

## **Paper 4: Does current UK postgraduate training give doctors the knowledge, skills and experience to meet future need for patient involvement in their care and treatment?**

### **Introduction**

This paper considers in detail evidence to inform the Shape of Training theme of patient expectation and need. In anticipating the direction in which postgraduate medical training should go it is imperative that the patient perspective is taken into account. Within health professional education and practice there is a long history of patient involvement (Towle and Godolphin, 2011). The nature of this involvement is changing though. The patient is no longer just the subject or object of discussion in the classroom or clinic. The classroom encounter between patient and medical student has become, in some settings, 'a meeting of experts' (Spencer et al, 2011; Boylan et al, 2011), and the patient is now often asked to give feedback on student and trainee performance. Whilst there is a considerable amount of material describing how patients and service users have been involved in medical education, there is limited material on patients' understanding of doctors' career paths and the differentiation between doctors at different points in their careers, save work by the Royal College of Surgeons of England (2012) on the term 'surgeon'. There have been public facing documents describing doctors' roles, such as the PMETB / AoMRC publication 'Do you know who is treating you?', but the impact of these has not been evaluated.

This review takes account of evidence about the evolving nature of the 'patient' and also evidence on how doctors and doctors-in-training take account of patient perspectives to inform their work. There is an increasing onus on patient engagement, involvement and patient centred or patient focused care. These notions have different meanings in different medical contexts. What there is a reasonable consensus on is that patient centred, patient involved and patient engaged practices are on a continuum and that increased patient involvement, engagement and patient centred-ness are to be strived for in all healthcare settings (Chisolm and Askham, 2006; Coulter and Ellin, 2006; Royal College of Physicians, 2010, 2011; Scraggs et al, 2011; Taylor et al, 2010; PMETB, 2008; Parsons et al, 2010). Taylor et al (2010) talk about a 'mutuality' approach to patient involvement, citing examples of existing practice in Scotland. This covers a breadth of patient - provider relationships, from the dynamic between service users and providers when making shared decisions about what is best for the individual patient, to the dynamic between people and health provider systems and the dynamic between health systems and communities. Patient engagement may be about individual doctors and patients working together but it also means increased involvement at system, provider and commissioner level, with bodies representing the patient voice being involved in commissioning and monitoring services (with the newly formed Health Watch England as a prime example). It is worth noting, however, that not all current trends in UK healthcare promote increased patient involvement. Dixon et al (2011) describe the Quality and Outcomes Framework approach to incentivising aspects of general practice as mechanised and medicalised in a way that inhibits patient centred-ness.

Patient input is a central aspect of medical revalidation. The rationale for this is that patients are well placed to measure those aspects of medical competence that

*'extend beyond medical knowledge and clinical expertise to include additional competencies such as communication, professionalism and interpersonal skills.'*(Armitage et al, 2007, p1) .

Patient involvement in medical revalidation is symptomatic of a wider recognition of the potential impact of patient input on improving quality and safety in healthcare, through being involved in quality, safety and care evaluation, clinical decision making and service development and through being enabled to increase their health literacy and self care (Coulter and Ellin, 2006). Patient involvement in service and professional improvement is again symptomatic of the way relationships with doctors have altered in recent years. This has been described as 'the decline of paternalism' (Christmas and Milward, 2011). Christmas and Milward's scoping study for the Health Foundation offers 5 reasons for this: from a moral perspective where there should be 'no decision about me without me'; because of the proliferation of information; because medical knowledge is no longer the sole domain of the doctor; because of growing evidence that subjective experience can impact on outcomes - so the patient may well 'know best'; the increased emphasis on partnership with patients taking responsibility for their health; and finally, because of a reduced trust in doctors because of public awareness of 'bad doctors' and of other influences on health care decision making.

The report of the Royal College of Physicians' Working Party on the Future Physician (RCP, 2010) recognises similar factors that will increasingly impact on doctor-patient dynamics, namely the impact of the internet, changing and increasing sources of information and increasing data availability on doctors' authority and expertise. This is also borne out in the report of the PMETB on the future roles of doctors and patients in healthcare (PMETB, 2008). The RCP working party argues that doctors will have to become skilled at 'steering' patients through this information, and will have to deal with a variety of patient responses to this information proliferation. For the RCP this analysis of consultation responses has led to calls for a revision of medical training to take account of the new demands on doctors, and the new partnerships that must be engaged in (RCP, p25). Askham and Chisolm(2006, p2) set the range of doctors' interpretations of 'patient -centredness' (working in patients' interests; practising according to patients' preferences or wishes; being in partnership with, or involving, patients; taking a person-centred approach) in the context of a range of available discourses on the role of patients and doctors (activity and passivity ; power and autonomy; conflict and collaboration; emotion and objectivity). There is therefore, within this wider discourse on patient engagement, involvement and centred ness a range of possible interpretation and other discourses. Whilst some bodies may argue for a particular approach or interpretation, or may conjecture as to where this discourse will be in the coming years, the key message has to be that it cannot be ignored. Doctors must consider their relationship with the patient, individually and collectively, when considering what it means to be a member of the profession.

**Background: patient need in the context of the Shape of Training review**

Patient need is one of the five themes of the Shape of Training review. The terms of reference for the review describe a concerning lack of transparency for patients and services about the standards attained by trainee doctors (Shape of Training, 2012d). The Shape of Training consultation call for evidence asked respondents to consider how and whether this clarification should occur (Question 8). It also asked respondents to look ahead to the next 30 years and consider how doctors must change to meet changing patient needs (Shape of Training, 2012e). The Introduction to the themes of the Shape of Training review discusses changing patient expectation, in terms of trust, leadership and balancing communication, teamwork and respect.

The Shape of Training review derives this impetus to consider patient need from various key sources (Shape of Training, 2012b). Increased responsiveness to patient need and expectation is called for in the GMC's State of Medical Education and Practice (GMC, 2011 and 2012). The State of Medical Education and Practice (2012) finds that there has been an increase in the number of fitness to practise cases concerning doctor- patient communication and respect. The GMC links this not necessarily to a decline in doctors' ability to communicate but to rising patient expectations. The GMC cites work by the King's Fund on different perceptions of outcomes between doctors and patients and also calls for doctors to enhance their consideration of patient feedback and insights. The Academy of Medical Royal Colleges report on consultant-delivered care (AoMRC) concludes that this model of working will best meet patient expectations regarding access to the right doctors. A GMC focus group of lay reference group members considered patient and public involvement in medical education and training. The findings of this group also called for more clarity about what to expect from trainees according to their stage of training, and that patients are interested in involvement at a high level in education (Shape of Training, 2012b).

Expectations regarding how to work with patients are set out in the GMC Standards for Trainee Doctors (GMC, 2011). The trainee doctor in any specialty is expected to 'work in partnership' with patients. This involves listening, information giving, respecting their decisions and supporting self care, helping them to make decisions, exploring choices and options. The standards for F1 doctors reflect several of the elements of working with patients discussed above. The F1 doctor is required, for example, to demonstrate effective relationship and communication skills, to recognise the patient's own expertise and ability to make decisions, to communicate effectively with groups as well as individuals, to be sensitive to diverse needs (GMC, 2011, p48-49). The question for the Shape of Training review is therefore whether these standards go far enough to ensure that the trainees partnership working - in practice - goes far enough to incorporate the range of meanings that 'working in partnership' might encompass.

## **Reviewing the literature**

### **Review methods**

Papers have been searched for systematically and measured against pre -decided inclusion and exclusion criteria. The quality and relevance of each included paper has been appraised. The final analysis is a synthesis of findings and discussion of the research methods used.

## **Conceptual framework**

The purpose of this evidence review is to support decision making around the future shape of medical training in relation to recognising and responding to patient - identified need, as identified by the patient. The inclusion of 'patient need' as one of the key themes for the Shape of Training reviews assumes firstly that patient need should be an important factor for consideration within the review. It assumes that current reference to patient need could be improved upon. It also assumes that patient needs and service provision will alter in years to come and thus medical education must adapt to these changes. It might be best, for the purposed of clarification to redefine 'patient need' as 'patient-identified need', to set this apart from 'patient need' as identified or assumed by the doctor.

## **Inclusion/ exclusion**

Included papers were published between 2006 and 2012, with this cut off being set to reflect a post - Modernising Medical Careers educational environment. Included papers were written about UK postgraduate medical education, albeit some were published in non-UK journals. Excluded papers were pre- 2005, not referring to postgraduate medical education and not referring to UK medical education.

## **Search strategy**

A review of the grey and research literature from key stakeholders was included: the General Medical Council, the Health Foundation, Care Quality Commission, the King's Fund, Academy of and Royal Colleges, British Medical Association, Medical Education England, Picker Institute, Patients Association, Royal Colleges of Physicians, Surgeons, General Practitioners, Psychiatrists, the Professional Standards Authority.

A systematic search was also conducted using the following databases: Medline, PubMed, EBSCO Academic Search Complete, Science Direct, Web of Science, Web of Knowledge, Social Science Citation Index, Google Scholar.

Search terms 'medical practice' 'medical education' 'doctor' AND 'patient understanding', 'patient involvement', 'service user engagement' , 'patient engagement', 'patient awareness'

Abstracts of papers were reviewed in order to determine relevance. Seemingly relevant papers were accessed in full and reviewed for inclusion/ exclusion in the study. The papers were appraised for relevance and quality and the key information from each paper was logged on a data extraction record.

## **Summary of findings**

The included papers are mostly either discussion papers or reports of working groups, with some reviews of the evidence on patient involvement and engagement, for example as part of the Health Foundations's work on shared decision making and patient engagement, the Picker Institute work on patient views and expectations, and the King's Fund's work on patient choice and the Point of Care. Of the literature

reporting primary research the papers tend to be either surveys (Hamann et al, 2012; Han et al, 2013; Harmsen et al 2008; Hasman and Graham, 2006; Illing et al, 2008; Palmer et al, 2010; Pardon et al, 2013; Royal College of Surgeons of England, 2012; Robinson et al, 2012; Schouten et al, 2007; Tsimtsiou et al, 2007); reports of interview studies (Arar et al, 2011; Bastiaens et al, 2007; Goodrich and Cornwell, 2008; Yedida, 2007) or focus group studies (Bombeke et al, 2012; Jha et al 2009; Muir and Laxton, 2012). There were some reports of mixed methods studies (Bombeke et al, 2012; Chisolm, Cairncross and Askham, 2006; Dixon et al, 2010) and one Randomised Controlled Trial (Cooper et al, 2011).

No papers looked specifically at whether current postgraduate medical education prepares doctors for working with patients and the public in such a way as current trends dictate. Papers looking at doctors working with patients have tended to look at either patient or doctor views about patient involvement in care or reviews of attempts to involve patients in care. This involvement may be at the individual, collective or representative level. Terminology and meanings of patient involvement may be different in different settings and different studies. There is an acknowledgement that patient involvement may have different meanings and require different skills in obstetrics and gynaecology versus surgery versus general practice versus psychiatry. There is a danger in assuming one size fits all, where patient centredness is concerned.

Dixon et al (2010) found, in the four Trust settings they researched, that patient choice was valued highly by 75 % of respondents, particularly by older patients with fewer qualifications and from non-white or mixed backgrounds. Goodrich and Cornwell (2008) conducted interviews and focus groups with patients, families and hospital staff, along with a review of the literature, in their report on patient centred work, as part of the King's Fund Point of Care project. This study looked at different aspects of the patient experience and sought to identify means of improving it. The report finds that improving patient experience is a whole team effort and depends on organisational and system factors as well as individual interactions. It finds limited evidence for the effectiveness of particular improvement interventions and also call for improved leadership in this area. The doctor in training might, therefore, be seeking to redress this gap by developing and evaluating patient experience improvement interventions in their area of practice or by leading and contributing to organisational change to this end.

Within the profession, there is evidence that doctors are aware that their relationship with patients, and therefore their sense of their own role is changing. Levenson, Dewar and Shepherd (2008) report from the King's Fund / Royal College of Physician consultation events held with doctors and their colleagues to look at the future of the medical profession. The consultation events showed that whilst doctors' notions of professionalism might not be altering, they were aware of shifts in notions of medical paternalism, with patients becoming better informed, patients taking on a consumer role and with increasing drives for patient and public involvement. The decline of paternalism and increased impetus to involve patients in decision making is reflected also in Leatherman et al's (2007, for the Health Foundation) commentary on their published charts and guidance for providers looking to improve quality. They cite

increasing evidence that patient engagement can impact on cost effectiveness and outcomes. Mulley, Trimble and Elwyn (2012, for the King's Fund) talk about 'the silent misdiagnosis' of ignoring patient preferences. They argue for a change in doctor skills and attitudes wherein patient preference is not just about place and time of treatment but about wider issues and choices.

The Royal College of Obstetricians and Gynaecologists (2012) Working Party looking at future training needs has incorporated survey findings from both clinicians and women. This acknowledges the need to respond to women's changing views and needs, and to be more involving of women in decision making. Ipsos Mori (2012), for the Department of Health, has surveyed and analysed patient responses to the 'Caring for our future' review of social care and support. One of the major themes here was about the key role of information and advice for service users. The Royal College of Physicians (2010) Working Party Report on the Future Physician predicts that technological change, the internet and the proliferation of information will challenge assumptions about doctors' authority and expertise. According to this report, the doctor's role becomes about assisting the patient to make informed choices and to steer patients rather than about their being the source of information and decisions. The Working Party also calls for patients and patient organisations to assert their demands for patient centred and personalised care. Also, the Royal College of Physicians Commission on Dignity call for improvements in communication, basic care and treatment, responsibility, accountability and continuity.

There is a history of patient involvement in medical education (Hanson and Randall, 2007; Towle and Godolphin, 2011) which has seen this progress towards partnership approaches. Spencer et al 's (2011) large scale evidence review on patient involvement in the education of health professionals, including doctors, looks at case studies of involvement at various points on continuum and finds that provision of this is variable as is the quality of research on the subject. Muir and Laxton (2012) report on the benefits of patient feedback in medical education, following their focus group study. Jha et al (2009a, 2009b, 2010) look at patient involvement in teaching doctors in training. They conducted focus groups with students and educators and review the literature. They find that patients in most settings are employed in teaching roles, but in some settings they are involved in assessment and feedback and curriculum development. They find limited evidence of the the impact of these on the outcomes of training programmes. Lucas and Pearson (2012) present case studies on the benefits of patient centred approaches through patient involvement in undergraduate medical education. Worryingly, Tsimitsou et al(2007) surveyed doctors in training in Greece and found them to be more doctor centred by the end of course, with a move towards authoritarianism as the course progresses. This is more so for men than women. Bombeke et al's (2010, 2012) interview and focus groups study in Belgium also found a decline in patient centred ness during training, and report on an attempt to improve this with communication skills training.

Some research studies have considered how doctors enact the requirements for working with patients set out in Good Medical Practice. Palmer et al's (2010)survey of junior doctors' observations in practice presents a mixed picture regarding involvement

of patients in decision making and respect for patients. Scraggs et al (2012, for Rand and the GMC) have looked at the published evidence as to why doctors do not follow Good Medical Practice. Patient centredness is one aspect considered. They find that evidence regarding some conditions, for example depression, suggests that doctor and patient goals are not the same and this has implications as to how shared decision making is enacted, for example with doctors emphasising medical treatment while patients may emphasise self-management. Scraggs et al cite further research in the stroke setting where clinicians perceptions about patient ability impact on whether shared decision making takes place. The implications of shared decision making are also explored in Robinson et al's (2012) paper comparing GPs and patient analyses of evidence for and against a certain treatment. This found that whilst GPs tend to value RCT evidence most highly, patients may more highly rate other sources of evidence.

Regarding revalidation, Sheldon, Swain and Harris (2011, for Picker) conducted a discourse analysis of the published material. They found that whilst patient and public involvement is virtually absent from this discourse, it does emerge in four ways: 1. when the purpose of revalidation is presented as being of benefit to patients, 2. when revalidation is related to new medical professionalism (and the implications of this for doctor-patient relationships), 3. When lay input to the process of revalidation is discussed and 4. when patient feedback as part of 360 appraisal is discussed. The authors argue that the first and second discourses are at odds, in that the first positions patients as passive recipients of benefit, whereas new medical professionalism is about partnership working.

### **Patient centredness, patient engagement and patient involvement**

Whilst for some authors the difference between these terms is not defined, for others there is difference. Patient centredness is a term coined in 1969, according to Illingworth (2010), but it has multiple dimensions and interpretations. Parsons et al (2010) describe patient engagement as being involved in one's own health, care and treatment, whereas for them, patient involvement is about being involved in service design, planning and delivery.

Hopkins et al (2009) review the literature on service user expectations of inpatient mental health care. They find that respect for dignity and autonomy are key here, and are best reflected in clinicians' communication skills. Bastiaens et al (2011) conducted interviews with older people in 11 European countries, asking about their views on involvement in primary health care. They found that people over 70 do want to be involved in their care but that to them involvement is about relationships and person centred approaches rather than active participation in decision making. The authors argue for an approach to involvement that acknowledges individual differences. This is also reflected in Schouten et al (2007) and Harmsen et al (2008)'s study in the Netherlands looking at patient from different cultural backgrounds' views on GP interactions and communications, where there are different expectations of communication between different ethnic groups, ages and attitudes. Recommendations from this study are around GPs being culturally aware and sensitive and being able to match interaction to patient. As with the Royal College of Physicians working group and

others, Parsons et al discuss the implications of improved health literacy of patients. They link improved health literacy to improved outcomes, and report that for it to have the most impact it should be individualised and personally delivered. How the individual doctor determines what is required in each patient-doctor interaction is certainly up for debate though, as Christmas and Millward (2011, p44) describe an assumption that doctors can know what kind of doctor-patient relationship is required as 'perhaps the most insidious paternalistic strand in the Traditional Perspective.' Even the promotion of shared decision making may be seen as an imposition to some patients, as not all patients may want to work in this way, as Hamann et al found in their 2012 survey study of German patients.

Parsons et al's (2010) review of the evidence on patient involvement and engagement includes a consideration of barriers to its development. They find that engaging patients is prominent in health professional codes, legislation and regulation of recent years. This has led to a heightened focus on partnerships with patients in education and training. Parsons et al find that this has primarily meant an increase in communication skills training, but question whether this has actually led to an increased involvement of patients in decision making or an improvement in the experience of all groups of patients. One suggested reason for this is that whilst recently trained doctors may have the requisite patient partnership skills, those trained less recently, who are also more likely to be in senior and leadership roles, will not have been thus trained. They also consider that whilst patient engagement is one priority, some teams may be driven to focus more on administrative and financial targets, which do not necessarily reflect patient reports of improved engagement and experience. Parsons et al acknowledge some fears within the profession about the increasingly demanding patient as consumer, but counter this with research evidence that this is not the mindset of most patients. They argue for increased consultation time in primary care, seeing this as a means of meeting the requirements of increased patient involvement and understanding and choice about their health and treatment.

For doctors who seek to develop a partnership working approach, one skill to be developed is that of 'shared decision making' (DeSilva 2011, 2012, for the Health Foundation). What this means in practice and how it actually improves outcomes is not totally clear. DeSilva's review of the evidence found that there is limited robust evidence of its impact, beyond improving satisfaction with care results. She did find, however, that the evidence suggests that the impact of shared decision making may be best felt when it is one aspect of a 'broader ethos of care' along with collaboration and self management approaches. As with the research studies described above, patient demographic factors, professional attitudes and speciality impact on how shared decision making works. Yedida et al's(2007)interview study looking at what medical education can learn from palliative care argue for a place within medical education for preparing doctors for the emotional and relational aspects of the role, that have at times been seen as things to avoid.

The Health Foundation (2013) evidence scan on involving patients in safety improvement found some benefit in patients being involved in feedback, planning and improving their own safety but the conclusions from this evidence review are that

patient involvement here is facilitated by professional attitudes and behaviors. Do doctors need to be equipped to facilitate this? As with other reviews in this area the Health Foundation talks about a continuum of involvement, so solutions may be about doctors being aware of the continuum and developing the skills to match involvement strategies to the task in hand.

DeSilva also points out that a shared decision making approach suits certain situations better than others, for example palliative care or psychiatry (where multiple options for treatment may be available) rather than emergency care (where decisions must be made fast). She notes that making information and tools available is not enough, rather the clinician must support and encourage patient use. again, this has implications for the training of doctors, if they are becoming facilitators and navigators rather than providers. For Arar et al (2011), based on their interviews with primary care workers, improvement in patient involvement in medical care homes is about workers being skilled at health promotion and self care management. Again, these are not the 'traditional' realm of the doctor. Fischer and Erault (2012, for the Health Foundation) have applied a systems approach to making sense of doctor-patient interaction. They offer a model of shared decision making within the doctor-patient interaction that offers various aspects: it can mean competition, cooperation, negotiation or co-evolution. They consider, based on the findings of their consultation and workshops, that 'shared decision making' in terms of 'co-evolution' is not usual practice at the moment. Coulter (2007, for the Picker Institute) reports on an evidence review looking at improving patient experience in cancer care. She reports on evidence of patient involvement at service design level and at individual level. At the individual level this is about information sharing, communication and joint working, offering patient choice, and getting patient feedback. Coulter and Ellins (2006, for Picker and the Health Foundation) review the evidence on patient focused interventions. This review groups interventions according to several themes and reviews each paper in turn. It offers an insight into the variety of patient focused approaches and uses of such. This further adds weight to the suggestion that doctors in training need to have multiple approaches at their disposal and to have the ability to discriminate when and what to use.

## **The themes of the shape of training**

### **Theme 1 - patient need and expectation**

As discussed above there are various imperatives for doctors to become skilled at identifying, soliciting and responding to patient's expressed needs and expectations. This is a fundamentally aspect of Good Medical Practice (GMC, 2010). Evidence suggests that doctors in training are not being as well equipped as they might be to practise in this way. The research on attitudes of trainee doctors that finds that patient centredness decreases in training suggests that more could be done to promote partnership working approaches. The evidence regarding whether increased patient involvement and engagement improves outcomes is mixed, although this is a field whose evidence base is expanding.

Patients are not always correctly informed about roles, treatments and evidence (PMETB / AoMRC, 2010; RCSE 2012 survey on public notions of the work of surgeons; Robinson et al, 2012). This arguably means that there are risks involved in weighting power and decision making more with the patient. There is also evidence that patients' preferences for involvement are about interpersonal communication and professionals spending time with them (Bastiaens et al 2007). This suggests that postgraduate training should equip doctors to enable patients to consider themselves involved and to understand complex ideas. This is borne out in Chisolm et al's qualitative research on the public views of doctors, which found that listening and communicating are key, and that more could be done to work out how to proceed when doctor and patient views diverge.

The heterogeneity of patient views and expectations is considered in several studies. This suggests that consideration of patient need and expectation may require different sorts of approaches for each specialty. Within specialties patients express a range of wants regarding information giving and decision making (see Pardon et al's, 2012 study of lung cancer patients in Belgium) and a range of understandings of what this might look like (see Arcuri et al's 2013 study of perceptions of doctors giving a cancer diagnosis). Also Hasman et al (2006, for Picker) survey patient and carer expectations regarding intensive care and find that these differ, with patients valuing giving of patient information and involving patients in decision-making more whilst relatives value skill in giving bad news and treating patients as individuals.

Two developments are bound to impact on how doctors in the future respond to patient needs and expectations. First, the introduction of medical revalidation in 2012 requires doctors to gather evidence of patient feedback. Also the increasing practice of patient access to medical notes and electronic records will mean that doctors records will be more readily available for scrutiny by service users. Leveille et al (2012) in the US are conducting a large scale multi site trial of on site availability of patient notes in primary care, with the aim of finding out how this might impact on patient attitudes and outcomes.

## **Theme 2 - workforce need: specialists or generalists**

The requirement for the doctor to meet the various expectations about patient involvement and engagement is about values and attitudes as well as interpersonal skills. It is about matching the approach to the individual patient and the specific setting, and also acknowledging that they might not always be able to gauge how this should be done. If the doctor's role is moving from that of information holder and decision maker to that of partner then does this mean the doctor must no longer just understand and perform medical practice but evaluate it and explain it. The Commission on Generalism (2011) talks about 'guiding patients through complexity'. The risk here, as Christmas and Milward point out, is that medical paternalism is still in force, but in a new guise. Consideration of what patients want in the context of the move to increasing the number and type of generalist doctors may mean that more doctors have to become more skilled at matching their approach to a variety of patient expectations depending on context and individual.

Patient involvement practices are not consistent within education. Towle et al (2010a, 2010b) and Towle and Godolphin (2011) have surveyed the literature on active patient participation in health professional education. They find that this challenging of the ideology of professional expertise through a increased valuing of knowledge held by patients 'is only just beginning to be articulated' (Towle and Godolphin, 2011, p498). This suggests that alongside a specific, individualised, tailored approach there may be room for some consistent standards and expectations to be set here across post graduate medical education

### **Theme 3 - training and service need**

The Shape of Training review is considering the role of trainees within service delivery (Shape of Training Terms of Reference, 2012d). This is associated with the move to a more consultant-delivered care and to revised expectations of trainees in practice. Evidence from the PMETB/ AoMRC (2010) and the Royal College of Surgeons (2012) suggests that patients are often not currently aware of the expertise and seniority of who is treating them.

When considering why patient centredness may decline throughout training, Bombeke et al posit that this is in part due to lack of role modelling within the hospital environment. They see the supervisor-student relationship as key here, and describe a gap between classroom and practice. Bombeke et al's findings are based on focus group research with students in Belgium so may be argued as not applicable to the UK. Illing et al (2008, for the Northern Deanery) look at student preparedness to practice from the point of view of three UK medical schools. They find that there is a potential mismatch between the prescribed outcomes of undergraduate education and actual requirements in clinical practice. The respondents in their study describe how patient centred approaches learned in the classroom do not sit well in a practice environment where there is less and less supervision and more and more administration to contend with. This links well with Dixon's (2010) points that other aspects of the current regime do not align well with approaches that enhance patient involvement. There is a challenge to address here, about changing perceptions. If patient involvement and shared decision making are a given, and are enshrined in Good Medical Practice, then they cannot be seen as disposable add-ons that take time and energy away from other aspects of the work. The Health Foundations (2013) publications on patient involvement in safety improvement consider that this can be valuable in a variety of ways, but that facilitating this depends on the attitudes and behaviours of professionals.

### **Theme 4 - breadth and scope of training**

This theme for the Shape of Training review is concerned with whether doctors in training are exposed to the range of experiences they need in order to equip them for future practice. Again, as said above, with regard to patient involvement and engagement, this is about doctors developing the ability to match their approach to their patient and also about doctors demonstrating 'new medical professionalism' in their approach to patients. The research evidence on trainee doctors suggests that

there remains a range of opinions here, and that not all doctors in training demonstrate the values and beliefs that such an approach demands. Burke (2008) in her thesis on doctor-patient relationships uses five conceptual frameworks to describe them, based on her interviews with trainee doctors. These were paternalism; guided decision-making; partnership; the clinical and consumerism. Askham and Chisolm (2006, for Picker) discuss four themes within the debate on professional versus patient roles: activity and passivity; power and autonomy; conflict and collaboration; emotion and objectivity. The policy push at present is clearly towards increasingly active and empowered patients, and towards collaboration. Where trainees sit now on these continuums is not clear, and as yet there is no definitive answer as to how to ensure all doctors end up at a certain ideal point of attitudes and behaviours.

Coulter (2006, for Picker) compared survey data from 6 countries looking at how the UK fares comparatively on the question of engaging patients in their care. She also looks at differences between the 4 countries of the UK. She finds little difference between the 4 countries, surmising that policy and resource differences do not necessarily affect clinicians' relationships with their patients. Whilst Coulter finds that none of the countries surveyed were excelling at promoting patient engagement, UK patients were less supported to engage than elsewhere. She argues that there are shortcomings in professional education and low expectations from professional and regulatory bodies. She says that:

*'What is needed is a major change in the way professionals work with patients in the UK. In particular, doctors, nurses and other health professionals need training in how to promote health literacy, support self-care and self-management and involve patients in treatment decisions, and their effectiveness in this regard should be monitored in regular patient surveys.'* (2006, p3)

It is worth noting that there have been several developments in recent years that speak to Coulter's recommendations, in particular the revised Good Medical Practice and the inclusion of patient feedback in medical revalidation, although similar calls are made in the more recent work by DeSilva (2011, 2012)

## **Theme 5 - flexibility of training**

This theme is concerned with whether training offers doctors enough flexibility in order to meet doctors diverse career and personal intentions. As such the evidence reviewed here does not have anything to inform consideration of this theme.