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Résumé de l'article

Le lien entre les soins axés sur le patient et la famille et l'engagement des patients d'un côté et la qualité et la sécurité des soins, tant pour les patients que pour les prestataires de services, de l'autre, a été solidement démontré. Les attentes en matière de soins axés sur le patient et la famille ont évolué et elles ne se limitent plus à recueillir le point de vue du patient et à prendre en considération ses souhaits. On préconise désormais une approche participative faisant intervenir les patients en tant que partenaires dans leur cheminement clinique. Toutefois, certaines attitudes à l'égard des soins axés sur le patient et la famille freinent la mise en pratique d'une telle démarche. Dans les organismes de services de santé, le passage d'une approche centrée sur le système à un modèle de prestation de soins axé sur le patient et la famille constitue un terrain glissant. Nous proposons ici quelques stratégies pratiques pour aider les enseignants en médecine à faciliter l'acquisition par les étudiants des connaissances, des attitudes et des habiletés qui favorisent les soins centrés sur le patient et la famille.

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Canadian Medical Education Journal

Black Ice

Six ways to get a grip on patient and family centered care during the undergraduate medical years

Six stratégies pour bien cerner la notion de soins axés sur le patient et la famille pendant la formation médicale prédoctorale

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Abstract

Patient and family-centered care and patient engagement practices have strong evidence-based links with quality and safety for both patients and health care providers. Expectations for patient and family-centered care have advanced beyond hearing the patient perspective and taking patient wishes into account. A participatory approach including patients as partners in their care journey is expected, but attitudes toward patient and family-centered care remain barriers in practice. As health service organizations shift from a system-centered approach to a patient and family-centered care delivery model, black ice occurs. In this Black Ice article, we present some practical tips for medical educators to improve opportunities for medical students to develop knowledge, attitudes, and skills that support patient and family-centered care.

Résumé

Le lien entre les soins axés sur le patient et la famille et l'engagement des patients d'un côté et la qualité et la sécurité des soins, tant pour les patients que pour les prestataires de services, de l'autre, a été solidement démontré. Les attentes en matière de soins axés sur le patient et la famille ont évolué et elles ne se limitent plus à recueillir le point de vue du patient et à prendre en considération ses souhaits. On préconise désormais une approche participative faisant intervenir les patients en tant que partenaires dans leur cheminement clinique. Toutefois, certaines attitudes à l'égard des soins axés sur le patient et la famille freinent la mise en pratique d'une telle démarche. Dans les organismes de services de santé, le passage d'une approche centrée sur le système à un modèle de prestation de soins axé sur le patient et la famille constitue un terrain glissant. Nous proposons ici quelques stratégies pratiques pour aider les enseignants en médecine à faciliter l'acquisition par les étudiants des connaissances, des attitudes et des habiletés qui favorisent les soins centrés sur le patient et la famille.

Introduction

Provision of high-quality, safe patient-centered care is a competency for collaborative interprofessional practice and a central role of the physician.[1,2] Patient- and family-centered care (PFCC) is an approach to the planning, delivery, and evaluation of health care grounded in mutually beneficial partnerships.[3] The Patient First Review is a catalyst for the shift away from system-centered care to PFCC in the Canadian health care system.[4] Four key concepts or "pillars" of PFCC redefine relationships in health care (respect and dignity, information sharing, participation and collaboration).[3] At entry to medical school, one American study demonstrated that approximately 40% of students were not sure family members should be part of the care team or welcomed to participate in care. The authors conclude that we must embrace patients and families as partners through all phases of medical training.[5] Patient engagement is expected and encouraged as a part of effective medical practice.[6] Patient engagement is associated with quality and safety as well as other positive outcomes for patients,

providers, and health care systems.[6] Barriers such as cynical views toward PFCC, inflexible decision-making, little motivation for change, and lack of engagement in quality improvement initiatives contribute to the black ice of an historically system-centered approach.[7,8] An echo from the original Patient First Review report resonates, “with any change to the established and habitual ways of operating, there will be resistance from those more interested in *preserving the status quo* [emphasis added] than responding to the voices of patients and their families. A passion for quality, a willingness to innovate, and the ability to collaborate will be prerequisites for ... leaders.”(p. 55).[4] By utilizing the tips described, educators can get a grip on the black-ice that tends to slide students towards a system-centered learning experience and thus better prepare students for a future practice that embodies PFCC.

How to

1. Share the evidence for PFCC in course work.

PFCC is woven through many health care organizations across Canada and around the world and there is a substantial body of evidence describing the benefits. Patient engagement often challenges the assumptions and perceived needs for health care professionals and has been shown to improve quality of care, including patient safety, financial performance, hospital survey scores, patient outcomes, and employee satisfaction and retention.[6,9] The Canadian Institutes for Health Research Strategy for Patient-Oriented Research and clinical accreditation standards endorse patient engagement as a means to ensure research and service delivery focus on patient-identified priorities, which ultimately have been demonstrated to improve patient outcomes.[10]

2. Create spaces for students to connect in meaningful ways with patient and family partners (PFPs).

The hallmark of PFCC is a partnership, working ‘with’ patients and families not doing ‘to’ or ‘for’ them.[3,8] Relationship building is foundational to support PFCC practice. By situating students in a position of learning directly from patients and families as instructors with valuable knowledge to share, the posture of PFCC is created at onset. See Table 1 for Tips for PFPs and Medical Students Engaging in PFCC Learning Opportunities in Medical School. In practice, unsupportive staff attitudes are identified as barriers to practice of PFCC, along with organizational factors.[7] Encourage students to compare their expectations for PFCC in practice to examples from their clinical experience (e.g. small group discussion, reflective essay, discussion forum). As a learning opportunity, PFPs may support students in a small group setting to analyze the patient experience in the context of each key concept. By engaging with a PFP in this learning, students are afforded the opportunity to have their assumptions challenged by a patient or family member with lived experience to shape the outcomes of their education experience.

Table 1. Tips for patient family partners and medical students engaging in patient and family-centered care learning opportunities in medical school

	Patient Family Partners (PFP)	Medical Students
1.	Remember you are an expert in your health care experience with a rich and unique health care story that needs to be shared and heard.	Be mindful of the power imbalance often created between professionals and patients/families prior to entering the learning opportunity and embody a posture of respect for the patient/family experience.
2.	Prepare some notes to keep on track and to find the style that works best for you in presenting your key points.	Consider how you feel about learning from a PFP instead of a typical instructor and ways you can engaging in learning differently as a result of that.
3.	Speak from the heart; share your experiences authentically.	Listen actively. Do not use a phone or computer during session. Make eye contact, smile, and use visual cues to show you are listening. A PFP who is sharing their story with students is being vulnerable. Body language that cues you aren’t listening is particularly disrespectful in that context.
4.	Pause on occasion and ask if there are “any questions?” to promote participation and encourage a dialogue since students may not want to interrupt.	Don’t expect your learning experience to be exactly the same as other students. This is not identical curriculum to be covered as in other areas. Embrace the uniqueness of learning with your specific PFP as everyone’s experiences are different.
5.	Use specific examples from your lived experience.	Ask questions that help you learn from the experiences the PFP shares.
6.	During conversations, bring in timely topics related to health care and what the students are learning in classes.	Draw connections between the PFPs sharing and other content you’re learning to make the associations of PFCC.
7.	Encourage a human-to-human interaction instead of a student-patient interaction. Spend time connecting and building a relationship whenever possible.	At times, both PFPs and Students may feel emotional in these interactions; being present with patients and families amidst emotions can help develop compassion and empathy.

3. Model PFCC principles in the classroom.

The term, "patient-centered" has come to mean more than exploration of the patient perspective and incorporation of their wishes into care planning. A participative approach characterized by shared or joint decision making is expected.[3,8,11] Patient Family Partners (PFP) may unite with medical teachers to help ensure that from the beginning, students experience patient-centered language in class, assessment, and course materials (e.g. support course development, contribute to development of assessment questions).

4. Teach clinical skills within a PFCC framework and continue to have expectation for PFCC at transition to practice.

When describing the key concepts of PFCC, link them to interpersonal factors (attitudes, knowledge, and skills) impacting their expression.[3] Reflection on responses from the values clarification checklist is recommended by the IPFCC for patient partners, staff, and physicians before beginning to work together.[x] Sample competencies may be adapted from the core concepts as set out by the IPFCC.[3] Sample standards for clinical academic clinical practice, including patient bedside rounds and other interactions may be adapted from tools that support application of PFCC principles to bedside rounds.[13] See Appendix A for a sample competency framework for practice of PFCC in undergraduate clinical settings.

5. Include learning experiences of patient engagement at all levels of a health care system as a part of medical education.

The Carman Framework describes a continuum of engagement from consultation and partnership to shared leadership with patients at three different levels within the health care system ranging from direct care, organizational design and governance, to policy making.[6] Ensure medical students are provided concrete examples of how patients have effectively informed health care through engagement at all three levels.[6] By inviting PFPs and health care leaders to describe to students the influence patient engagement has had on direct patient care and organizational structure and priorities, students will be able to gain a broader understanding of the application of PFCC in the organizations they will practice within.

6. Consider the role of patient engagement to support social accountability within your medical school.

Patient engagement is not yet an accreditation standard for Canadian Medical Schools; however, medical educational programs do address commitments to social accountability through admissions, curricular content and educational experiences.[6,12] Engagement may include consultative processes such as focus groups or an advisory committee comprised of a diverse patient population. In the future, educational or funding priorities may be influenced by patient priorities and progress along the continuum to more fulsome engagement, such as shared leadership on committees within medical school structures.

Summary

PFCC principles must be embedded in medical education in ways that impact learning outcomes and support students to embody PFCC principles in future practice. These six ways to get a grip will help medical teachers support PFCC learning in medical education. Despite underlying black-ice, health system priorities continue to shift toward PFCC through patient and family engagement. In the future, more fulsome engagement may include patients and families having formal roles within medical school structures.

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Appendix A.

A competency framework for practice of patient and family-centered care in undergraduate clinical settings

Key Concept[3]	Values Clarification[3]	Sample Competency[3]	Sample Standards for Students
Respect and Dignity	"Do I believe that patients and family members bring unique perspectives and expertise to the clinical relationship?"	Listens to and honors patient and family perspectives and choices. Incorporates patient and family knowledge, values and beliefs and cultural background into care planning and delivery	Greets the patient warmly and introduces self with name, level of training, and role in care.[8,13] Introduces the patient and family members by name to other team members (e.g. This is Anne and this is her father, Dan.)[13] Describes the patient condition without defining the patient by the condition (e.g. Anne, you are four years old and live in Saskatoon; you came in to hospital with an asthma exacerbation or flare").[13] Acknowledges the lived experience that the patient brings, living with a condition and validates the patient's feelings. Invites patient to define their 'family' and determine how they will participate in care and decision-making; clarify if specific information should be protected.[13] Asks permission to explore sensitive topics and to examine patient.[13] Provides patient with privacy when disrobing and throughout physical examination. Student does not allow personal bias to impact decision making.
Information Sharing	"Do I encourage patients and families to speak freely?"	Shares complete unbiased information with patients and families in ways that are affirming and useful. Provides timely, complete, and accurate information to support effective participation in care and decision-making.	Implement verbal and non-verbal active listening strategies.[8] Maintains an open posture and eye contact, at patient level.[8,13] Demonstrates consistent use of open questions.[8] Tailors information provided to address patient concern and seeks to confirm understanding. Utilizes professional translation services.
Participation	"Do I listen respectfully to the opinions of patients and family members?" "Do I encourage patients and family members to participate in decision-making about their care?"	Encourages and supports patients and families to participate in care and decision-making at the level they choose.	Invites patient (and family) to participate in discussion (e.g. rounds) and thanks them for contributing.[8] Clarifies patient goals for meeting.[8] Demonstrates joint goal setting and decision making with patient and interprofessional team members.[8] Encourages further participation (e.g. "is there anything else I can do for you today").
Collaboration:	"Do I encourage patients and family members to be active partners in assuring the safety and quality of their own care?"	Collaborates with patients, families, health care professionals and leaders in professional education and care delivery (may also include program development/evaluation and facility design)	Asks the patient to define their care team and implements information sharing agreements as required.[2] Clarifies roles and scope of team members.[2] Engages patient partner to explore how organizational policies and practices create or reduce barriers to PFCC.[3] Encourages the patient to speak up if concerned about their safety.[8] Invites patient participation as a partner in quality improvement, research and education.[10]

Core concepts and sample competencies are from the core concepts as set out by the IPFCC. Institute for Patient and Family Centered Care (IPFCC) What is Patient- and Family-Centered Care? (part I), on page 4.[3] The Values Clarification are from A Checklist for Attitudes about Partnering with Patients and Families (part VI) on page 17.[14] PFCC Applying Patient- and Family-Centered Care to Bedside Rounds,[13] and Module 7a of the Canadian Patient Safety Institute Patient Safety program.[8]