

2. Greater use should be made of patients as teachers. Both real and simulated patients have a potentially useful part to play and there is scope for extending and developing their role.
3. The validity and reliability of different assessment methods in this area needs to be established and explicit criteria for establishing competence in supporting patient partnership should be developed. Methods for obtaining systematic patient feedback, using both qualitative and quantitative methods, may have a useful role to play.
4. Attention needs to be paid to the role models encountered by doctors in training (the hidden curriculum). Trainees may require help to deal with discrepancies between what they have been taught are acceptable attitudes and forms of behaviour and what they observe in practice.
5. Selection procedures should aim to identify desirable and undesirable attitudes and take account of these when selecting entrants to medical schools or postgraduate programmes.
6. Healthcare managers should ensure that sufficient priority is given to medical education and that educationalists are given adequate support to provide high quality training in patient-centred approaches. They should also aim to promote respect for patients throughout their institutions.
7. More funding and support is required for research and development in medical education to ensure that innovative developments are properly evaluated. Research should focus on assessing the relative effectiveness of different approaches to teaching communication skills and methods for engaging with and supporting patients.
8. The organisations responsible for medical education should work together to promote and disseminate good practice wherever it is identified, with a view to strengthening the move towards the sort of medical practice that effectively supports and engages patients.

Appendix

Literature review

A literature review was carried out to identify studies evaluating the effectiveness of relevant educational initiatives. We undertook electronic searches of Medline, Embase, CINAHL, DH-DATA, PsycINFO, AMED, British Nursing Index, Cochrane Library, and the King's Fund Library, together with a reference scan of key papers. In order to provide background and contextual information we also carried out a selective assessment of other evaluative and descriptive studies and reports, and key policy documents from the Departments of Health, Royal Colleges, General Medical Council and Postgraduate Medical Deaneries. The search strategy was restricted to articles published in the English language between 1995 and 2005.

The following search terms were used:

Search Terms	Number of papers identified
(medical education OR Training) AND (effectiveness OR Impact) AND (Communication skill)	774
(medical education OR Training) AND (effectiveness OR Impact) AND (assessment methods OR tool)	3,439
(medical education) AND (effectiveness OR Impact) AND (self-management)	65
(medical education OR Training) AND (effectiveness OR Impact) AND (self-care)	342 (most of which look at training for patients)
(medical education OR Training) AND (effectiveness OR Impact) AND (shared decision-making)	46

From this initial search, articles were retrieved that met the following criteria: systematic reviews, controlled trials or before-and-after studies of education strategies or interventions that objectively assessed the effectiveness of educational initiatives to improve patient engagement.

Studies evaluating educational initiatives designed to enhance doctors' skills in patient engagement		
Origin	Number of controlled trials and other studies	Number of systematic reviews
United Kingdom	11	4
United States of America	13	0
Continental Europe*	9	2

* Belgium, Denmark, the Netherlands, Norway, Spain, Switzerland

Systematic reviews and randomised trials are still not commonplace in medical education research. Of the almost five thousand titles and abstracts initially identified as relevant to the research question posed here, only six were systematic reviews and only 33 were controlled trials or before and after studies.

Interview participants

Interviewees included educational experts from medical schools, postgraduate medical deaneries, the Royal Colleges and other bodies in England, Scotland and Wales:

- Dr Michael Bannon, Postgraduate Dean, Oxford Deanery
- Professor Dame Carol Black, President, Royal College of Physicians
- Professor Nicky Britten, Peninsula Medical School
- Professor Steve Field, Postgraduate Dean, West Midlands Deanery
- Dr Kenneth Fleming, Head of Medical Sciences Division, University of Oxford
- Ben Griffith, General Medical Council
- Dr Gareth Holsgrove, Head of Postgraduate Educational Services, Royal College of Psychiatrists
- Dr Catherine Hood, Clinical Tutor, University of Oxford
- Paul Loveland, Head of Post-qualification Learning and CPD, Department of Health
- Professor Stuart Macpherson, Postgraduate Dean, Scottish Council for Postgraduate Medical and Dental Education
- Brenda Nathanson, Royal College of Obstetricians and Gynaecologists
- Professor Edward Peile, Warwick Medical School
- Sarah Qureshi, Head of Postgraduate Training, Royal College of Obstetricians and Gynaecologists
- Professor David Rowley, Director of Education, Royal College of Surgeons, Edinburgh
- Dr Theo Schofield, Clinical Tutor, University of Oxford
- Professor Simon Smail, Dean of Postgraduate Studies, School of Postgraduate Medical and Dental Education, University of Wales
- Professor Dame Lesley Southgate, Royal Free and University College Medical School
- Professor Ian Watt, Department of Health Sciences, University of York
- Professor Graham Winyard, Postgraduate Dean, Wessex Deanery
- Dr Hani Zakhour, Director of Training and Educational Standards, Royal College of Pathologists

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