Engaging with patient variety in health professions education - HANDOUT

Our vision document outlines the challenges healthcare professionals face when treating a diverse patient population, including an attempt to unravel this patient variety.
This document contains suggestions how to integrate this 'engaging with patient variety' approach in medical education. The aim of this handout is to provide concrete tools to teachers and curriculum builders to develop and deliver medical education that is safe, diverse and inclusive. Next to this handout, the faculty offers other sources to facilitate and stimulate the integration of diversity in medical education: workshops, a database with resources in Canvas, and consultancy.

The list of practical suggestions is divided into two parts:

- Presentation of variety in patient cases
- General 'inclusive language' recommendations

Presentation of variety in patient cases

Based on the idea that variety in patients is the norm (and not an add-on), it is important to sensitise students (and staff) to consider this variety from the start. For students, it is relevant to become aware of the types of differences as identified in the table below, and how they use this information in patient consultations. To prevent stereotyping and 'othering', it is important to be mindful of how patients are introduced and described in the course material. For every course, learning task, and assignment (or medical issue, e.g. abdomen, lungs, psychiatry), both in the bachelor's and master's programme, it should be determined which ***direct*** and ***indirect aspects*** (from table below) are relevant. In principle, all the types of differences (***biological and contextual***) play a role in ***every patient case***. The details of this information differ per course, depending on what is relevant for the medical theme at hand. For example in CORE/Intervision the focus probably needs to be more on aspects relevant for communication and reflection (cultural orientation).

The approach that 'categories (indirect group information) are constructions' and that the 'normal vs. deviant' distinction is not the 'golden truth', might be an important lesson to include in the core curriculum for *all* students, including in research focussed curriculum parts.

Course and programme coordinators should verify that, overall, all these relevant aspects are covered in their course/programme.

Level of impact / Variations	Direct impact		Indirect impact
Biological	genetics, anatomy, skin colour, body posture, height, weight, body fat	muscle volume, reproductive organs, hormones, blood pressure, amount of lactase enzyme, psychological vulnerability	sex, age, ethnicity, (dis)ability
Contextual	medical history, family situation, epigenetics, work situation, living conditions, lifestyle, dietary habits, health capabilities, illiteracy, life story (history), language (skills)	communication styles, coping styles, using a wheelchair, economic circumstances ideas about: - health/death/life/etc., - how medicine should be delivered, - the doctor-patient relation	ethnicity, gender, age, socio-economic status (ses), level of education, nationality, religion, sexual orientation, cultural orientation, (dis)ability

Authors: S. Heeneman, M. van Lierop, J. Reijnders, J. Sieben, J. Vernooy, A. Zanting

Concrete ideas for presentation of variety in patient cases

- Integrate *sufficient relevant varieties* in the clinical reasoning decision tree.

- In *every* patient case, include information on (at least) these four elements:
  a. always use last name (first name is optional)
  b. date of birth
  c. place of birth (if necessary context)
  d. sex (m/f/other)

  So not only mention a patient's place of birth when this is non-Dutch or non-western, or a patient's age when it is outside the middle-age range, but *always* mention *all four aspects*.[1] This consistent presentation prevents stereotyping, and encourages students to consider which (ir)relevant characteristics need to be taken into account in clinical reasoning.

- Next to these four aspects, *always* include *contextual* information in the patient case besides *biological* aspects. Throughout the entire module or course, this contextual information in patient cases should reflect the variety among real patients, covering as many aspects as possible and moving past stereotypes. By including this information students learn to consciously consider which aspects may be (ir)relevant to take into account when making a diagnosis or drafting a treatment plan.

  Examples: a Dutch teenager, an Islamic director, an independent woman of 65 years old, a homosexual grandfather, a hetero teacher of 30 years old, a modest housewife from St. Geertruid, an illiterate grandmother, an unemployed single father with 4 children, an English speaking professor in a wheelchair, a smoking priest, a chess playing transgender patient, a student top athlete, a toddler with hearing impairment, an extravert actress, etc. etc. etc..

- In patient cases, *indirect aspects* (such as ethnicity, sex, age, religion) should not be presented as an immediate medical cause, but only as *illustrative information*.

  Example: instead of saying "it is to be expected that founder mutations can be different in different ethnic/racial populations. E.g. certain founder mutations only prevail with Ashkenazi Jews and in Japan (relatively isolated island)", it is suggested to say: "it is to be expected that founder mutations can be different for people living relatively isolated (for example Ashkenazi Jews or inhabitants of an island)".
  In this way, the direct cause (living isolated) is presented as a core aspect that is crucial to consider as a (future) doctor, whereas certain groups or circumstances are only mentioned as illustration.
  Example: people are not more frequently infected by COVID due to their non-Western migration background, but because they have different types of jobs or live together with many family members in small housing, which can be related to ethnicity. The link between ethnicity and a disease is explained by another (socio-cultural) factor.

- Ensure that patients' names reflect a variety of backgrounds (Fatima, Kees, Bèr, Genevieve, Mei-Lan..., also last names). Google offers examples of names that are popular in different parts of the world. As part of CORE training: ask patients how they want to be addressed (it can be offensive in many cultures to address patients by their first name).

- Ensure that pictures in the course material represent diverse backgrounds.

- Ensure that patients with a migration background are not only included in stereotypical themes such as female circumcision, arranged marriages, violence or (unplanned) pregnancy. These patients also get all sorts of diseases. The same applies to for example homosexuality and HIV.

- In case a patient's sexual orientation is relevant, implicitly refer to it without stigmatizing, for example by saying the patient is accompanied by her wife. The same applies to patients with a disability.

- Use cases to (subtly) question stereotypes instead of (implicitly) confirming them. Offering cases which are not in line with stereotypical expectations or images helps students reflect on their own implicit biases, to think more inclusively and to offer them role models. Play with prejudices about societal role models

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[1] For the moment, this suggestion does not concern assessment, since it contradicts an important assessment principle which argues to limit the amount of irrelevant information. Nevertheless, in order to follow the Constructive Alignment principle, 'engaging with patient variety' needs to be integrated in assessment as well.

Examples: present a female surgeon, or a male nurse, a professor in a wheelchair, a 65-year-old homemaker (instead of housewife), or a father (instead of mother) to come to the consultation hour with his child. Make connections (e.g. by using pictures) such as 'ambitious law student' wearing a 'headscarf' (as religious attire); or 'child wish' with 'professional athlete'.

- In case you need to mention a patient's skin colour (for example since it is relevant given a vitamin D deficit), then use descriptions such as 'lighter' or 'darker' skin colour.

- Identity aspects should be presented as equally relevant, without (implicit) distinction between 'standard' and 'deviation'. So female and non-Western aspects should not be presented as a deviation from the reference man.
  Example: menopause should not be presented as a deviation from the male body, and black skin not as aberrant from white skin.

- Avoid using references to culture in the sense of ethnicity or nationality, only use them when referring to values, habits, perspectives, expectations.

- Encourage students to reflect on their own personal (cultural) perspectives, values or standards, since these impact the treatment of patients. Self-reflection should be emphasised, as it is essential to realise that in some situations there is no golden standard to determine what is normal.

- Encourage students to ask questions like: 'what if this patient were not X but Y, how would that change your diagnosis and/or treatment?'. In order to have a meaningful discussion and to limit the risk of stereotyping, concrete examples of X and Y that are relevant for the medical topic at hand, should be provided. Students could be stimulated to look for literature that addresses the impact of patients' biological and contextual variations (in the Canvas database, or perhaps to find out that such literature is scarce).

If these suggestions are implemented throughout the ***entire curriculum***, a specific extra course on diversity or intercultural communication is not necessary, and even not recommended. Teaching about diversity in a separate course suggests that 'engaging with varieties' is something exceptional and difficult, whereas patient diversity is a fact, a basic starting point.

Inclusive language suggestions

Below are more general suggestions that can be applied in patient cases, but also in other texts or in classroom communication. This is not a comprehensive list; more ideas and background information can be found in the Canvas database.

- Use references to people (students or patients or doctors) in which everybody feels recognized
  Example:
  - If a male patient in case 1 is referred to as 'patient', and a female patient in case 2 as 'a woman', then the implicit message is conveyed that a 'standard' patient is male.
  - Do not always talk about father and mothers, which implies that hetero is the norm. Refer to 'parents' or 'partner'.
  - Try to use all-encompassing gender terms, such as 'dear students' (instead of dear 'ladies and gentlemen')
  - Do not only refer to a patient's ethnicity if they are non-white: this implies that a white patient (with Dutch background) is the norm.

- Do not use references that are scientifically problematic and historically controversial. Some terms are very broad and not specific. Also, they can be experienced as hurtful due to associations with slavery, colonialism or inappropriate us vs. them thinking. [2]
  Examples: race, non-Western, allochthone, negroid, handicapped…

  Avoid using the word 'race' and replace it with 'ethnicity'. There is broad scientific consensus that genetic races do not exist – genetic differences between two black persons can be bigger than the differences between a black and white person. Ethnicity is a more dynamic term.

  Terminology that originates from racial science, and an alternative:

[2] van den Muijsenbergh METC, Quarsie J, Jako S. Onderscheid naar etnische afkomst. *Ned tijdschr geneeskd*. 2021;**165**:D5445

- Negroid -> replace it by giving a description of the migration background, such as ‘Creole-Surinamese Dutchman’, ‘Ethiopian-Dutch’ or ‘African-Dutch’
- Caucasian -> replace it by giving a description of the migration background, such as ‘West-European’ or ‘European-American’
- [in Dutch] blank -> replace by ‘white’. ‘Blank’ is not an objective and neutral term, but a term that emerged in relation to ‘the other’ during colonialism. ‘Blank’ is associated with pure, clean, untainted, colourless.

- Avoid using the word ‘allochthone’ and replace it by ‘migration background’. The term allochthone (from another country) excludes and is incorrect for second generation migrants who are born in The Netherlands.

- Avoid using general terms like ‘handicapped’ or ‘disabled’ and replace it by more precise terminology for example ‘a visual disability’, which describes the specific disability.

- People are first and foremost a person and not a (chronic) disease or impairment. Try to use names or say ‘a patient *having* a certain disability’ instead of saying ‘*is* disabled’ or referring to ‘the deaf’ versus ‘the normal’ (referring to for example a sister). People should not be reduced to their impairment but be presented in a way that indicates that the disability is only one aspect of the person’s identity. Alternatively, ask patients with a chronic disease and/or disability how they identify themselves and want to be addressed (some people do identify as – for example – ‘an autistic person’).

- More in general: do not reduce people to one aspect of their identity. A white, practically educated, lesbian woman does not have the same health outcomes as a black, academically trained, heterosexual woman, although they both belong to the category ‘woman’.

- Never use ‘us’ and ‘them’ to indicate differences between people. Using ‘us’ may imply that not all (students, colleagues, patients, etc.) belong.
  Example: students or staff with a migration background may feel excluded when is spoken from the perspective of a majority narrative (‘we’ like beer, ‘we’ like hockey) as if this is ‘normal’ for everyone present.

- Be mindful that Dutch patients with a migration background are not only associated with that migration background. Use terminology such as ‘Dutch patient with Turkish background’ or ‘Turkish-Dutch patient’, and not: ‘Turkish patient’ (unless it clearly concerns a non-Dutch patient from Turkey).

- Diversity and inclusion regarding gender concerns more than equality between men and women, but also about transgender persons and people outside the gender binary. Trans men are men, and trans women are women. And diversity and inclusivity regarding sexual orientation concerns more than only hetero- and homosexuality, but also bi-sexuality and a-sexuality (see helpful video in Canvas database).