The Expert Patient Clinic: a psychiatric educational activity to improve experience in community mental healthcare

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Submitted to: JMIR Medical Education
on: November 04, 2024

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Abstract

Background: The vast expansion in medical student numbers makes a meaningful educational experience of community psychiatric care increasingly difficult.

Objective: To evaluate a co-produced teaching intervention, the Expert Patient (EP) clinic, which aims to provide students with the opportunity to develop and enhance skills and confidence in running a psychiatric outpatient clinic.

Methods: Pre/post evaluation of the teaching intervention using confidence rating scales and qualitative feedback to assess efficacy and learning outcomes.98 students took part in the teaching session as part of the pilot study at Derby Psychiatry Teaching Unit.

Results: Rating scales showed a significant increase in confidence in all tasks, and qualitative feedback demonstrated the benefit of involving and receiving feedback from real patients and feedback from peers and clinically trained facilitators.

Conclusions: This pilot of the EP Clinic endorses the involvement of those with lived experience in teaching, allowing students to practice communication skills in a realistic but safe environment. This paves the way for further EP involvement in training in community mental health for medical students and crucially enhancing clinical opportunities in response to growing numbers of medical students.

(JMIR Preprints 04/11/2024:68359)
DOI: https://doi.org/10.2196/preprints.68359

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Keywords: Innovation, education, medical, undergraduate, expert patients

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Author contributions: The project was devised by ND, JH, MR, KR, EM and SD. The project was conducted by ND, JH, MR, KR and EM. Data was analysed by MS. Report was drafted by ND and MS and critically revised, commented on and approved by the rest of the authors.

Funding: No funding was received for this project

Ethical approval: This project was brought to the attention of the University of Nottingham Medical Ethics Committee and classed as service evaluation, therefore no ethical approval was required. All work was carried out in accordance with the Declaration of Helsinki, participants gave fully informed consent, and project data were stored securely according to NHS Trust policy.

Introduction

Psychiatry is predominantly a community specialty (1), but growing medical school cohorts, limited outpatient clinic observation opportunities, and limited educator capacity mean that student doctors struggle to experience outpatient mental healthcare (2). Moreover, students frequently report that their learning opportunities are impeded due to clinicians lacking time to teach in busy clinics, missed appointments or patients declining student presence. Consequently, many foundation doctors faced with their own first outpatient clinics may not have had any experience of leading in outpatient clinical work, a factor which has been stated to be a main obstacle to students' preparation for clinical practice and reducing their self-confidence (3, 4).

There is a strong correlation between the quality of doctor-patient communication and health outcomes (1). The effects of excellent doctor-patient interaction include increased adherence and compliance, self-regulation, coping and earlier return to work (5). Doctor-patient communication is especially important in psychiatry where effective communication and the development of a good therapeutic alliance are essential aspects of person-centred care. For example a systematic review of doctor-patient communication and treatment adherence in mental healthcare showed that agreeing on the tasks of treatment, using collaborative styles of communication and discussing the specifics of treatment may be important for adherence (6). This emphasises the need for medical students to practice these vital skills themselves, to be able to apply theory into practice appropriately and effectively, rather than simply observing doctors in their clinics.

Experiential learning theory (7) is key to understanding how medical students can learn to communicate. Kolb's learning cycle proposes certain elements of learning that must be present for optimal learning to take place: concrete experience, reflective observation, abstract conceptualization and active experimentation. The optimal learning conditions are where a student is involved, engaged, participating in the process and 'learning by doing' (8). It is also a situation where interactions with people are key (9) and learners are asked to take responsibility and find solutions to real-world problems (8). Experiential learning also requires the skills of critical analysis and reflection which are important components in learning and developing communication skills within psychiatry (10). It is clear that the present form of outpatient clinic observation, with growing student cohorts, hurried clinicians and unwilling patients, does not fulfil the criteria of an optimal learning environment. There have been efforts to increase students' ability to practice and learn communication skills through using simulated patients, virtual patients (11), and even virtual reality (12), but there are concerns about the lack of realism and the specialized scenarios which can limit students' ability to experiment with learning (12). Studies which have compared learning experiences with virtual patients to those with real patients found that students preferred interacting with real patients and the differences in student learning were either insignificant or better with real patients (11).

The Psychiatry Teaching Unit (PTU) at Derbyshire Healthcare NHS Foundation Trust has been in the vanguard of patient involvement since 2007. Patient involvement in medical education is required by policy (13), but co-production is an ethos embedded within Derby PTU. We have a large group of Expert Patients (EPs), members of the public with lived experience of mental health conditions, engaged in medical education in various forms. The EPs have extensive and diverse experience of inpatient and outpatient psychiatric care and of collaborating with faculty staff in medical education activity. Previous research has also shown that participation in medical education is empowering and even therapeutic for the EPs involved (14, 15). Students' lack of opportunity to practise communication in outpatient settings was brought to the attention of the teaching department through student feedback which outlined the difficulties in accessing outpatient clinics and also highlighted the lack of autonomy or ability for students to take a lead in these sessions. Students emphasised that, as a result, they lacked the skills and confidence to lead or engage in psychiatry outpatient work.

Upon recognising this gap in learning outcomes, a working group was initiated consisting of teaching staff, EPs and students, with the aim of developing a medical student training session where

students could experience leading an outpatient psychiatric clinic and undertake common reviews with real patients. Based on Kolb's model (8), the learning activity was designed to replicate an outpatient clinic where the students take responsibility to complete a psychiatric review for genuine patients (concrete experience), incorporate opportunity for shared feedback with peers and a clinician (reflective observation), develop strategies for the next patient in the clinic (abstract conceptualization) and use their shared learning for other patients in the clinic and future patient encounters (active experimentation).

Collaborating with the EPs meant that students were talking to real patients who approach the session as an opportunity for psychiatric review as well as a teaching opportunity. This brings an element of realism and unpredictability to the session. Students receive relevant feedback from the patients on areas such as use of empathy, respect, sincerity and warmth alongside self-reflection, feedback from peers and 'bedside' teaching from a member of the teaching staff.

Methods

The study design is a pre/post evaluation of a teaching intervention, the EP clinic. Students in their third year of studying for their undergraduate medical degrees at the University of Nottingham and completing their psychiatry placement at Derby PTU took part in an EP Clinic.

Procedure

The session began with a briefing where students were told about the concept and purpose of the EP Clinic in allowing students to lead a clinic, that the patients they were to review were genuine mental health patients who work with the PTU in their teaching, and the support available in the form of a member of the teaching department (See supplementary file 1 for the full briefing).

Nine students took part in each clinic. After giving consent students were asked to complete the pre-session rating scales (Fig. 1) and were then given a clinic room which was theirs for the duration of the clinic, with three students per room. Students were provided with the histories of the three EPs they were to review and the type of review they were to undertake (patient-specific, psychosocial, current mental health; see supplementary file 2 for descriptions of review type) with each EP. Each student was allocated to lead a review with each EP while the other students observed. Once given the EP information, students were given 30mins to prepare and teaching staff were available during this time.

EPs were directed to a waiting room on arrival. Following preparation, students called the EP from the waiting room to the clinic room and completed the review. Each review took a maximum of 30mins: 20mins for the review itself, and 10mins for feedback, discussion and debrief. EPs were asked to give feedback on elements of communication such as therapeutic alliance and empathy. Students were asked to give feedback on what they thought went well or what could be improved. The clinically-trained facilitator (psychiatrist or mental health nurse educator) fed back on elements such as use of time, structure, and how well different areas were covered such as medication or assessment of risk. The EPs and review tasks were arranged over the course of the clinic so that each group of students saw each EP and each EP experienced three types of review. See Table 1 for EP and review type allocation.

Table 1. EP and Review type allocation

	Group 1	**Group 2**	**Group 3**
Review 1	Current mental health review	Patient specific review	Psychosocial review
	Aimee	Zoe	Charlie
Review 2	Psychosocial review	Current mental health review	Patient specific review
	Zoe	Charlie	Aimee
Review 3	Patient specific review	Psychosocial review	Current mental health

		review
Charlie	Aimee	Zoe

Measures

All students completed pre/post rating scales where they were asked to indicate their level of confidence in their ability to complete certain tasks out of a maximum of ten (See supplementary file 3 for the pre/post rating scale questionnaire). Students were asked to rate confidence reviewing a patient in a psychiatric outpatient clinic, confidence in discussing current levels of risk with patients in a psychiatric outpatient clinic, competency in developing a management plan for patients in relation to psychosocial factors in the community, and confidence in leading a psychiatric outpatient clinic with a patient. There were also specific measures dependent on the patient-specific review in that session e.g. confidence reviewing medication, ability to assess the severity of depression, anxiety or OCD. Students were also given the opportunity to write in free text what they thought was good about the EP Clinic and what could be improved.

Results

Confidence rating scales

In total, 98 students took part in the EP clinic pilot. The results from the pre-clinic (M=4.0, SD=1.7) and post-clinic (M=7.1, SD=1.4) overall confidence ratings indicate that participating in the EP clinic resulted in an improvement in confidence, $t(97)=20.5$, $P<.005$. The effect size is 1.8 which is considered a large effect size.

Results from the pre-clinic (M=4.4, SD=1.7) and post-clinic (M=7.3, SD=1.3) confidence ratings for reviewing a patient in an outpatient clinic indicate that participating in the EP clinic improved their confidence, $t(97)=18.6$, $P<.005$. The effect size is 1.7, a large effect size.

The pre-clinic (M=4.8, SD=1.7) and post-clinic (M=7.1, SD=1.5) confidence ratings for assessing risk in an outpatient clinic indicate that participating in the EP clinic improved their confidence, $t(97)=15.2$, $P<.005$. The effect size is 1.3, which is considered a large effect size.

The results from pre-clinic (M=3.7, SD=1.5) and post-clinic (M=6.2, SD=1.7) ratings for confidence in developing a management plan indicate that participating in the EP clinic resulted in improved confidence, $t(97)=16.6$, $P<.005$. The effect size is 1.7 which is considered a large effect size.

The chart below, Fig. 1 shows the differences in pre-clinic and post-clinic scores.

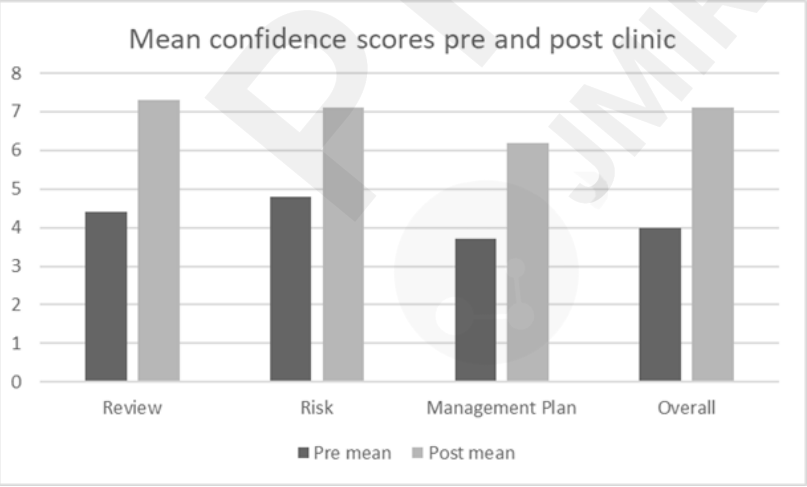

Fig. 1 Mean confidence score pre and post clinic

Qualitative Feedback

Students were also given the opportunity to give additional feedback in a free text box. Thirty-four students out of the 98 participants gave additional feedback. Most responses were positive, remarking that the session was ‘helpful’, ‘insightful’, ‘useful’ and ‘enjoyable’. The features of the EP clinic that the students most remarked upon were the smaller setting feeling less pressurised, the benefits of peer observation and feedback, the benefits of feedback from the EPs as ‘real patients’,

the opportunity to practice skills in a safe and supportive environment and the opportunity to do more than is possible when visiting wards or observing an outpatient clinic. Some said they wished this teaching method was used in other placements. See table 2 for direct quotations from the students involved.

Table 2. Positive feedback quotations

Feature	Feedback and participant no.
Small setting	I like the small groups, less pressure on student (Participant 3)
Peer observation	This was the most helpful clinic/teaching that we've had so far. Being able to watch peers, see their feedback and practice ourselves in a small comfortable environment was a great opportunity. (Participant 55) I found EP clinic very helpful. Observing from peers as well as doing your own task is very helpful for practising skills in a safe environment whilst also not being manufactured (Participant 56)
EP feedback	Really enjoyed and appreciated session. Real patients made a big difference. (Participant 74) One of the best sessions in the rotation. Enjoyed it and was great to use my consultation skills with a patient who is not an actor and get lots of constructive feedback. (Participant 78)
Safe/supportive environment	I thought session was great. I got very useful feedback which I will implement. It also felt like a very supportive environment and I wasn't afraid to make a mistake. (Participant 76)
More opportunity for practice	Session was very helpful since we don't get much opportunity during outpatients clinics. (Participant 20)

Participants also gave feedback about ways in which the EP clinic could be improved in the future. These mainly included having the clinics more often during the placement, having more equipment available for the physical examination task, not having to use an OCD questionnaire and having written feedback that could be used in their workplace-based assessments. See table 3 for student feedback on possible improvements.

Table 3. Feedback for possible improvements

Improvement	Feedback and participant no.
More EP clinics!	I think these sessions would be really productive if it's possible to regularly integrate them into the placement. (Participant 2)
More equipment available	To improve, more equipment for observations e.g. oxygen saturation monitor, blood pressure, stethoscope. (Participant 1)
OCD questionnaire	OCD questionnaire took a lot of time out of the session and not helpful in the task. Although questions did allow me to know the symptoms, it would probably be more useful as a reading material outside the session. (Participant 20)
Written feedback	Could have feedback in written form to take away from session for WBPA/end of placement review (Participant 74)

Discussion

This paper has presented a pilot for a teaching intervention which allows medical students to practice

their communication skills and experience leading an outpatient clinic, the EP clinic. The feedback from students suggests that this intervention significantly increases the confidence of students in leading an outpatient clinic as well as increasing their confidence in specific skills such as reviewing a patient, assessing risk and developing a management plan. Qualitative feedback has emphasised the usefulness of the small setting, peer observation and feedback, receiving feedback from real patients, a safe environment for practise and the opportunity to practise these skills. Students also suggested some improvements, e.g. that more clinics could be integrated into the placement, more equipment for physical examination should be available, a shorter questionnaire be used for the OCD review and that some written feedback could be given which could be used in the student's workplace-based assessments. These improvements have been implemented for the subsequent cohorts.

This study documents a unique intervention which, to the authors' knowledge, is the first of its kind. Although other research has documented the trialling of mock clinics, these have all used simulated patients or virtual patients rather than people with real lived experience of mental health problems. This teaching activity incorporates the realism and responsibility of interacting with real patients in a safe, supportive environment. Piloting this intervention in a number of student cohorts, with similar results, shows that this intervention is reliable in increasing student confidence. As this study was a pilot, we were not able to compare confidence levels with a control group or examine student learning of communication skills, yet the student feedback is promising for a more comprehensive evaluation of this intervention.

The results of this study support Kolb's model of experiential learning (7, 8). According to Morris, a concrete learning experience is an experience in which "learners are involved, active, engaged, participants in the learning process. Learner participation is central, where "learning by doing" is a founding concept. It is a "hands on", task-oriented process, which is based on direct experience that necessitates that learners are active in the process" (8). The elements of the EP clinic that students found most useful were the opportunity to participate, rather than simply observe, and to practise and receive feedback from real patients. The elements of reflective observation, abstract conceptualization and active experimentation are also evident in the students' comments about the benefits of feedback and practice. Students had a clear desire to practise skills with real patients rather than an 'actor' in a 'manufactured' environment. Although offerings in the area of simulation and virtual reality are improving (11, 12) the realism of involving those with lived experience is an option that may promote the concrete learning experience and make the feedback given by the patients more credible for students.

Future research in this area will assess student learning as a result of the EP clinic, evaluating performance in communication skills or an OSCE review scenario. One of the criticisms of Kolb's model is the lack of empirical data supporting it (8). Future research should also seek to elucidate the impact of the elements of this model by introducing or removing certain elements such as reflection to establish the necessity of these elements.

Conclusion

Allowing students to practise their crucial communication and reviewing skills in a simulated clinic attended by EPs increases their confidence to lead an outpatient clinic. Involving EPs not only fulfils medical school policy obligations (13), but brings a level of realism that enhances the learning experience and brings credibility to feedback, factors essential to Kolb's experiential learning cycle (7, 8). Medical schools should consider involving those with lived experiences in similar teaching interventions.

Acknowledgements: Our thanks go to medical students from the University of Nottingham for their keen participation and enormously helpful feedback. We are indebted to our wonderful Expert Patients and Lived Experience Facilitators who are at the core of the education we offer.

Conflict of Interest

None declared

Author Contribution Statement

Authors contributed in the following ways: Original concept; ND, JH, MR, KR, SD, resources; ND, SD, project design; ND, JH, MR, KR, project delivery; ND, JH, MR, KR, EM, analysis; MS, original draft; ND, MS, editing and approval of final draft; ND, JH, MS, MR, KR, EM, SD.

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