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EDITORIAL

Educational collaboration can empower patients, support doctors in training and future-proof medical education

Medical teaching has been transformed during the COVID-19 pandemic[1] for both undergraduate[2] and postgraduate education.[3] The changes have included pre-learning in flipped classrooms[4]; social distancing-imposed limits on classroom capacity; COVID-19 exposure, testing and self-isolation for students, teachers and educational supporters including real and simulated patients; care adaptation altering educational opportunities (including default phone consultations, very limited face-to-face care, and virtual consultations: both 1:1 and in groups – using video and audio communication). The changes also include physical examination risk mitigation with PPE and exclusive use of actors or virtual examinations with real patients. A restricted systematic review concluded that medical students mostly had positive views of tools used, but evidence was limited to student assessments and presented in only 4 of 60 studies identified.[5] There has also been heightened awareness of lifestyle factors as key drivers of COVID-19 mortality risk along with ethnicity, and lifestyle interventions including government advice for daily exercise, with powerful examples of public engagement in both identifying predictive symptoms like loss of smell[6] and the importance of personalised dietary factors.[7]

These changes present educational opportunities as well as challenges for both patients and students. It is desirable for medical training to support healthcare's quadruple aim of (1) better care at (2) reduced per unit cost, which is enjoyable for (3) patients and (4) staff.[8] Meeting these criteria and also embedding effective patient and clinician education (as a 5th aim) leads us to here propose healthcare's quintuple aim (see Figure 1): (1) better care outcomes, (2) care and education delivery for the same or lower cost, with high satisfaction for (3) patients and (4) clinicians (including those in training) and (5) better-quality education for all stakeholders. Enjoyment (or satisfaction) is not a minor part of successful care and education; it is a core aspect of both.

FIGURE 1 Healthcare's quintuple aim

1 | POSITIVE PANDEMIC RESPONSE

One positive to emerge during the pandemic is a greater number of opportunities to meet virtually, making regional, national and international collaboration and knowledge exchange somewhat easier.[9] We highlight in this editorial a national patient-focused educational partnership – the Doubleday Medical Schools' Patient Partnership Collaborative – as one community of practice. This collaborative was created in 2020 by inviting all UK medical schools to contribute, and has instituted quarterly virtual meetings to share best practice and develop educational strategy with regard to including patients as full partners in medical education including its design, delivery, and assessment.[10]

2 | PARTNERSHIP WITH PROFESSIONAL BODIES

The General Medical Council (GMC) will use this collaborative as a reference group for involving patients in education. GMC representatives have already attended one of its meetings, expressed support for this initiative and lauded examples of patient engagement and ownership in education. The Royal Society of Medicine (RSM) supports this initiative: we are acting as a key stakeholder group with the RSM to support, facilitate and promote our work around patient and public involvement in medical education. We

are also acting as facilitators to promote the Doubleday Medical Student Prize (https://sites.manchester.ac.uk/doubledaycentre/patient-partnership-medical-schools-collaboration/) jointly with RSM for the academic year 2021–2022 including being actively involved in judging the submissions. The much newer, but rapidly expanding British Society of Lifestyle Medicine is also very supportive, as our collaborative aligns well with their values including empowering patients, keeping medical education relevant and codesigning care, for example with virtual group consultations: a choice that addresses inequality and supports both care and education.[11] These partnerships and involvement are at a level required as necessary to ensure change and embed patient involvement at all levels in medical education.[12]

3 | PROMOTING EDUCATIONAL ENGAGEMENT OPPORTUNITIES

The educational engagement opportunities this collaborative initiative can promote include offering virtual and hybrid learning options for students (minimising future impact of absences), including patients in student the student selection process, upskilling patients for virtual teaching and assessments. The opportunities also include developing patient–educator roles, sharing best practice and setting standards for education using virtual group consultations, wider use of interprofessional learning to include patients and potentially embedding lifestyle medicine more explicitly within curricula, as Imperial College has already done.[13]

4 | THE PATIENT PERSPECTIVE

Patients derive a significant benefit from being treated holistically in terms of disease treatment and management.[14] The recognition and use of the patient voice both in teaching and care planning have shown significant improvements in both uptake of care and patient outcomes[15,16] as well improving self-worth and well-being.[17] Willingness of patients to participate in education is generally enthusiastically forthcoming. Patient educators provide input in many ways, ranging from sharing treatment stories to assisting with structuring curriculum, delivering teaching and within assessments. Their involvement should be acknowledged and explicit.[18] Most feel that this is an excellent way of 'giving back' to a service that has provided important medical help. The majority who participate wish to continue to be involved in delivering education and some wish to have further training – possibly leading to a formal qualification. However, challenges remain in the area of differing recruiting models and funding practices which potentially impact the current lack of diversity. As medical professionals must provide care for a very diverse population (in terms of ethnicity, culture, age, ability and gender), it is considered very beneficial to have full and appropriate representation of those groups in our patient educators. Recognition needs to be given to the difficulties that some patient educators now face: unpreparedness of some for the digital age, the costs of phones and internet and the increased personal COVID-19 related health risk. Many of those that are elderly, or who live with chronic ill health face challenges in face-to-face teaching environments. In contrast, new educational formats emerging from the pandemic can (if well supported) provide new opportunities for some patient educators. Participation in remote teaching may have the additional well-being benefit of adding purpose and alleviating isolation in those shielding or separated from normal direct forms of human contact.

5 | FUTURE-PROOFING MEDICAL EDUCATION

The great benefits of patient involvement in medical education[19] seen pre-pandemic need to be maintained and developed within the revised formats emerging during and post-pandemic. We need to look at how to up-skill our patient partners and extend and revise recruitment programmes as well as enable our educators and students to capitalise on the new ways of delivering effective teaching and valid patient experiences. There are risks, however; for example, the medical workforce is depleted and fatigued, so delivering both safe and effective medical care as well as high-quality medical education is a challenge. But there are also potential benefits, including there being broader patient engagement and breaking down of geographic barriers within the virtual space.

6 | CONCLUSIONS

Medical teaching has been transformed during the pandemic but should still aspire to support what we feel should be healthcare's quintuple aim: better-quality education as well as care for the same or lower cost, enjoyable for patients, students and teaching staff. A national patient-focused educational partnership – the Doubleday Medical Schools' Patient Partnership Collaborative – has been created in 2020 by inviting all UK medical schools to contribute. The GMC will use this as a reference group for involving patients in education, and the RSM also supports this initiative. This partnership will inform curriculum development and help to future-proof medical education in the United Kingdom and worldwide.

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We are grateful for all the support patients have given to enhance medical education and encourage patients and clinicians to collaborate to ensure our education is diverse, representative and helps to address inequality.

PATIENT INVOLVEMENT

Patient involvement is integral to good medical education and we consider codesign is ideal; therefore, we are delighted to have a patient as a co-author (AJ).

CONFLICT OF INTEREST

We have read and understood Lifestyle Medicine policy on declaration of interests and have the following interests to declare:

All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: no support from any organisation for the submitted work; FB has received research grants for spread and evaluation of group consultations from Sir Jules Thorn Trust, National Institute for Health Research, Medical Research Council and is editor-in-chief for the Wiley open access journal Lifestyle Medicine.

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