Patients as educators: Interprofessional learning for patient-centred care

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Abstract

**Background:** Patients with chronic conditions have unique expertise that enhances interprofessional education. Although their active involvement in education is increasing, patients have minimal roles in key educational tasks. A model that brings patients and students together for patient-centred learning, with faculty playing a supportive role, has been described in theory but not yet implemented.

**Aims:** To identify issues involved in creating an educational intervention designed and delivered by patients and document outcomes.

**Method:** An advisory group of community members, students and faculty guided development of the intervention (interprofessional workshops). Community educators (CEs) were recruited through community organizations with a healthcare mandate. Workshops were planned by teams of key stakeholders, delivered by CEs, and evaluated by post-workshop student questionnaires.

**Results:** Workshops were delivered by CEs with epilepsy, arthritis, HIV/AIDS and two groups with mental health problems. Roles and responsibilities of planning team members that facilitated control by CEs were identified. Ten workshops attended by 142 students from 15 different disciplines were all highly rated. Workshop objectives defined by CEs and student learning both closely matched dimensions of patient-centredness.

**Conclusions:** Our work demonstrates feasibility and impact of an educational intervention led by patient educators facilitated but not controlled by faculty.

**Introduction**

The active involvement of patients in health professional education is increasing partly due to the recognition that patients have unique expertise derived from their experience of illness, disability or the effects of the social determinants of health (Towle et al. 2010). Many people living with chronic conditions become “experts by experience” through performing a range of tasks required for self management (Towle & Godolphin 2011a). However, little attention has been paid to how this experiential knowledge can best be incorporated into, and taught in the context of, curricula that are based on a scientific paradigm in which the health professional is the expert (Towle & Godolphin 2011b) and in which physicians are encouraged to believe that disease is more important than illness (Kleinman 1988). Kleinman suggested that to change this situation “it is necessary to make the patient’s and the family’s narrative of the illness experience more central in the educational process”.

Most contact between learners and patients occurs in the clinical context when the priority for the patient is clinical care, not teaching. Patients who have designated educational roles at the undergraduate (pre-qualification) level are typically guests brought into the classroom; some may be trained to co-facilitate a small group with a faculty member. They have minimal roles in key educational tasks such as setting objectives, determining content or evaluation. Faculty not only control curriculum content and format, but decide which patients are recruited (i.e., whose voices are heard) and sometimes require them to be trained in order to participate. There are major institutional barriers to authentic involvement, including the hierarchical nature of academia, stigma and discrimination, validation and accreditation processes, definitions of knowledge and inappropriate payment and support systems (Basset et al. 2006). Professionals have difficulty letting

**Practice points**

- Interprofessional workshops designed and taught by patients are described.
- Student learning maps to dimensions of patient-centredness.
- Patient-led workshops respond to some difficulties in providing IPE.
- This sustainable model illustrates patient-centred learning with faculty in a supporting role.

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go of their expert role, leading to tokenistic involvement rather than partnership which requires a reduction in the power difference between patients and professionals (Felton & Stickley 2004).

Patients as educators challenge the nature of expertise (and power). Rees et al. (2007) note a failure to explore the social issues surrounding patient involvement, such as how students learn with rather than just about patients: learning with not only implies a greater level of activity on the part of patients but also reflects the dynamic mutuality that occurs between students and patients. They use a socio-cultural learning framework to apply the theory of legitimate peripheral participation (Lave & Wenger 1991) and its related concepts such as power, identity, roles and discourse to patient involvement in education. Bleakley and Bligh (2008) build on these concepts to propose a radical shift in emphasis that inevitably brings with it a shift in power, role and meaning – from the relationship between doctor (as teacher) and student (as learner) with patients playing a supportive role, to the relationship between patient (as educator) and student (both as learner and co-educator) with the doctor-educator playing a supportive role. The empirical work of Henriksen and Ringsted (2011) confirms how this model creates a different learning environment and power dynamic between teacher and learner. However, although their Patient–Instructors designed and taught the session, they had been recruited and trained by professionals.

We know of no examples in the patient involvement in health professional education literature in which patients have been given the power to educate students without the mediation or control of faculty. One reason that this shift in emphasis could be considered important is to enable students to learn directly from patients about what they consider to be important that students learn; in other words, about patient-centred care. Bleakley and Bligh (2008) note that currently patient-centredness is typically framed as a set of values and virtues learned from doctors and role models and reinforced through structured educational input from medical educators. In other words, patient-centredness is “paradoxically learned mainly from doctors rather than from patients.” Therefore, the problem we are considering is how to translate the theoretical conceptualization of Bleakley and Bligh (2008) into an educational intervention that puts patients at the centre, leading the education process in a way that maintains their authentic and autonomous voice. We describe the development and outcomes of an educational model in which patients with chronic disease and their families (“community educators,” CEs) were supported to design and teach workshops for health professional students.

We explored the following questions.

(1) What are major considerations when creating an educational intervention (workshop) designed and delivered by patients (CEs)?
(2) How are educational sessions designed and delivered by CEs received by students from different health disciplines?
(3) To what extent do students learn aspects of patient-centredness when the education is led by CEs?

Methods

Guiding principles

In order to translate the theoretical concept of patient-centred education into an intervention we adopted three guiding principles.

- Patients who are experts by experience have important things to teach health professional students that they cannot learn from, or mediated by, faculty.
- In order to facilitate the patient’s authentic and autonomous voice, it is necessary to reduce the power imbalance.
- What is taught should be what the patients want students to learn, in the way they want to teach it, and at the location of their choosing.

Context

We chose a workshop format for the intervention since we wanted to create an interactive learning experience; in addition this is an educational format frequently used in community-based non-profit organizations. Several interrelated factors prompted us to develop this as an interprofessional education (IPE) intervention. Firstly, chronic disease management requires an interprofessional approach; most people with chronic illness (including the CEs) have concerns and experiences beyond the purely medical and interact with a variety of health and social care providers. Secondly, most health professions espouse a version of patient- or client-centred care, and it has been emphasized that partnership with the patient is at the centre of collaborative practice (Orchard et al. 2005). Thirdly, the increased attention to IPE, as a consequence of competency development and new accreditation standards, demands new educational approaches that overcome identified challenges such as facilitation, scheduling and professional rivalries. Because the workshops were interprofessional and voluntary, they were held outside scheduled curriculum time, usually in the early evening.

Foundations

We established an Advisory Group comprising the core project team (including a coordinator), faculty, students and representatives of community-based patient advocacy and support organizations, some of whom were also patients, identified from a previous project on patient involvement in health professional education. The faculty and students were volunteers from various health professions who were committed to the concept of CEs as teachers. The community organizations all had mandates that included education (though not necessarily for health or social care professionals) and had a key person in the organization interested in being involved in health professional education. The Advisory Group articulated a vision (“Patients at the core of health professional education”) and a set of values to drive the development process. A faculty, student and community member from the Advisory Group volunteered to join each workshop development team.
Workshop development and delivery

CEs were recruited by the organization representatives and usually drawn from individuals known to them. One organization posted an open invitation in community centres and to support groups. The planning team for each workshop was typically 3–5 CEs, the organization representative, 1–2 faculty, a student and the project coordinator. Planning teams developed workshop objectives and activities based on what CEs thought were important for the students to learn. A debriefing focus group was held following the initial workshop at which time interest in doing a repeat workshop was gauged.

Workshops lasted two to three hours at locations chosen by the CEs (e.g., a community centre). They typically began with a round of introductions and a statement about the need for confidentiality and respect. Sometimes there was a short didactic presentation about the condition. Presentations and demonstrations were given by each CE with time for students’ questions, supplemented by activities intended to give students an experience of what it is like to have the condition, case studies and/or small group discussions with individual CEs. The coordinator was present at all workshops; one or two faculty from the planning team observed the initial workshop but did not participate.

Student recruitment

Students from all health and human service programs were invited to the workshops, which were advertised as a “community-led interprofessional workshop opportunity” through the faculty and departmental e-mail lists. Registration was mainly on a “first come-first served” basis and numbers limited to 12–20 as determined by the planning team. Minimal selection was done to ensure a good interprofessional mix.

Evaluation

Students were surveyed at the end of the workshop or by e-mail a few days later. There were two scored items and three free-text questions that asked what they learned, what they felt was missing from the experience and suggestions for improvements. The free-text responses were analyzed thematically with respect to three broad categories: workshop highlights; student learning; and workshop deficiencies/unmet needs. Themes were compared across workshops. Debriefing sessions held by the workshop planning teams, including the CEs, were audiotaped, transcribed, and summarized. Detailed reports of the planning, delivery and evaluation of each workshop were drafted by the project coordinator. Workshop reports included factual information about planning and delivery, the project coordinator’s observations and reflections, student evaluations, and the key points from the debriefing sessions. Reports were reviewed by the core project team and Advisory Group to agree the most important and generalizable lessons learned. Evaluation of the CE experience was done as part of the workshop debriefing sessions and a subsequently commissioned evaluation by an external agency who conducted in-depth interviews with 12 key informants including CEs and community organization representatives.

Results

Workshop development and delivery

Ten workshops were held between October 2008 and January 2011 by five different groups of CEs: epilepsy, arthritis, HIV/AIDS, and two mental health groups. Each of the five initial workshop groups wanted to implement a repeat workshop. Many of the CEs were the same as for the first workshop but some were not available and others were recruited in their place. One CE was not invited to participate a second time by the workshop planning team because of non-attendance at planning meetings. In total there were 24 individual CEs, 10 of whom taught more than one workshop.

Between 2 and 5 meetings of about two hours in length were required to plan the first workshops for each group. Repeat workshops took about half the time to plan as the first; faculty presence was not required if a student was on the team. Minor changes were made to workshop activities based on the evaluation; objectives remained the same.

The specific roles and responsibilities required of the key stakeholders in order to hand over the control of the education to patients were clarified in retrospect from the debriefing focus groups and were similar across workshops.

- The community organization representative was responsible for recruitment and coordination of CEs, assisted with workshop planning, participated in workshops as educator, facilitator or trouble shooter, gave feedback on presentations and workshops, and provided information about the organization’s resources to students.
- The CEs identified what it was they wanted students to learn and how they wanted to teach it, and worked as a team to deliver the workshop.
- Faculty’s most important role was to encourage CEs to articulate what they (the CEs) wanted students to learn and to help them translate this into the form of instructional objectives familiar to students and faculty. They also assisted with ideas for workshop design and evaluation.
- Students provided information about their learning needs and feedback on proposed activities through participation in the planning teams or post-workshop evaluations.

At first, the responsibility for evaluation was devolved to individual planning teams but this led to different approaches and workshop-specific questions which made it difficult to compare workshops. Subsequently, we adopted a centralized evaluation and generic survey questions to allow better comparisons across workshops. E-mailing post-workshop surveys yielded more elaborate responses to questions compared to when students filled out surveys immediately after workshops when they were in a hurry to leave. However, themes were the same.

Student response to workshops

Workshops were attended by 142 students from 15 different disciplines. 93% came from eight disciplines: occupational therapy (19%), pharmacy (19%), nursing (18%), medicine (12%), dietetics (8%), social work (8%), physical therapy (6%),...
and counseling psychology (4%). Seven other disciplines each accounted for about 1% of participants. The students were at different stages in their programs, from first year to post qualification. Students from all years of the occupational therapy, pharmacy, nursing, medicine, and physical therapy programs attended at least one workshop. All workshops were over-subscribed by 5–23 students.

Quantitative data were collected from 61 students (last five workshops only). When asked to rate the workshop “compared to other workshops I have taken” on a scale of 0 (I would NOT take this workshop again) to 5 (I would take this workshop again), 56 students (92%) gave a rating of 4 or 5. The results from the independent external review documented positive benefits to CEs including the opportunity to help others by sharing their experiences, increased self confidence, and more interprofessional interaction.

Free text responses were collected from 110 (85%) of 129 students attending nine workshops; no comparable data were collected from one workshop. Table 1 summarizes the major themes from these responses under the categories of workshop highlights (five themes) and workshop deficiencies/ student wants (seven themes). Highlights were exposure to the lived experience of patients and interprofessional interactions. The main deficiencies related to workshop format and presentation, specifically with time management and a case study used in one workshop, and the desire for more interprofessional interaction.

Student learning outcomes

Although workshops were developed independently by each planning team, the objectives had many commonalities and could be grouped into the following main categories: biopsychosocial perspectives, the client’s individual experiences, challenges with the health care system and issues related to stigma and stereotypes. When grouped in this way, the objectives mapped well to each of the key dimensions of patient-centredness as identified by Mead and Bower (2000) and each of the subthemes identified by Thistlethwaite and Moran (2010) for IPE learning outcomes related to “The Patient” (Table 2). Some workshop objectives related to disease-specific biomedical topics such as early diagnosis, information about common symptoms and approaches to management. Student learning as derived from thematic analysis of the post-workshop survey responses also mapped well to the key dimensions of patient-centredness; illustrative comments are given in Table 2.

Results from the independent external review documented positive benefits to CEs including the opportunity to help others by sharing their experiences, increased self confidence, the chance to meet new people and inspiration to seek other opportunities to educate health professionals (Social Planning and Research Council of British Columbia 2011).

Discussion

Our results demonstrate that it is possible to translate the theoretical conceptualization of Bleakley and Bligh (2008) into a successful patient-centred educational intervention in which the patient is the teacher, not interview subject or co-tutor with faculty. CEs were central to planning, determining objectives, and format; they agreed the location and ran the workshops.

Workshops were well received by students, a finding consistent with most other reports of patient involvement (Towle et al. 2010). Objectives were similar across workshops, even though they were developed independently by the CEs on each planning team, and were correlated with the dimensions of patient-centredness that have been developed by professionals. Learning outcomes reported by students

### Table 1. Post-workshop data from student surveys: summary of free text, by theme, of workshop highlights and deficiencies.

<table>
<thead>
<tr>
<th>Workshops*</th>
<th>MHa1</th>
<th>MHa2</th>
<th>MHB2</th>
<th>AR1</th>
<th>AR2</th>
<th>HIV1</th>
<th>HIV2</th>
<th>EP1</th>
<th>EP2</th>
<th>Totals (% of respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of workshop attendees</td>
<td>13</td>
<td>16</td>
<td>17</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>20</td>
<td>11</td>
<td>12</td>
<td>129</td>
</tr>
<tr>
<td>Number of health disciplines</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Number of survey respondents</td>
<td>12</td>
<td>15</td>
<td>14</td>
<td>13</td>
<td>12</td>
<td>10</td>
<td>18</td>
<td>9</td>
<td>7</td>
<td>110</td>
</tr>
<tr>
<td>Workshop highlights</td>
<td>Exposure to lived experience of patients</td>
<td>8</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>17</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Interdisciplinary interaction with other students</td>
<td>4</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Small group interaction with patients</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Summary of ‘condition’ facts and best practices</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>24</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Patient experience related to other classroom learning</td>
<td>1</td>
<td></td>
<td>4</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Workshop deficiencies/unmet needs</td>
<td>Better workshop format/presentation</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>More interprofessional focus</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>More information (questions answered)</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>More time and interaction with CEs</td>
<td>2</td>
<td></td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Practical tips to improve practice</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Wider range of perspectives (individuals with the ‘condition’)</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>More personal experiences</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

Notes: *MHa1, MHa2, MHB2 = Mental health teams a and b, workshops 1 and 2; AR = Arthritis team; HIV = HIV/AIDS team; EP = Epilepsy team.

†No comparable survey data for MHB workshop 1 (13 attendees; five disciplines).
Table 2. Workshop objectives and student learning in relation to dimensions of patient-centredness.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Workshop objectives* (number of workshops)</th>
<th>Illustrative student quotes from post-workshop surveys (student 1 – workshop1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centredness (Mead &amp; Bower 2000)</td>
<td>IPE: “The Patient” (Thistlethwaite &amp; Moran 2010)</td>
<td>I really enjoyed how the teachers were patients, I really appreciated the speakers’ narratives that evoke examples of their medical care/experiences with the psychosocial experiences of their medical condition. (SW1-AR2)</td>
</tr>
<tr>
<td>The bio-psychosocial perspective</td>
<td>Understanding the patient’s (family/carer’s) perspective</td>
<td>I really enjoyed how the teachers were patients, family members and partners. Seeing all of the different perspectives made me realize the extent that epilepsy can affect someone’s life in many ways – financially, socially, emotionally… (Med2-EP1)</td>
</tr>
<tr>
<td>The patient as person</td>
<td>Recognition of patient’s needs</td>
<td>I really appreciated hearing more about how the disease affected each individual. It is very easy to understand the pathology, but the impact it has on someone’s life is hard to imagine unless they share it with you. (PT1-AR2)</td>
</tr>
<tr>
<td>Sharing power and responsibility</td>
<td>The patient’s (family/carer’s) central role in interdisciplinary care; Patient as partner within team</td>
<td>It is helpful to hear from the patient what aspects of the condition affects him most as this ‘priority list’ may be different than the priorities outlined in the therapeutic plans explained in textbooks. (Med4-AR1)</td>
</tr>
<tr>
<td>The therapeutic alliance</td>
<td>Working together collaboratively in the best interest of the patient</td>
<td>Understanding how they want to be treated (for example, they did not want people to ask how they acquired HIV) will make me more conscious about my communication. (OT2-HIV1)</td>
</tr>
<tr>
<td>The doctor [health professional] as person</td>
<td>N/A</td>
<td>Our discussion revolved around how our different professions may (and do) work together in caring for individuals with epilepsy. (CP1-EP1)</td>
</tr>
<tr>
<td>Patient safety issues</td>
<td>Discuss the safety and security concerns of persons living with HIV</td>
<td>I learned that there are many ways that a person with arthritis can be given the correct tools/education to function better in our society. (Med3-AR1)</td>
</tr>
<tr>
<td>N/A</td>
<td>Identify community resources available to people with [condition] (4)</td>
<td>The importance of the health care professional’s role in instilling hope in the client was another idea that was emphasized. (OT2-MHb1)</td>
</tr>
</tbody>
</table>

Notes: *This wording of the objectives has been modified slightly to make the descriptions consistent; actual wording varied between workshops but the sense has been retained here.

SW = Social Work; Med = Medicine; PT = Physical therapy; Pharm = Pharmacy; OT = Occupational therapy; CP = Counseling psychology; Diet = Dietetics; Nurs = Nursing. The numeral following the abbreviation is the student’s year in the program, e.g., Med4 is a Medical student in the 4th year of his/her program.

Abbreviations for workshops (e.g., AR2) are as in Table 1.

N/A = not applicable.
were also similar across workshops and mapped to the dimensions of patient-centredness. Some of the learning outcomes were consistent with other examples of patient involvement in IPE, including appreciation of the lived experience, affective learning that challenged assumptions and values, linking theoretical learning with practice and valuing patients as a knowledge resource (Turner et al. 2000; Solomon et al. 2005). However, the diversity of CEs and their experiences (gender, age, illness trajectory, role as patient or caregiver) emphasized the individual nature of the illness experience and the need for care to be personalized. These concepts form the foundation of patient-centred care and are things students rarely learn in classes, where the similarities, rather than the diversity, among patients with a particular disease are emphasized.

Our experience provides insights into the role of the expert professional teacher as a resource envisaged by Bleakley and Bligh (2008). Professional educators often express concerns about giving up control of content and delivery (Daykin et al. 2002), and those who have genuinely tried to develop partnerships have had their own views and beliefs challenged, especially in mental health education (Basset et al. 2006; Ion et al. 2010). Radical educational change requires careful selection of faculty leaders. We chose faculty who were committed to the aim of handing over control to CEs and helped develop the guiding principles. Initially, faculty on the planning teams needed to consciously and frequently encourage the CEs to focus on what they (the CEs) wanted the students to learn, and help them move beyond their starting position which was to ask the faculty what they wanted the CEs to teach. This proved to be an important step in handing over power and resulted in the content being determined by patients not faculty. However, we also identified some limitations to handing over control to CEs. In particular, we identified the need for faculty to assist with initial formulation (i.e., the form not the substance) of objectives and for there to be centralized control of evaluation questions to allow comparison of outcomes across workshops.

Preparation and support for patient educators, especially those from vulnerable populations, has been identified as essential (Hatem et al. 2003). However, we perceive an ambiguity in the patient involvement literature between the need to prepare patients for their role as educators while allowing them to remain true to their own ways of teaching and learning and not turning them into academics like us (Ion et al. 2010). Attempts to reduce the power difference and develop a more equal partnership can be resource intensive (Ion et al. 2010; Anderson et al. 2011), and may not be sustainable. Our work highlighted the critical role of the community organization representatives who were brokers between the two cultures of academia and community. Their experience in recruiting volunteers was invaluable in helping to find people who were most suited to be CEs. Many of the CEs they recruited had previous experience with facilitation and teaching through roles as peer support workers or patient educators. This ensured they had a foundation of relevant skills. They developed the workshop as a group and supported each other, working in a team teaching mode, in contrast to models in the literature, where patients speak to students on their own or co-teach with faculty. Our approach is closer to the peer support model with which many of our CEs were familiar. It also meant that repeat workshops required little or no input from faculty and promoted sustainability. The workshop program is now in its fifth year.

Our intervention has advantages for IPE as it permits flexible scheduling and provides meaningful learning for students at different stages in their programs and from a wide range of disciplines. There was no need for expert IPE facilitators (Reeves et al. 2007). Students are focused on the patient and the contributions to care by their discipline rather than on professional identities or hierarchies. The ability of the patient experience to unite students in ways that are meaningful and constructive rather than competitive has been noted by others (Turner et al. 2000). However, we noted a tension between a focus on the patient experience and interprofessional learning which itself involves numerous goals (Daykin et al. 2002). Workshops are attractive to students because of both the patient focus and IPE, but it is hard to satisfy fully both needs within a single workshop. Indeed, time management is a recurring problem. CEs get engrossed in their stories and lose track of time; students have many questions; there is tension between learning from CEs and IPE that involves learning from and about other students (CAIPE 2002); most workshops are held in the evening and everyone gets tired if they last more than two and half hours. The workshop power comes from the real stories of the CEs; case studies intended to stimulate interprofessional discussion were perceived as artificial.

One limitation of our study is that students were self-selected volunteers; their enthusiastic responses may not be typical of all students. However, as workshops were usually after a full day of classes, did not attract academic credit and were held off campus, it could be argued that students would have high expectations and little tolerance for activities that did not meet their needs. Although student learning outcomes are self reported, social desirability bias is unlikely to be strong since students had neither prior knowledge of what learning was expected nor any prompting from faculty to attend. We cannot make any claims about the comparative effectiveness of our approach to learning about patient-centred care as we did not have a control group who received a different intervention.

In conclusion, we have demonstrated the feasibility and impact of a model that puts patients at the centre as educators. The important things that CEs identify that they want to teach and that students learn closely match the dimensions of patient-centredness. Further studies are needed to investigate the long-term impact with respect to effect on practice and to describe more fully the nature of learning that takes place. In addition, as highlighted by Towle et al. (2010), if education is to promote partnerships with patients as the basis for health care, we must move from isolated initiatives to coordinated programs for patient-centred learning.

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**References**


