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RESEARCH ARTICLE

Learning to be patient-centred healthcare professionals: how does it happen at university and on clinical placements? A multiple focus group study [version 1]

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Abstract

This article was migrated. The article was marked as recommended.

Background: Developing patient-centred skills in health professional students relies on their learning experiences at the university and on clinical placements. It is not known what students perceive about their teaching on patient-centredness and their views to develop the curriculum in this aspect.

Methods: Multiple focus groups were conducted with students who had experienced a minimum of two clinical placements from Medicine, Physiotherapy, Nursing and Speech and language therapy programs. Thematic analysis was conducted independently by two researchers and then themes were compared and integrated.

Findings: Five focus groups with 26 participants with a mean age of 23.8 years contributed to 286 minutes of recorded data. The key findings were that their curriculum focussing on patient-centred skills used artificial methods and teaching focussed largely on biomedical aspects, but, shared modules and specialist training enabled learning. Longer and diverse placements with good role models to emulate, enabled learning. As strategies they suggested reflections and role-modelling were vital along with further interprofessional working, goal-setting and understanding of human psychology.

Conclusion: Though the study is limited by its generalisability, strategies suggested by students can be further developed by superimposing them on learning theories. These strategies need to be tested in future studies.

Open Peer Review

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"Migrated Content" refers to articles submitted to and published in the publication before moving to the current platform. These articles are static and cannot be updated.

	Invited Reviewers			
	1	**2**	**3**	**4**
version 1 26 Mar 2020	report	report	report	report

1. **P Ravi Shankar**, American International Medical University
2. **Tharin Phenwan**, University of Dundee
3. **Puja Dulloo**, Pramukhswami Medical College
4. **Subha Ramani**, Harvard Medical School, Brigham and Women's Hospital

Any reports and responses or comments on the article can be found at the end of the article.

Keywords
Clinical placement, Curriculum, Healthcare students, Patient-centred skills, Patient-centred attitudes

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Integration of analysis from two analysts		
1st analyst		**2nd analyst**
	Let's move on. I mean, you've mentioned role models, you've mentioned examples, and where you've learnt, and good strategies of how to be more patient-centred. Is there any other place where you learn patient-centred care from, apart from having role models in the hospital?	
	F: Being a patient ourselves, maybe.	Learning from illness experience
Learning PCC from ourselves [?]	**Oh wow.**	
	That's a good one.	
	F: That's great.	
	Actually, I think that's probably...	
	Putting yourself in the shoes of the patient.	
PCC and empathy		
	F: Yes.	In Patients' shoes

Empathy for PCC without direct experience is not possible. Empathy is possible for PCC to some degree.	I think that's probably the only... F1: I think it's hard to put yourself in the shoes of a patient unless you've actually been a patient, though. You can't just imagine it. Because we're in hospitals all the time, so you kind of do the imagining, but until you're actually a patient, you don't really know how daunting it feels. M2: But I think we can all sympathise and empathise when we've seen a GP and we can tell they're just so dismissive. I remember, I wasn't even looked at when I asked for something, and they're just, 'Yeah, there you go. Just go'. So we can all empathise to that degree. So I think, yes, that's a great answer, actually.	Learning from illness experience Dismissive practitioners In patient's shoes
	Any other ways that you've learned to be more patient-centred, or where it's taught to you to be patient-centred?	

Learning PCC through practice, reflection and group discussion	F1: In the GP, in CBM we had - on every Friday we used to have like lecture days, and they did this really good session about shared decision making, and we had to make videos of a good consultation and a bad consultation, and I thought that was really useful, because it wasn't just practicing it, but it was then reflecting on it together and going through it as a group and being like, 'This is why it was good. This is why it was bad'. So I think that was helpful because I - I've never really been taught how to be patient-centred, it's sort of something that just either comes or doesn't come for certain people, so I think, to have it formalised like that, gives you - it points you in the right direction. So that was good, I thought.	Lecture on Shared decision making Video-making Reflections Group work Practitioner's personality Formal teaching
PCC and rules to follow, as not natural for all due to personal qualities.	F3: I quite like having rules to follow, and I know you shouldn't have just rules, but sometimes all the really obvious things, like you said about patient-centred care, wouldn't come naturally to a lot of people, especially if, when you first come to med school, you've just been out of school, and you've never had a	Helpful Structure Practitioner's personality PC skill not natural

Lack of experience to provide PCC. Teaching and PCC.	job before, all you've been around is your friends. Like I'd never had to speak to members of the public before. I was quite shy when I came to med school, so it was quite a big step, so simple things like getting down to eye level. I'd worked in a care home, but some people would never have been round elderly people before, or children. I guess, for some people, maybe, it would seem really obvious, but just being told those things might have been helpful, like at the beginning of third year, because I didn't know, actually, when I first started third year, it didn't twig that you should pull the curtains round when you're talking to a patient, because I'd never been in hospital before, so I didn't know that was the thing. So just someone saying, 'When you're talking to a patient pulls the curtains round. Get down to eye level'. We get taught about communication skills, like what to say, but not necessarily the non-verbal bits of...	Lack of hospital experience Shy nature Lack of care experience Structured learning Lack of hospital experience Nonverbal communication

Teaching and PCC	**How to behave, yes.** M1: Yes, they might seem like really small things, but just having them as part of a formal teaching, even a lecture about these things, it keeps... F3: Just like when we have like teaching at hospitals in our firms, just like five minutes just to say, 'This is how you should do a consultation', or in the GP, just five minutes at the beginning of your placement, like, 'I tend to get the patient to sit here. I sit here'. I don't know.	Formal teaching Brief teaching Outline PCC strategies
	No, that's really important. I think that's valuable, like, you know. F: Kind of. That's just like how my brain works.	

Role play and learning PCC	**No, it's helpful. I think it's helpful as well. Any other ideas or - how has it been taught to you on the course currently? You've given us examples of communication skills and the GP.** F3: I don't really feel like we've had... M1: The role plays that we've had as part of our - especially the final year GP placement, I found them very engaging and very helpful. So I think, having role plays is one - is another way [?to communicate to somebody 0:33:08.3].	Role play Engaging
Role play focuses on pathology due to time and not PCC	F1: I feel like, from the GP part, the GP stations, when they ask you, they kind of want us to - you know, we are told that we need to focus on asking the patient about their ideas, concerns, and expectations, and I think that's all part of trying to do the shared decision making, and more of a patient-centred model, but then they, in reality, give you ten minutes, they've given you a set of results that you have to give a new diagnosis.	Exploring patient concerns Limited time Exam expectations

	They then want you to explain that diagnosis to the patient, and then you need to create a management plan, and as a student in an exam situation, I'm thinking, right, I need to show what I know about managing this condition, and suddenly what should be something where the patient's doing at least half the talking...	Focus on pathology
Perceived exam focus on approach 'being nice' not being natural	M2: Becomes a tick-box exercise. F1: Me trying to say everything that I know, and then I forget to ask about their ideas, concerns and expectations. I think, they're trying to, almost, examine you on asking - you know, being nice and talking to the patient and asking about their ideas concerning expectations, but I don't think... **It's hard to be in those very nervous...**	Tick box exercise Exam expectations Unnatural behaviour

	F1: It feels very hard in that situation, and I found myself actually behaving in a way which I really - that's not me. M1: It makes it unnatural, in a way. F1: Very unnatural, yes.	
Taught approaches affecting natural approach PCC cannot be learnt from books as need experience and self-reflection	M2: That's the thing, don't you find that, as you said, that ICE thing that we always use, don't you think that that makes it artificial, the whole conversation? F: Yes. M2: I don't think that - I agree with what people are saying in terms of having some rules and things, but the whole point of medicine is that this is supposed to be a human connection between two people, and I don't think - there are some things, for instance you could read 1000 books on how to bring bad news, but I don't think that will necessarily make you any better at	Unnatural behaviour Cannot be learnt

	doing it. I think it's something that you have to experience, and this is - I hate to use the word reflect on, but it is something that you just need to, you know, you need to approach and think how could I do that slightly better. It's just...	Experiential learning Self-reflective learning
Consultations feel unnatural but structured reminders help	F3: I find that in a consultation, or when I'm clerking a patient or something, if they've come in with chest pain, I'm immediately thinking what questions do I have to remember to ask about, because I'm still kind of learning them and it's not natural. It's still not like engrained in me, and ICE is just one of those things, and if I remember it - I know it is artificial, and I don't say, 'Do you have any ideas about what it is?' I don't say that, and it does come way more naturally when the conversation is flowing, but in those consultations or clerking when the patient is so conversational, or it's a really complicated history, little things like that make me remember to ask it.	Disease oriented Structured learning Reminders Professional responsibility

	M2: Isn't it odd, though? I mean, we're in a healthcare profession when we work for the benefit of others, and yet we need to be reminded to explore some of these concerns and expectations. F: Very. That's why I find it odd.	Need for reminder
Frameworks help people be more PCC.	F: I think, for some people... F3: Seeing as we're trying to save their life at the same time. M2: In a ten-minute clerking, I don't think you're saving their life, I think you're just - it just seems odd to me that we need prompting. F3: But I think, maybe for you, you're just the sort of person that would do that anyway, but I think a lot of people aren't, and so, by having that framework to	Focus on disease Reminders are odd Practitioner's personality Structured learning

	work by, it aids a lot of people in being more patient-centred.	
Having responsibility helps to remind people of the what is needed, as not natural	F2: Then it will be built on - like we've only been at med school for five years. Like people have been in hospital a variety of amounts over the last three years, and we've never had the direct responsibility, and I think once you start having the responsibility of thinking, oh my God, I have to actually figure out what chest pain is, and deal with their blood results, having just a little thing to remind you to ask - it just won't come naturally to other people, as it does to... M2: Well, I think that I just find that there are two separate issues: investing the chest pain, and me just asking them what they're concerned about. I don't see why they're somehow... F3: I think that's just you. Like some people just... M2: Yes. I think it's a very personal thing, basically.	Direct responsibility Focus on disease PCC not a natural skill Practitioner's personality

Natural approach and PCC and personality linked with PCC.	F2: Yes, it comes from also just naturally how you approach a person to begin with, whether you're in a hospital and working or whether you're meeting a new group of people socially; everyone approaches people in completely different ways, don't they? They have sort of safety nets they go to. Some people will sort of get someone to spill their heart out in a few minutes of conversation, or other people feel very, very awkward in that circumstance and it takes a lot more to actually bridge those sorts of conversations, so it just depends. **It's all about personality. You said you were quite shy when you started off, when you came into medicine. I don't think D was ever shy.** M2: No...	Variable social skills Practitioner's personality
Personality helps PCC but a framework or guidelines can too.	No, I'm just saying. It's a little bit of what comes across here is it's down the person, so it's a bit of personality. It can be nudged, it can be increased, it can be developed with a little bit of structured framework.	Nudging personality Personality development

Personal approach observed in practice. Framework helps those not naturally PCC. Self-awareness affects PCC	Obviously, then bits within your personality, the framework or ground rules or guidelines that you're given. F3: That's what I was saying as well. So some doctors have a more paternalistic viewpoint, and some are completely different to that, and I think you can observe people and see how people do it differently, and I think it's quite a personal thing, and it depends on the doctor as well. So if we have more of a framework to stick to, it does help those who are maybe not so patient-centred naturally. F1: I think, maybe, also, actually, people need to have awareness of their own self and how they interact with people. M2: Yes, I agree.	Helpful Structure Paternalistic practioners Observing PC practice Helpful Structure Self -awareness
Course lacking exploration of patient interactions and own levels of confidence and approaches.	F1: I think that's probably what's missing from the course, is actually thinking about, okay, what situations	Reflective learning

	do I feel comfortable in, how would I naturally interact with people in different circumstances, and actually, for me, what's important to remember in circumstances, because the other person you're interacting with in hospital is also their own person who also interacts in their own way as well, and you need to have an understanding of yourself before you can really tailor yourself to work with someone else.	Varied circumstances Understanding personalities Self-awareness
Lack of teaching about personality, its impact on interactions with patients, and generally about human nature.	F2: It's weird that we don't get taught anything, really, about personalities and stuff, because our whole job is interacting with personalities and finding out patients' concerns and stuff. I find it comes quite naturally if a patient is anxious, you can, obviously, think, okay, so what's concerning you, but someone who's like shut up and is like, I just want this done, they might have major problems going on that you don't know about because they don't come across that way, and it's a bit weird that we don't get taught anything about human nature, when our entire job is about...	Lack of structured teaching Knowledge of personality/natures Anxious patient Reserved patient Focus on disease Knowledge of human natures

The importance of underrating oneself for PCC. Natural PCC inclinations. Formulaic approaches and still be effective. Can be shown how to be PCC.	F1: I'm a graduate entry, and we had, right at the end of the year, we did the Myers Briggs personality thing, and we did have a session of talking about... F2: Really? F1: Yes, how we sort of come across. F2: I think that would help in just like studying and stuff, so like understanding more about yourself. This is getting very deep, isn't it? Because then you can reflect more in situations, because there's, obviously, so many different personalities in medicine, and everyone can still be patient-centred, but I think it wouldn't necessarily be the same way. Like someone might find it very natural to ask about concerns, and they might do that conversationally, but that doesn't mean that someone who has to remember to ask about it in a more formulaic way at the end can't still deliver patient-centred care. So it wouldn't have to be like one	Understanding self Understanding self Self-reflection Varying personalities PCC Tangible for all personalities

	size fits all, but it's more like we understood more about how we feel most comfortable interacting with people, then people wouldn't necessarily feel like they're being shoe-horned into like - because some people aren't really like - they're quite empathetic, you have to be a bit, but some people, it just doesn't come naturally, but they can be shown how to be patient-centred in a way that isn't necessarily the same as other things.	No one size fits all Understanding self No shoe-horning PC not a natural skill Structured learning
Teaching experiences about PCC important as experiences vary and cannot be planned.	M1: I completely agree that it's something that you have to experience, but because a large med school like us, you can't really control what students are going to experience on a day-to-day basis in the hospital. It's one way of, perhaps, giving the same type of teaching to everyone, so that everyone has at least a similar background, and they can see different role models, different examples in the hospitals. I think that's why I said having some form of formal teaching.	Experiential learning Uncontrolled experiences Formal teaching Basic framework Role models Formal teaching

Importance of self-reflection to develop PCC.	F3: I think what D was saying about reflection, though, as well, actually just at some point having a think about circumstances where you felt really uncomfortable because some sort of communication wasn't going right, and actually just having a sit down and a think about, okay, so why didn't I feel comfortable in that situation. You know, was it that I was watching a situation that was going wrong, or was I actually involved in the communicating in that, and what could have been done better, and that kind of thing. A lot of, I guess, people skills, does come from actually just experience.	Reflections Self realisation Experiential learning
Protected time to reflect and discuss with supervisor helps develop PCC.	F2: In psychiatry, psychiatry trainees have like - well, when I was on my elective, they have like an hour a week of protected time when they talk with their consultant and they talk about... F1: Supervision.	Psychiatry as exemplar Mentor discussions

Videoing approach to gain insight.	F2: Supervision, yes. I mean, you kind of have tutors on placement, but they kind of just ask whether things are going all right, but I don't know, if people were a bit more aware of things and said - I guess, if you had the opportunity to talk about consultations you'd had that felt like a bit uncomfortable - yes, you kind of do that in GP, I guess, but it is useful to like talk through it. M1: I think we did something called video consultations in family GP. I found them very helpful, because I think the best way to kind of get an insight into your own weaknesses is by getting some one-to-one feedback. It's all good learning about all of these, but you might not realise that you're not doing something, or you're doing something wrong, and it's very difficult to know that, unless you get some feedback from someone else.	Inadequate supervision Mentor discussions Reflective discussions Videoing consultations Mentor feedback
	Can I just ask, when you were on placement, do you get individual feedback on your performances?	

Lack of feedback in practice on communication approach.	F1: No. F2: Rarely. I mean, we have like senior academy tutors, but... F1: They don't see us in the clinical environment. M2: Unless you request it from somebody you're shadowing. F1: I met mine once. Is that something you're going to ask, 'Oh, can you watch me talk to...'? In the second year GP they might... F3: You don't get feedback on like communication either. So there are doctors, they say, 'Oh, go and present her history', so you're saying your history a doctor, and they'll say, 'Oh, did you ask about change	Inadequate mentoring Mentoring gaps Inadequate mentoring Student’s reluctance Feedback on communication Focus on disease

	in the stool colour?', or something, and they'll talk about the things that you didn't ask them about, but no one will have watched you do the talking, so you don't know if you've communicated well. **That's quite important.**	Gaps in mentoring
One-to-one feedback from a mentor.	F3: You do that a bit more in third year, but once you get to fifth year it's kind of like just expected. F2: There's a few situations I've had where I have had one-to-one feedback, but it's much rarer than... **Those situations were about interaction, or about your knowledge?**	Expectation from final years Feedback from mentor
Observation and feedback in practice.	F2: So one was a junior doctor who watched me take a history from - it was a paediatric rotation, and he watched me take a history from a girl who was suicidal. So that was quite useful feedback, because it wasn't the easiest communication. The other was actually talking to a family of a relative who had died and I'd	Experiential learning Feedback Experiential learning

	been with him when they died, and they wanted to speak to me because I'd been the last person to see him, and so I had a doctor come in with me, because that was a pretty scary situation, and I got the feedback on that, mainly because that was something that needed to be talked about, kind of would it have been okay to have just sent me home after that. But they weren't really everyday situations, and they were just situations that I found myself in without really ever having sort of planned - I know proactive people, as well, who were offering to come with me. **So that's not a routine thing that happens. How are we with time?**	One-one feedback Grim experience Compulsory situation Grim experience Proactive mentors
	F3: I think we might have to go. Yes.	

Multicultural experience helps view more widely.	**Okay. I think I've got through most of the questions. Is there anything else you need to add about your concepts, how you're being taught, how you can be taught better? Anything at all?** F3: The only other thing I would say is, I think we're really lucky being in Birmingham, because there's such a sort of cultural variety that, actually, it almost sort of - because everybody likes to be cared in different ways, and I've had lots of people want different things, it makes you ask people, 'Actually, what are your wishes. How would you like this done? Is this okay for you?' and I think that's key. I grew up in Cambridge, and I think it would be very different being a medical student there, with much less variety in the community.	Multicultural society Cultural variety Exploring wishes Exploring concerns Cultural variety

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Version 1

Reviewer Report 12 April 2020

https://doi.org/10.21956/mep.20002.r30477

Subha Ramani
Harvard Medical School, Brigham and Women's Hospital

This review has been migrated. The reviewer awarded 5 stars out of 5

I comment the authors for conducting this study on patient-centred care and I agree that their learning experiences influence how they acquire these skills. I might venture to say that clinical placements more strongly impact increase in PCC skills than university based learning, as the hidden and informal curricula are more important than the formal curriculum. What they learn at the university as part of their formal curriculum can either be reinforced and enhanced or undone by what they learn in their clinical experiences.Given the caring model emphasized by nursing education, there is a lot to be said for interprofessional learning especially for medical students. If medical students are not engaged with other professionals, they might continue to assume that the science based or task based learning are more important- based on social constructivist theoretical principles.The problem statement is well written and real, study objective is clear and the mixed methods adopted are appropriate. The authors justify data collection methods and they purposively sampled a variety of health professional students. Ethical approval was obtained.The authors collected focus group data with rigour- after piloting, conducted by a researcher with no affiliation to the programme and observed by another researcher and both were educationalists. Data analysis is clearly described and cited. The authors describe their qualitative analysis step by step which will enhance dependability and transferability. The themes are very well described and quotes are representative of themes. I like the fact that one of the themes focussed on strategies to design PCC. The theme related to role-modelling is not surprising and it is good to see that students recognized its importance. The central importance of engaging patients as teachers is another critical theme.I like the emphasis on role-modelling and interprofessional learning in the discussion section, and agree with the limitations as noted. The authors have demonstrated rigour in several ways- triangulation, piloting, member checking etc.I enjoyed reading this well written paper very much as it deals with an important topic and outlines strategies for other health professions educators to enhance PCC very clearly. I would say that these findings and recommendations are important to all health professions

educators whether they are involved in designing PCC or not. Regardless of their educational role, they are all role-models and need to be conscious about their communication skills with learners, other teachers, patients, families of patients and all healthcare professionals.

Competing Interests: No conflicts of interest were disclosed.

Reviewer Report 08 April 2020

https://doi.org/10.21956/mep.20002.r30475

Puja Dulloo
Pramukhswami Medical College

This review has been migrated. The reviewer awarded 5 stars out of 5

Interesting article, since patient centered care is important component of the recent curriculum within our country. Every aspect of the article was clear and well explained. In methodology data collection and analysis was explained in detail. Majority of themes and sub-themes framed were interesting. I liked the theme “Role models & interprofessional learning” highlighting the scarcity of positive role models, particularly in medical schools. Working with other professionals enabled students to develop a holistic understanding of patients’ needs, which in my opinion, will allows students to communicate well with the patient thus have better patient care. This approach, probable, would create good repo among the student and patient. Discussion was well written, although a question, as already asked by one of the reviewer, was there difference of opinion as per the age of the students’ since there were young and middle aged students.Over all I enjoyed reading it.

Competing Interests: No conflicts of interest were disclosed.

Reviewer Report 01 April 2020

https://doi.org/10.21956/mep.20002.r30474

Tharin Phenwan
University of Dundee

This review has been migrated. The reviewer awarded 4 stars out of 5

This article provided students' perceptions of their learning on person-centred care and their recommendations from different disciplines.The background introduction part was clear, with relevant literature. The methods section was well-described. Readers can follow the authors' process easily. DiscussionNot a comment but rather a question. There were several mature students in this study. Should they use the same framework, compared to younger students?Strengths/limitationsThe strengths and limitations were well described. I would not worry about the issue of generalisability since this is the qualitative study and the findings will be in-depth and relevant on that context with that participants and researchers. Data checking was also a good way to improve the rigour but the authors already have other methods in place so it was fine and robust.This article will be of interest to educators and healthcare professionals who are involved with interprofessional educations, curriculum developments, curriculum evaluation, and professionalism.

Competing Interests: No conflicts of interest were disclosed.

Reviewer Report 31 March 2020

https://doi.org/10.21956/mep.20002.r30476

P Ravi Shankar
American International Medical University

This review has been migrated. The reviewer awarded 5 stars out of 5

This is an interesting and detailed study examining the teaching-learning of patient-centered care at a university in the UK. The authors have examined the perceptions of students of medicine, nursing, physiotherapy and speech and language therapy. The authors have provided a detailed description of the methodology of the study. The results section is comprehensive and detailed insights have been obtained both regarding the strengths of the program and how to further strengthen areas of weakness. The free-text comments are the strength of the study. I enjoyed reading them. The limitations have also been mentioned. The study will be of interest to most medical educators as patient-centered care is becoming an increasingly important component of the curriculum.

Competing Interests: No conflicts of interest were disclosed.