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5 **Patient-centred medical education: A proposed definition**

6 Key words: undergraduate medical education; patient-centred care; patient involvement;
7 service users

8

9 **Abstract**

10 Multiple papers have been presented to define patient-centred care, with regulatory bodies such as the
11 General Medical Council mapping this in their professional standards. Educational institutions clearly value
12 instilling appreciation of patient-centredness in medical training, and attempts have been made to make
13 medical education more patient-centred in practice. Such attempts are often limited to expert patients
14 sharing personal stories, and public involvement in teaching. Despite the drive towards patient-centred
15 care and medical education, there has been no attempt to formally define what patient-centred medical
16 education is and what it means to medical educators globally. This paper proposes a definition of patient-
17 centred medical education that is **about** the patients, **with** the patients, and **for** the patients, to ensure
18 current and future doctors remain sensitive to all of the needs of the people they care for. This should be
19 considered at both the micro and macro community levels.

20 **Patient-Centred Care**

21 Patient-centredness is increasingly prioritised across medical schools and medical practice,
22 with the General Medical Council (GMC) standards for Promoting Excellence in Medical
23 Education (2015) emphasising its importance in the UK. However, patient-centredness may be
24 poorly understood and there have been few attempts to formally define *patient-centred medical*
25 *education*. This underscores the key aim of the present paper.

26 In order to begin to define patient-centred medical education, it is important to draw on
27 our current understanding of *patient-centred care*. Few common definitions can be found
28 across the literature (Kitson, 2013), but three core themes can be identified: patient
29 participation and involvement, the relationship between the patient and the healthcare
30 professional, and the context in which health care is delivered. That is, health care is delivered
31 in a way that is meaningful and valuable to the individual patient. It has also been recognised
32 that the best way of measuring patient-centredness is an assessment made by the patients
33 themselves, with evidence (Little *et al.*, 2001) highlighting that patients want patient-centred
34 care which (a) explores the patients' main reason for the visit, concerns, and need for
35 information; (b) seeks an integrated understanding of the patients' world—that is, their whole
36 person, emotional needs, and life issues; (c) finds common ground on what the problem is and
37 mutually agrees on management; (d) enhances prevention and health promotion; and (e)
38 enhances the continuing relationship between the patient and the doctor.

39 Patient-centred clinical practice is a holistic concept, in which components interact and
40 unite in a unique way in each patient-doctor encounter, implying the requirement for doctors
41 to be flexible in their approach to each patient. This is supported by the recent White Paper
42 published by the Department of Health (2012), which set out the UK government's vision of a
43 National Health Service (NHS) that puts patients first; where 'no decision about me, without
44 me' is to be the norm. This has led to agreement that medical education is required to support
45 the development of doctors who can effectively partner with patients, families, and other
46 healthcare disciplines to foster optimal patient outcomes (American College of Physicians,
47 2018). For this approach to become embedded in doctors' daily practice, it is imperative that
48 deep appreciation of the utility of a strong partnership and improving/managing health through
49 the patient's eyes is fostered from the outset in medical training.

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51 **Patient-Centred Medical Education**

52 So as to illuminate the current understanding of patient-centred medical education, a systematic
53 approach was used to search MEDLINE in May 2018 to identify any publications that

54 described patient-centred medical education. This included the following search strategy:
55 ‘patient-centred’ OR ‘patient-centered’ AND ‘medical education’. The search was limited to
56 results from 2000 to 2018 and to full-text articles. 123 articles were identified, at which point
57 titles and abstracts were screened and any referring to patient-centred care only were removed.
58 A final eight articles were identified that made reference to patient-centred medical education
59 (see Figure 1). These are discussed further below.

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61

62 ***INSERT FIGURE 1 HERE***

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65 All of the articles identified made reference to patient-centred medical education, with many
66 attempting to describe what patient-centred medical education looks like in practice. For
67 example, ‘patient-centred learning’ has been described as focus on patients who have medical
68 problems or are being seen in practice for the purpose of health maintenance, particularly those
69 seen multiple times over the course of the students’ training (Smith, Cookson, McKendree, and
70 Harden, 2001; Walters and Brooks, 2016. There is a need for community-based learning
71 (Howe, 2001) with a call for education to make use of the developing digital technologies that
72 can contribute to patient- centred care (Glick and Moore, 2001).

73 However, no published work could be found that has formally and holistically
74 integrated patient-centredness into the entire undergraduate medical curriculum. This may lead
75 to a lack of evidence and guiding structures upon which to develop and evaluate undergraduate
76 medical curricula. To progress, we need a working definition of this concept and our proposed
77 definition is:

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*‘Patient-centred medical education is **about** the patients, **with** the patients, and **for** the patients, to ensure current and future doctors remain sensitive to all of the needs of the people for whom they care.’*

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There have been calls to make medical education more patient-centred. Previous attempts to integrate patient-centredness into medical education have been made by Barr, Ogden and Rooney (2014), who have implied delivering this remit by introducing senior medical students to patient-partner-programmes. They report on students meeting with a patient partner with a chronic illness to hear their narrative and practice consultation skills. Others initiatives include

88 the use of expert patients in teaching and assessment (Towle & Godolphin, 2013), and
89 contributions from the community in student selection, and curriculum development,
90 implementation and evaluation (Spencer & McKimm, 2010). The Ladder of Patient
91 Involvement (Tew, Gell, & Foster, 2004) denotes five levels of patient involvement in medical
92 education, ranging from ‘no involvement’ (level 1) through to ‘systemic and strategic
93 involvement in all key decisions’ and ‘consistent participation in teaching sessions’ (level 5:
94 partnership) in which patients are valued as peers, recognize themselves as such and are made
95 aware in detail of the improved education and how this impacts back on the patients
96 themselves. However, the primary focus of medical education and discussions remain focused
97 on what the trainee is required to do in order to reach a diagnosis and effectively treat the
98 condition. Such discussions invariably stop short of addressing how the medical professional
99 can best understand the social circumstances surrounding the patient, and the holistic impact
100 that a diagnosis has on someone’s life. This underscores the need for a central definition of
101 patient-centred medical education upon which medical curricula can develop to best meet those
102 needs and mitigate the impacts. The aspiration has to be that upon graduation, students have
103 developed the commitment and skills to provide patient-centred approaches in their future
104 career.

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109 ***About the Patients***

110 This element of the definition principally describes the local morbidity and mortality within
111 the social and cultural context of the patients in their environment, acknowledging that patients
112 do not exist in isolation, but are in communities. The base envelope covers the local causes of
113 morbidity and mortality; equally factors such as the wider family, socioeconomic, ethnic and
114 other pertinent groupings and circumstances have a significant impact on health and health
115 equity (Braveman, 2014), and should be considered in educational settings. Traditionally
116 educational publications have been focussed on long term conditions with their impact on
117 multi-morbidity. This may well be due to the relative focus in a developed health system. In a
118 developing country, greater focus may be placed on communicable diseases and macro factors
119 affecting the health of the patients as a whole. Medical curricula are already themed on mental
120 and physical disease, and regulatory guidance encourages this approach to consider the wider
121 cultural and social backgrounds (GMC, 2018). Whilst this inspires a broader understanding

122 and learning of the health issues for the patient population, the challenge is for curricula to
123 demonstrate an analysis of that population group's needs and is then adaptive as those needs
124 develop.

125

126 ***With the Patients***

127 In addition to the wider sociocultural context in which the patient lives, their unique, individual
128 health and illness context balanced with the communication and consultation challenges
129 presented are just as important to consider, when studying the diagnostic challenge. Indeed,
130 patients are not simply collections of organ systems requiring pharmacological intervention,
131 but present as humans with historical and cultural narratives, values, goals, concerns, and
132 sexual and relational functioning. As such, the GMC advocate that Medical Schools should
133 provide students with opportunities for early patient contact that increases as the student
134 progresses, to follow patients through care pathways, and to learn about the role of the
135 aforementioned narratives and values in health and health care (GMC, 2015). Any curriculum
136 that places emphasis on these, and values the patient as an integral partner within the
137 curriculum, is anticipated to ultimately yield more successful outcomes in teaching and
138 learning (GMC, 2011).

139 Such integration will be diverse, dependent on the local sociocultural context and will develop
140 over time as the population base changes and the trainee's expertise matures. This should be
141 recognised in curricula, an endeavour undertaken using a complexity model approach at our
142 School. Here, students are taught to approach clinical problems with their physical, mental and
143 social dimensions in their entirety in order to achieve a pragmatic solution that fits the
144 individual patient's context. This is done by taking account of this clinical complexity and
145 breaking it down into constituent parts which then inform the curriculum. As such, clinical
146 problems that students encounter at the start of the curriculum begin relatively simply,
147 including single morbidity patients. As they progress through the curriculum, students are
148 exposed to clinical problems that increase in therapeutic, diagnostic, and psychosocial
149 complexity, such that their appreciation of patient-centredness develops appropriately and in
150 accordance with their clinical knowledge. The complexity model will need further discussion
151 as the debate and definition of patient centredness matures.

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153 ***For the Patients***

154 The definition proposed above draws on the quote by Abraham Lincoln: 'Government
155 of the people, by the people, for the people, shall not perish from the Earth'. Just as Mr Lincoln

156 was keen to break the link between aristocracy and government, perhaps now is the appropriate
157 time to acknowledge that medical education in general, and undergraduate medical education
158 in particular, has for too long been dominated by a western, first-world perspective. It is
159 therefore proposed that governance of medical education requires input from the patients who
160 will be served by tomorrow's doctors at every level. This naturally requires the involvement of
161 patients in medical education, who can act as a powerful vehicle to provide insight from the
162 patient perspective as to where educational priorities should be placed and whether desired
163 attitudes are being effectively developed and integrated into students' daily practice. However,
164 this requires that patient and public involvement moves beyond tokenistic inclusion on Boards,
165 such that patients are placed at the centre of medical education, rather than on the periphery.
166 Their involvement should, move towards holistic inclusion in the selection of medical students,
167 curriculum development, teaching, assessment, feedback, and quality assurance and
168 governance. Caring for, and improving the health of, patients is at the heart of what it is to be
169 a doctor and should therefore be at the heart of medical education. Holding this, and other
170 vocational attitudes and values, is fundamental to the professionalism that any medical teaching
171 organisation aspires to engender.

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174 **The role of patient-centred education in teaching professionalism**

175 The essence of this definition of patient-centredness has been adopted by the Academy of
176 Medical Educators (AoME, 2017). The AoME describe five core values of medical practice,
177 each of which is underpinned by professionalism and ethical values (see Figure 4). Through
178 engagement with assessments of professionalism (e.g. via revalidation by regulatory bodies
179 and personal reflection), students and practitioners can demonstrate commitment to patient-
180 centred care and continued patient-centred education and development (Phelps & Dalton,
181 2013). However, demonstration of and commitment to professionalism is most effectively
182 developed through receipt of feedback, which can enhance deep learning and personal
183 integration of professionalism (Papadakis *et al*, 2001). Students often receive feedback
184 regarding clinical exposure from medical practitioners, patients and their peers as part of their
185 ongoing professional development planning discussions, thereby demonstrating a patient-
186 centred approach to learning in the context of professionalism. Reflection on patient feedback
187 can be recorded by educators, but also, and often more efficiently, by students themselves (in
188 keeping with the constructivist learning style). Students can reliably evaluate their peers

189 (Arnold, 1981) and peer-rating forms have high inter-assessor concordance when measuring
190 professional behaviour (Davis and Inamdar, 1988). This form of reflection on patient feedback
191 is especially desirable for professionalism training considering that peer-assessment facilitates
192 the professional attributes of self-regulation and accountability (Leach, 2002). Moreover,
193 patient feedback on these attributes is integral to the regulatory concerns and fitness to practise
194 processes that feed back to students. Likewise, patients need to be made aware of the
195 importance of their input and both theoretically and practically and the benefits that arise. This
196 reinforces the importance of patient-centred approaches in medical education and the
197 alignment of professionalism training to be about the patients, with the patients, and for the
198 patients is integral in supporting students to align their professional identity with a professional
199 and patient-centred focus.

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203 ***INSERT FIGURE 2 HERE***

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206 **The Future of Patient-Centred Medical Education**

207 There is no widely accepted definition of patient-centred medical education. We have
208 endeavoured to propose a definition in this paper, which encapsulates an educational approach
209 that is about the patients (considering local demographics and wider sociocultural factors that
210 influence health), with the patients (in view of their unique and individual historical, relational,
211 and cultural narratives), and for the patients (who are holistically integrated into the centre of
212 medical education).

213 The proposal within the paper is intended to invite wider debate on what it means for
214 medical education to be patient-centred. It is envisaged that, if our proposed definition is
215 accepted in principle then measurable criteria could be developed against which students and
216 doctors as well as their institutions could be assessed in terms of their degree of patient-
217 centredness in their approach to education and learning. The three criteria, with the patients,
218 for the patients, and about the patients also need to be understood within the micro and macro
219 communities they represent. The concept is transferable across different geographies and
220 cultures with respect to the changing nature of what patient-centredness would entail within
221 those populations. It then follows that the teaching within those schools needs to be adaptive
222 to the local demographic. We would further propose that aggregated and appropriate

223 assessments of students' patient-centredness are made regularly throughout curricula that wish
224 to foster this value. Indeed, future work would focus upon the development of valid and reliable
225 measures of patient-centredness that are piloted in a variety of curricula approaches. Such an
226 assessment measure should provide actionable feedback to students, such that they can achieve
227 patient-centred care, and to medical schools, such that they are delivering holistic and
228 integrated patient-centred medical education.

229 We look to this paper inviting future discussions of what patient-centred medical
230 education is and means to medical educators globally, and we hope that all of those involved
231 in healthcare (patients, families, doctors, politicians, commentators and health systems) will be
232 involved in such discussions. We envisage partnerships to look at different themes which may
233 cover disease profiles, cultural awareness, resource implications, traditional models, national
234 and international transferability, self-care and tiered levels of education amongst others. The
235 active participation of patients, medical students, clinicians, and medical educators alike will
236 undoubtedly progress this discussion and ensure that future definitions and attempts to provide
237 patient-centred medical education are aligned with their perspectives and values.

238

239

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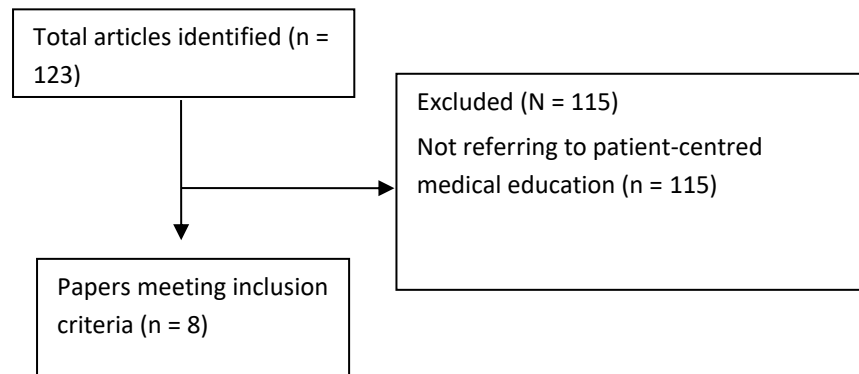
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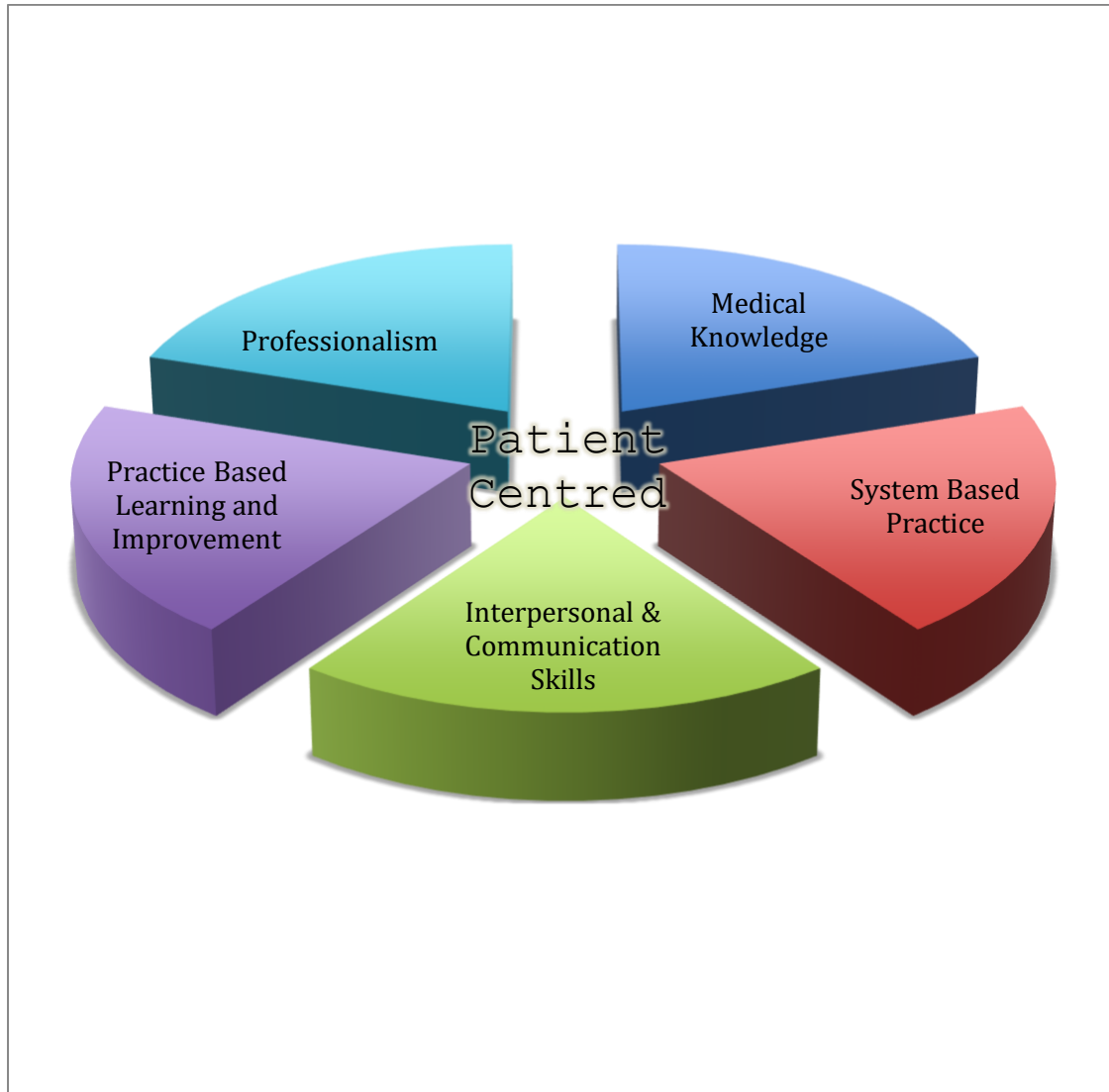


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322 Figure 1. Literature search results.

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327 Figure 2. Adapted from the core values of teaching professionalism (Academy of Medical
328 Educators, 2017).

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