The patient's voice in health and social care professional education
The Vancouver Statement

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Abstract

Purpose – The purpose of this paper is to present a statement about the involvement of patients in the education of health and social care professionals developed at an international conference in November 2015. It aims to describe the current state and identify action items for the next five years.
Design/methodology/approach – The paper describes how patient involvement in education has developed as a logical consequence of patient and public participation in health care and health research. It summarizes the current state of patient involvement across the continuum of education and training, including the benefits and barriers. It describes how the conference statement was developed and the outcome.
Findings – The conference statement identifies nine priorities for action in the areas of policy, recognition and support, innovation, research and evaluation, and dissemination and knowledge exchange.
Originality/value – The conference statement represents the first time that an international and multidisciplinary group has worked together to assemble in a single document specific priorities for action to embed the patient's voice in health professional education.
Keywords User involvement, Professional education, Patient involvement, Health professions education, Professional development, Public involvement
Paper type Viewpoint

History of patient involvement

Active involvement of people who use health and social services in the education of professionals who provide the care has expanded greatly over the past 20 years (Towle *et al.*, 2010). Its growth is the consequence of the convergence of trends in health care delivery, policy and research that have emphasized active participation of the public and patients in many aspects of their care.

Involvement of patients in health care arises, in part, from the ethical imperative of autonomy that moves us away from traditional paternalism toward inclusion of patients as partners in care and has been codified in legal trends that require informed choice. In addition, governments and influential institutions, especially in the UK, USA, Canada and Australia, have articulated the need for more patient and public involvement because of perceived direct benefits to health care. Patient involvement has been linked to various aspects of patient-centered care and quality assurance, including patient safety (Institute of Medicine, 2000; Department of Health, 2001), patient-centered outcomes, shared decision-making and adherence to joint management decisions, and involving people more actively in their care as the population ages and chronic disease increases (Nasmith *et al.*, 2010).

Patient's voice
in health and
social care

19

The imperative for patient and public involvement in health research has resulted in the creation of initiatives such as INVOLVE that supports active public involvement in the National Institute for Health Research in the UK (www.invo.org.uk), the Patient-Centered Outcomes Research Institute in the USA (www.pcori.org), Canada's Strategy for Patient-Oriented Research (www.cihr-irsc.gc.ca/e/documents/P-O_Research_Strategy-eng.pdf), and the New South Wales Agency for Clinical Innovation in Australia (www.aci.health.nsw.gov.au).

The involvement of patients in education (see footnote in conference statement for definition) to develop a workforce that is able to embrace patient and public participation is a logical development from these movements. This is particularly important because of some barriers inherent in the way we currently educate health professionals. For example, the work of O'Flynn and Britten (2006) suggests that the adoption of shared decision-making is limited by the need for practitioners to achieve a medical identity that currently does not involve significant sharing of power and responsibility, and the many studies that demonstrate an erosion of empathy and patient centredness during medical training (Neumann *et al.*, 2011). Patient involvement in education began in medicine (Wykurz and Kelly, 2002; Jha *et al.*, 2009; Towle *et al.*, 2010), nursing (Warne and McAndrew, 2005; Repper and Breeze, 2007; Terry, 2012) and social work (Cairney *et al.*, 2006; Robinson and Webber, 2013), and in the education of mental health professionals from a variety of disciplines (Livingston and Cooper, 2004; Happell *et al.*, 2014). It has more recently spread to other health professions such as physical therapy (Jones *et al.*, 2009), occupational therapy (Cleminson and Moesby, 2013), pharmacy (Grimes *et al.*, 2013) and dentistry (Renard *et al.*, 2015).

However, patient involvement in education is still not well established in the mainstream of educational practice. Involvement is often limited to a specific population of patients rather than reflecting the diversity of lived experiences, is fragmented and not embedded in the educational institution, and lacks appropriate infrastructure and sustained leadership and resources. Evidence of benefit is emerging but still patchy. The most wide-ranging and institutionally supported patient-as-educator initiatives are in the UK (Towle and Godolphin, 2011) where government commitment to the development of a "patient-led" National Health Service (House of Commons Health Committee, 2007) and, more recently, to the concept of co-production as an approach to the development of health and social services (Loeffler *et al.*, 2013) has extended to policy directives in education. Thus, service user and carer involvement in education has become enshrined in the standards of the statutory bodies responsible for the accreditation of educational programs in nursing and midwifery (Nursing and Midwifery Council, 2010), 16 other health and social care professions (Health and Care Professions Council, 2014) and more recently, medicine (General Medical Council, 2016).

What the literature says
Examples of patient involvement can now be found across the continuum of education from basic training through postgraduate and continuing professional development, and include a wide spectrum of educational activities including selection of students, a variety of teaching roles, feedback and assessment, curriculum development and decision-making at an institutional level (for a typology see Towle *et al.*, 2010).

The literature provides evidence that learning from patients plays a role in the development of clinical reasoning, communication skills, professional attitudes, empathic understanding and an individualized approach to the patient; it also motivates students by providing relevance and context (Towle *et al.*, 2010). Benefits to patients involved in education include satisfaction in giving back to the community, having an influence on the education of future professionals, and increased self-esteem and empowerment (McKeown *et al.*, 2012). The literature also identifies barriers to patient involvement in education including lack of institutional support and funding (Happell *et al.*, 2015), challenges to professional knowledge and power (Felton and Stickley, 2004), and issues of representativeness and tokenism (Forrest *et al.*, 2000). However, most of the research is descriptive and lacks theoretical understanding or critical explanation that might inform educational strategies (Regan de Bere and Nunn, 2016). There are few good evaluation studies, and there is a lack of evidence of the long-term impact on practice and benefits to the recipients of care (Morgan and Jones, 2009; Robinson and Webber, 2013).

"Where's the Patient's Voice?" Conference

In 2005, the first international conference on the topic, "Where's the Patient's Voice in Health Professional Education?" was held in Vancouver, Canada. The aim was to bring together pioneers in the field and "map the territory" through the presentations and discussions of 240 attendees with a wide range of backgrounds. The conference report documented the state of patient involvement in education, and identified emerging issues and future directions (Farrell *et al.*, 2006).

A second conference was held ten years later in November 2015 to look at progress since 2005. The conference committee (authors of this paper) worked toward production of a statement that would set the agenda for the next five years, and serve as a resource for participants in their own institutions and organizations. The conference was attended by 250 delegates from 16 countries and representing all of the major health disciplines. Most were educational leaders or practitioners; just over 20 percent identified themselves as patients or community members and 13 percent as students.

Development of the conference statement

The conference committee prepared a draft statement that was introduced to the conference registrants in advance. Delegates were invited to participate in its future development by providing feedback on the draft in one or more of the following ways: in writing, on the draft itself or an electronic version on the conference website, during an open meeting with the conference committee, and on the final morning of the conference.

About 90 conference delegates attended the final session and formed round table discussion groups with members of the conference committee or designates as facilitators. The round table groups were asked to provide general comments about the statement and to then focus more specifically on action items. The groups reported any substantive changes to the statement and recommendations. All comments and notes were collected and transcribed after the conference. A subgroup of the conference committee identified major themes from the feedback and incorporated changes into the post-conference version of the statement. This was circulated by e-mail to all delegates with an invitation to send further comments. Very few further amendments were suggested and there was strong support for the statement. The statement can be seen below.

Patient's voice
in health and
social care

21

Where's the patient voice in health and social care professional education?
The Vancouver Statement 2015

This statement aims to set the direction for patient involvement in education for the next five years[1]. It was developed in collaboration with attendees at the 2nd "Where's the Patient's Voice in Health Professional Education?" international conference, held in Vancouver from 12 to 14 November 2015. We acknowledge the excellent work that is already taking place to actively involve patients in education and the advances that have been made since the first conference ten years ago.

This statement is targeted at decision-makers responsible for the education of health and social care professionals, and is also relevant to individual educators and patients, and community organizations.

1. *Aim*

1.1 To promote and ensure that the education of current and future health and social care professionals includes the autonomous and authentic voices of patients and their lived experiences so that the care delivered is genuinely patient-centred.

2. *Patient involvement in the education of health professionals – what it is*

2.1 We mean that patients play an active and collaborative educational role, as teachers, assessors, curriculum developers and educational decision makers.

3. *Why this statement is important*

3.1 Health and social care should engage patients as partners in decision-making, service delivery and research.

3.2 Patient collaboration in education is essential to prepare current and future practitioners to work in partnership with patients in order to: i) deliver person-centred, relationship-based care; ii) engage in shared decision-making; iii) support self-care and resilience; iv) enhance communication, and empathic and caring relationships; v) promote patient safety and quality improvement; vi) foster shared values, inclusion and social justice.

3.3 Therefore we call on all educational institutions and providers of continuing education to respond to the need to prepare health and social care professionals to build and work in partnerships with patients.

4. *The current state*

4.1 Education that actively engages patients is innovative and evolving, especially with regard to recognition and respect for patient expertise and their lived experience, and is engaging for learners.

4.2 Opportunities are often missed to expand patient involvement in education beyond individual professional programs to promote team-based education and care.

4.3 Current activities are often driven by a small group of enthusiasts, are often fragmented or episodic rather than integrated into educational structures, and are often of low status and priority in the institution.

4.4 Institutional and educational barriers exist related to power, professional identity and location of learning which prevent patients from being heard.

4.5 Outcome data on the benefits of involving patients as educators are limited.

4.6 Funding for innovation, evaluation and research into the impact of patient involvement in health and social care professional education is often insufficient and insecure.

4.7 Resources to prepare, empower and give patients confidence to participate, and structures and support in place to support patients are often not present.

5. *Priorities for action in the next five years*

5.1 Promote the involvement of patients in health and social care professional education through directives such as accreditation standards, external and internal policies, pronouncements from professional bodies and best practice statements.

5.2 Foster institutional, local, national and global recognition of patient expertise that grounds this activity and makes it valued. Recognize achievement and celebrate success (identify and publicize information about funding to develop and disseminate educational innovations, increase publication opportunities).

5.3 Increase the diversity of people who are involved by harnessing the motivation and enthusiasm of patients, community agencies, patient advocacy organizations and community members who believe that being involved in the education of current and future health professionals is an intrinsically attractive and valuable activity.

5.4 Introduce the patient's voice initiatives to learners as early as possible, and sustain them throughout the educational continuum, including selections processes, curriculum and assessment.

5.5 Target patient involvement in new and emerging multi- and inter-professional learning activities in order to facilitate a more holistic approach to patient partnerships and teamwork.

5.6 Explore and create models to promote collaboration between educational institutions and community organizations to promote patient involvement in education.

5.7 Conduct and disseminate high quality, inclusive and accessible research and evaluation in partnership with patients, to provide further evidence of short and long-term impact of patient involvement in education, including patient and learner outcomes, and the processes by which it is achieved.

5.8 Lobby conference committees to involve patients in the planning, delivery and evaluation of conferences and educational events; lobby community organizations, colleges, universities and funding bodies to provide grants for patients to attend and present at conferences.

5.9 Create regional networks of people and champions to collaborate, disseminate information, share promising practices and plan further meetings.

Conclusion
We recognize that the statement was developed in collaboration with conference delegates and therefore may not represent the views of all those working in the field, and does not take into account the importance of context in determining the priorities for action and best practices. Despite these limitations the statement does bring together ideas, some already in the literature, into one document.

The conference statement highlights nine priorities for action over the next five years that we believe are necessary in order to embed patient involvement in the education of health and social care professionals. They are in the areas of policy, recognition and support, innovation, research and evaluation, and dissemination and knowledge exchange. Of these, the actions that are most likely to bring about substantive change, as evidenced by developments in the UK, are those related to policy. In particular, accreditation standards are powerful drivers for change in curriculum and educational settings. They are driven both by best practice within leading educational institutions and by policy directives external to them. Change at

this level requires leadership from decision-makers in the health care system and professional bodies, as well as those directly responsible for the education of health and social care professionals.

Failure by leaders, educators and clinicians to model and set expectations of collaboration and partnerships with patients early and often across the continuum of education will delay the realization of the enhanced outcomes we seek: improved quality of care, patient safety and improved health outcomes.

Note

1. We use the word "patient" as an umbrella term to include people with health conditions (service user, client, consumer, etc.), their caregivers (including carers, parents and family members) and others with relevant lived experience (community member, citizen or lay person), recognizing that no single word is adequate or universally acceptable. Education refers to the entire continuum, including undergraduate, postgraduate and continuing professional development. *The Vancouver Statement*, is ©Patient & Community Partnership for Education, The University of British Columbia. It may be freely reproduced in its entirety for the purposes stated in its aims.

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Patient's voice
in health and
social care

25

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