Patients!

Rachel H. Ellaway¹

Accepted: 1 November 2021

© The Author(s), under exclusive licence to Springer Nature B.V. 2021

Abstract

In this editorial the Editor considers the roles and representations of patients in health professional education and their implications for educational scholarship in this field. She also considers the implications of patient presence and engagement for the social contract and the ways it is being placed under stress and strain.

I take as my topic for this editorial the place of patient education and patient voices in a journal such as *Advances*. As the Editor in Chief, I get regularly asked whether this or that paper on patient education is in scope for *Advances* and the answer is generally ‘no’ as the study or idea being advanced does not consider or contribute to the training of health professionals. On the other hand, we have published articles on patient engagement and patient voices in the context of training health professionals (Binyamin, 2021; Brown et al., 2021; Cox & Li, 2020; Paton et al., 2020; Sturman et al., 2021), as have others (Jha et al., 2009; Kiger et al., 2021; Wald, 2018). Indeed, in this issue we present two such papers; Young et al. (2021) and Wang and Ho (2021).

So, why might we need to consider this topic more closely? Surely, we are interested in any research that involves patients but focuses on training health professionals. Well, yes and no. At *Advances* we are selective in the work we publish as our guidelines set out. However, setting aside the quality assurance and quality improvement aspects of our editorial processes, there are many other questions around patient presence in health professional education scholarship that deserve further consideration.

Clearly, patients are a part of health professional education. Bedside teaching and learning would have little value if those beds were empty, except perhaps in teaching how to make good ‘hospital corners’. Clinical learning experiences therefore engage patients *qua* patients, individuals seeking medical help whose interest in contributing to teaching and learning is secondary at best. And yet learning around, with, and from patients has its complications. Being a patient requires that an individual performs the patient role, that they submit to the directions and rules of a healthcare relationship while setting aside those aspects of themselves that do not ‘belong’ in that context (Leahy et al., 2020). Moreover, how a patient is seen is shaped by the frames of reference learners are directed to use. For

✉ Rachel H. Ellaway
rachel.ellaway@ucalgary.ca

¹ Department of Community Health Sciences and Office of Health and Medical Education Scholarship, Cumming School of Medicine, University of Calgary, Calgary, AB, Canada

instance, trainee doctors are expected to adopt a ‘medical gaze’ that transforms and elides patients’ stories to fit a particular biomedical worldview (Foucault, 1989). When the gaze is both medical and education-focused the transformation and elision may be even greater, leaving little of the patient *qua* person in these encounters. We might therefore reasonably examine the ways in which teachers and learners hear patient voices, as well as which voices are heard and which are not.

Outside of clinical teaching contexts, there also individuals with experience of being patients who seek to reproduce their patient experiences for others. There are many such individuals involved in clinical skills teaching, OSCE stations, and simulation activities, to name but a few. These activities each have their own rules and relationships that shape and direct how patients are seen or understood.

Our interest should not be limited to tangible human patients or those that represent them directly. A patient is implied even if not directly in some way or other in all health professional education. Even in teaching the more abstract aspects of physiology, say, a patient is present, albeit in a rather spectral way. When a teacher talks about alveoli or the Krebs cycle or pain receptors there is always (or should always be) an implied qualification ‘... of a patient’. All such abstraction is a sorting process, deciding what aspects are to be retained or emphasized, what aspects are to be disregarded or omitted. Again and again, patients are both created and elided in writing PBL cases and vignettes, in developing simulation scenarios and in developing OSCE stations. I would therefore argue that the many ways in which we abstract a patient presence also deserve more scholarly attention.

Patients playing a role in educating health professionals is not limited to formal educational programming. I have often heard it said by health professionals that all patient encounters are educational in some way or other. The health professional teaches the patient, the patient teaches the health professional, one health professional teaches another, and so on. There has long been interest in engaging patients suffering from chronic conditions as experts in their own care, as their own health professionals (Greenhalgh, 2009). The expert patient movement is partly pragmatic but also partly democratic; it seeks to reduce passivity and hierarchy that diminishes the quality of care. A democratization of medicine and medical research is a wider topic that nevertheless intersects with patient engagement in scholarly activities (Sacristán, 2013). One might even read the growing interest in social responsibility and social accountability as a matter of patient engagement even when its focus is more typically on collectives (communities, populations, and societies) rather than on individuals.

A more recent concern (albeit one with a long history in behavioural medicine (Kahn, 2007)) is that of patient resistance and hostility to healthcare providers. Recent concerns over vaccine hesitancy, and anti-vaccine protests that have directly targeted healthcare workers, have challenged science and healthcare as matters of ideology that can be legitimately denied. Health professional educators have long advanced narratives of patient partnership and respect for their learners, but are these viable or sufficient in the face of systemic resistance and distrust? Do the narratives of how to better serve society prepare learners to serve those individuals who have come to see healthcare as an enemy in a larger ideological battleground?

On one side there are the optimistic voices of Francis Fukuyama and Steven Pinker who argue that, despite some stumbles, there is an intrinsic improvement in the human condition over time, an irresistible expansion of wisdom, kindness, and inclusivity. Any self-respecting postmodernist (and by definition there are very few) would look skeptically at such grand narratives of enlightenment and progress. The rise of antiscientific, intolerant, and irrational libertarianism around the world and the ways in which it has been received

(reflected for instance in the gallows humour of the Herman Cain Award—<https://www.reddit.com/r/HermanCainAward/>) raises serious questions regarding the intrinsic beneficence of the patient voice wherever it might be heard. Teaching our health professional learners allyship and advocacy, to show up and lean in, to approach patients in good faith and with unassailable good intentions is essential, but is it enough when the very things health professionals do to alleviate suffering are ruled illegal or immoral? Do we, can we even, teach learners how to keep going when they are shouted at and threatened on the way to or from work by people who may have been or may end up being their patients?

More than a quarter century ago, Hafferty (1994) translated Snyder's concept of the hidden curriculum to medical education, sparking conversations and debates on what was hidden and what explicit, what the logics of hiding might be, and what was productive and what was destructive in the gaps between intention, delivery, and reception. While these conversations continue, the many hidden, tacit, informal, social, and other curricula of health professional education need greater scrutiny regarding the presence, representation, and impact of patients within them. This concerns educational scholars, not just as a subject of research, but as part of the way that we conduct and report on research. How viable is science that assumes beneficence, stability, and coherence when these things are in short supply? Professional responsiveness to societal needs is central to the social contract. However, when societal needs (or parts thereof) diverge from its desires then alignment is no longer sufficient, professionals may find themselves challenging and even resisting harmful policies and arguments. Do we prepare our learners for this? Should we? Can we?

I return to my opening question: Are we interested in any research that involves patients but focuses on training health professionals? Yes, but not only. We are interested in research and scholarly communications that explore all the representations, inclusions and exclusions, challenges and conflicts that arise from or might be addressed through engaging patients in health professional education. I fully accept that sometimes it can be easier to ask questions than answer them. Indeed, questions regarding patient voices in health professional education and the roles patients should play in training future healthcare professionals are perhaps unanswerable in any absolute sense as they depend on so many contextual and paradigmatic factors. These in turn create places where values and beliefs intersect and potentially conflict, all of which also needs to be examined. I am confident that contributors to the Journal will continue to explore these questions, and to challenge thinking and practice both in education practice and in education scholarship. However, in doing so, they might reflect on how to open the conversation to consider patient participation and representation in research and scholarship as well as in education. They might also reflect on the implications for academic resistance and resilience in the face of sustained patient hostility and irrationality. Scholars in our field will perhaps need to lean in every bit as much as clinicians and learners already do to explore what it means to engage patients in the work they do.

While we are on the homophonic subject of patience, I would like to thank those who have submitted their work to *Advances* over this past year and have borne with us when our editors and reviewers have struggled to meet deadlines given ongoing disruptions to their professional and personal lives resulting from the pandemic. Processing times have sometimes slipped, and while we do our best to mitigate delays, there have been some that have taken longer than we would like. Hopefully next year will be less challenging. I would also like to take the opportunity to acknowledge all those who have contributed to *Advances* this past year, as authors, editors, and reviewers, without whom there would be no Journal and no advances in our field. To you all, thank you.

References

- Binyamin, G. (2021). Strategies for resolving relational dilemmas while developing therapists' professional identity. *Advances in Health Sciences Education: Theory and Practice*, 26(3), 827–845.
- Brown, M., Proudfoot, A., Mayat, N., & Finn, G. (2021). A phenomenological study of new doctors' transition to practice, utilising participant-voiced poetry. *Advances in Health Sciences Education*, 26(4), 1229–1253.
- Cox, A., & Li, S. (2020). The medical consultation through the lenses of language and social interaction theory. *Advances in Health Sciences Education: Theory and Practice*, 25(1), 241–257.
- Foucault, M. (1989). *The birth of the clinic*. Routledge.
- Greenhalgh, T. (2009). Patient and public involvement in chronic illness: beyond the expert patient. *BMJ*, 338, b49.
- Hafferty, F. W. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine*, 69(11), 861–871.
- Jha, V., Quinton, N. D., Bekker, H. L., & Roberts, T. E. (2009). Strategies and interventions for the involvement of real patients in medical education: A systematic review. *Medical Education*, 43(1), 10–20.
- Kahn, M. W. (2007). Understanding and engaging the Hostile patient. *Mayo Clinic Proceedings*, 82(12), 1532–1534.
- Kiger, M. E., Meyer, H. S., & Varpio, L. (2021). “It is you, me on the team together, and my child”: Attending, resident, and patient family perspectives on patient ownership. *Perspect on Medical Education*, 10(2), 101–109.
- Leahy, D., Fitzpatrick, K., & Wright, J. (Eds.). (2020). *Social theory and health education: Forging new insights in research*. Routledge.
- Paton, M., Naidu, T., Wyatt, T. R., et al. (2020). Dismantling the master's house: New ways of knowing for equity and social justice in health professions education. *Advances in Health Sciences Education: Theory and Practice*, 25(5), 1107–1126.
- Sacristán, J. A. (2013). Patient-centered medicine and patient-oriented research: Improving health outcomes for individual patients. *BMC Medical Informatics and Decision Making*, 13, 6. <https://doi.org/10.1186/1472-6947-13-6>
- Sturman, N., Parker, M., & Jorm, C. (2021). Clinical supervision in general practice training: The interweaving of supervisor, trainee and patient entrustment with clinical oversight, patient safety and trainee learning. *Advances in Health Sciences Education: Theory and Practice*, 26(1), 297–311.
- Wald, H. S. (2018). Hearing the patient voice: Patients as educators in medical education. *Academic Medicine*, 93(10), 1421.
- Wang, X., & Ho, M. J. (2021). When patient-centred and family-centred approaches clash: Taiwanese health professions students' patient autonomy dilemmas. *Advances in Health Science Education*. <https://doi.org/10.1007/s10459-021-10064-9>
- Young, J. Q., Thakker, K., John, M., et al. (2021). Exploring the relationship between emotion and cognitive load types during patient handovers. *Advances in Health Science Education*. <https://doi.org/10.1007/s10459-021-10053-y>

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.