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Chronically ill patients and adherence: a new challenge for educators committed to training future health professionals

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Abstract

As academic educators committed to training future health professionals, we should understand and address the new educational needs they may perceive as a result of the global increase in the number of chronically ill patients. This paper aims to present a new learning/teaching strategy that has been implemented in a bachelor course for health professionals, based on the evidence of: a) the complexity of the issue of therapeutic adherence; b) the lived experience of chronic illness as a personal matter; c) the usefulness of therapeutic patient education (TPE) conceived only as a transmissive practice. In this course, some lectures were combined with workshops in which students were asked to deal with a real patient's story for whom they had to define an educational plan. The results show the success of the creative choices implemented from a training perspective and the satisfaction of the learners asked to experiment in the classroom a work practice with a high rate of autonomy.

Keywords: *Medical Education; Chronic ill patients; Therapeutic Patient Education; Collaborative Learning; Self-directed Learning.*

1. Introduction

As academic educators committed to the training of future health professionals, we should understand and adress the new demands coming from health organisations and the changes that people's health has undergone in the last 50 years.

According to a report published in 2003 by the World Health Organisation (WHO), the most significant event of the last century in the world of health and disease has been the global rise in chronic disease. The increase in therapeutic efficacy of medicine and the consequent increase in human life expectancy led to a change in the nature of disease from acute to chronic. Considering the Italian situation, the percentage of people reporting at least one chronic disease in 2020 is 18%. According to ISTAT projections, in 2032 the elderly population will represent

about 27.6% of Italians: this means that the costs related to their health management will also increase exponentially.

Chronic diseases have many definitions, but it is common ground that they are are permanent, leave residual disability, are caused by non-reversible pathological alteration and require a long period of supervision, observation or care (Goodman et al., 2013). Living with a chronic condition may have different psycho-social consequences: after diagnosis, patients may feel negative emotions such as shame, guilt, anger or sadness; may experience also frustration due to health professionals' requests about dietary or life style. Regarding social dimension, chronic condition may also change family relationships, making patients weaker and more dependent with consequences such as shame or anger (Engle, 2001). Moreover, adult patients may be worried about their employment, future career and life plan (Frank, 2013). In addition, their personal identity, developed over a lifetime, may disappear (Charmaz, 2002). Considering these reasons, many patients may have problems in accepting the new, ill identity, trying to hide or even deny it (Ezzy, 2000).

Chronic patients have also to understand and accept that they are going to face a life-long condition, as well as they has to comply with physician's requirements (Sand-Jecklin, 2007). Adherence can be described as "the extent to which a person's behavior (taking medication, following a diet, and/or executing lifestyle changes) corresponds with agreed recommendations from a health care provider" (Haynes, 1979). Poor adherence to long-term therapies (an increasing phenomenon in every countries) appears related to negative health outcomes and increased health care costs (Iuga, McGuire, 2014): adherence rates to date have averaged around 50% (Payero et al., 2014). Several factors have a potential influence on patient's behaviour. To counter this trend, a large body of research and study on therapeutic education has been developed over the last fifty years. Therapeutic Patient Education (TPE) is a widely recognised health practice, considered an essential part of treatment of long-term diseases (WHO, 2023). However, most of the TPE performed in Italian hospitals and health services consists in lectures done by a nurse or a physician and listend passively by a patient or a group of patients, without any tailorizing of the educative contents or methods applied for each patient. Conversely, according to many studies, TPE could not achieve any goal if it doesn't consider the patient from an integrated perspective, taking into account all the dimensions implied in the patient's choice to protect himself/herself and his/her health (Bury, 1982; Charmaz, 1991). A previously literature review let to identify a systematic group of dimension which can influence the patient adgiustment to chronic disease and his/her chance to be adherent. Patients should possess or achieve: a) an adequate level of cognitive (high and low level), motor (fine and gross) and communicative (reception and expression) skills, useful for understanding and applying medical prescriptions; b) a supportive social network; c) a good level of satisfaction with some life needs, such as autonomy, competence, and relatedness; d) an adaptive decision-making style; e) a good lived experience of illness; f) some constructive cognitive and metacognitive coping strategies

(Bobbo, 2020; Bobbo, 2022). According to this perspective, since each patient may express a different synchrony in the amalgamation of all these dimensions, TPE becomes a very complex strategy to face. Therefore, health professionals who deal with chronic patients on a daily basis should acquire specific skills to promote and implement some personalised educational pathways that have a chance of being successful.

From these evidences, an innovative experience of teaching/learning was developed in a bachelor degree of the University of Padova (Italy), frequented by young students who wish to become health professional (particularly Health Care Educators). The course of 40 hours was carried out from February to April 2023. In this course I'm the teacher.

2. The teaching/learning experience

2.1 The rationale behind the didactic choices that was made

Students who are gain their bachelor represent adult learners that have specific characteristics and expectations which should be known and respected by the teacher in order to enable them to reach a good understanding of the subject and to acquire the competences they are supposed to achieve. Indeed, according to Knowles (1973), adults are driven to learn by intrinsic motivation, seeking to increase their autonomy and competences in the work they want to do in the future. Moreover, young adult are searching for more autonomy in the learning process too, because they wish to prove to themselves and to others that they could be considered adults and ready to work (Green, du Plessis, 2023). Beside, according to Mezirow (1981-2014) adult learning can't procede without reflexivity, that implies debate, argument analysis and decision-making processes.

In addition, specific complex skills and competences, such as those that seem to be necessary for dealing with chronic patients, as described above, cannot be taught using only a trasmissive training perspective (Pratt, Collins, 2000). The complexity of the system of knowledge, skills and competences students should acquire, requires a mixed method teaching strategy, combining both the trasmissive and the active methods: lectures, Collaborative Learning (CL) (Dillenbourg, 1999), Problem Based Learning (PBL) (Wang et al., 2008), Self-directed Learning (SDL) (Barrows, 2000) and Clinical Simulation (CL) (Giuffrida et al., 2023) where mixed and combined in this experience. In syntesis, in this experience a emancipatory perspective was applied (Giroux, 2020).

2.2 Materials and methods used in the didactic experience

The rationale described above could be realised by the use of a new form of workshop, in addition to some lectures: students were called to deal —autonomously and in small groups— with a specific assignament which consists in defining an educative plan for a patient whose

story was proposed by the teacher. Taking two stories from my experience of long visits to health services and hospital units, as teacher I can give the students all the information they need about the patients. Nevertheless, in order to leave them more autonomy in the learning process, I choose to stimulate them to ask me what they think could be useful at different moments in the process of writing the educational plan.

The didactic choices implemented during the course develops in five steps:

1. 15 hours were spent in lectures in which the theoretical basis of the subiect was explained and shared with students;
2. 5 hours were spent to tell two patients histories asking to students, after having listed them, to choose one and to form some group of work.

   The two stories regard:

   — a 60-year-old retired military man suffering from terminal cirrhosis who had a so severe unadherence that he wasn't a suitable candidate for the liver transplantation; but without it he has no chance of survival;
   — a 35-year-old woman with type 1 diabetes since the age of 12 who wanted to become mother so badly that she was prepared to risk her life, despite the opposition of her family, including her husband.

   After the presentation of the two stories, some tools were presented and shared with the students. They are some non validated tools useful to analyse the patient's dimensions define above. The tools were:

   — Nine forms suitable for assessing the different dimensions involved in the patient's adgiustment to illness: cognitive, motor and communicative skills, motivation style, learning style, decision-making style, lived experience of illness, social network, cognitive and metacognitive coping strategies;
   — Five dialogue facilitation tools useful for understanding the patient's: a) social support network; b) experiential learning skills; c) divergent and reflective thinking skills; d) sense of mastery; e) daily micro-planning skills (Bobbo, 2020);

3. Third phase: the next 5 hour were spent by the students carrying out a sort of short interview with the two patients (interacting with me, answering their questions based on the information I knew about the patients). In this first interview, students had the chance in ten questions to understand the patient's strengths and weaknesses and which forms and dialogue facilitation tools they could have used to better understand the patients' educational needs (CS was used).

4. Fourth phase: the next lessons (10 hours) were spent in groups working on this task, and from time to time one, two or more groups asked me to fill in a form or to talk about the experience of patient using the dialogue facilitation tool they have chosen among the battery I give them in the previous phase. In this way they could get more information and better define their educational plan, but through autonomous choices (CL, PBL and CS was used; SDL was stimulated).
5. Fifth phase: at the end of the course, 5 hour were spent checking together, teacher and students, the quality of projects realized by students: group by group presented their educative plan and a discussion was opened to link the patient's needs or goals identified by the students to the theory, recalling concepts and constructs listened in the first lectures. Through dialogue it was possible to develop and fill of the lectures contents, through processes of induction and contradictions mediated by the teacher help (Akhmedov, & Khimmataliyev, 2023). More of this it is possible for students to have feedback of their work through which they can do a training self-assessment (Pinedo et al., 2023).

At the end of the course, learning was assessed by means of a written test with closed questions. The average score obtained by students in the first two examinations was 24 out of 30 (min 15, max 30 for distinction). The students' personal feedback on the didactic choices implemented was very good, and the university's evaluation of the teaching averaged 9 out of 10. Students did not suffer from the workload of the course (workload rating was positive, 9/10).

3. Experience conditions and future implementation

The mix-methods strategy implemented in this experience has at least two conditions that must be met to be successful. The first is that the students should frequent the second or third year of studies (third in this case), because they should have acquired a certain ability of self-directed learning (Dillenbourg, 1999): they often had to search for information on their own and make some decisions about which form or dialogue mediation tools would be better to use at different times during the plan writing process. The second condition concerns the possibility for the teacher to know very well the histories of the patients he/she would use: he/she should know the patient's life preceding the diagnosis, the caractheristics of the patient's social network and the mood whit he/she faces the diagnosis and the therapeutic path.

With regard to a possible future application of this method, the teacher could play the role of the patient if he/she is able to have a thorough understanding of the feelings and emotions that the patient himself/herself may have perceived and expressed living his/her condition: a man or woman whose life has been disrupted by a diagnosis may have indeed many different life perspective (Ezzy, 2000), may be bizarre or grumpy (Charmaz, 1991). So, in the moments of interview or dialogue, the teacher shouldn't just answer to some questions, but try to put himself/herself in the other person's shoes, to live and think like the patient could do. This could

open the chance to make the interview simulation realistic for the students and functional for the learning process. Some similar experiences have been carried out with the help of some actors —the so-called structured patient strategies (Deakin et al., 2006)—. However, having an actor in the classroom for the entire duration of the group-work can be costly for the course.The teacher, on the other hand, can be present throughout the course, and he/she can also know his/her students and therefore be more fluent and effective, adapting his/her action and driving each student towards learning. Moreover, if the teacher is able to play the role in a realistic way, the interview can also become an opportunity for the students to experiment some relational skills in dealing with a grumpy, introverted or aggressive patient, learning to express the emotional work they are called to acquire as health professionals (Bobbo, Rigoni, 2021).

4. Conclusion

This experience, which will be repeated in the coming academic years, has shown the need to make creative choices from a training perspective (Obidovna, 2023), especially when the subject is so complex and, above all, when the teacher has to train professionals who will deal with people who suffer from a fragility that has disrupted their lives and their biographies (Bury, 1982; Williams, 2000). From a pedagogical perspective, it is fundamental that operators learn that each patient is a person, so he/she must be accompanied in the acquisition of a new identity, disrupted the healthy one he/she had before the diagnosis. For these reasons, health professionals should learn to deal with the pain and despair, as well as with the inner resources that a person can find in his/her adjustment, knowing the importance of honouring the patient's history (Charon, 2008). To do this, health professionals should acquire some specific competences that, according to Michielsen and his collaborators, can be identified with person-centred communication, interprofessional communication and teamwork collaboration, which can be implemented through didactic strategies in which students could try, improve and assess the level of their autonomous ability to reflect on a problem, to search for some solutions, to communicate and to negotiate in a working group (Michielsen et al., 2023).

In summary, as educators committed to the training of future health professionals, we have to deal with new strategies to give students more and more opportunities to experiment themselves in autonomous situations, under careful supervision, in order to learn to face the complexity of human suffering. This experience and the strategies used can be a starting point for the development of didactic knowledge which can be improve by combining the didactic path with a more rigorous assessment through a research study based on a pre-post test approach, measuring the knowledge and skills possessed by the learners before and after the training path. This experience has the limitation of having been carried out with a small sample of students (37) and only in one type of health professional profile. It would be useful to prove this training strategy also among nursing students and physiotherapists, as operators who often have to deal with chronic ill patients.

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