PODCAST Winny Ang & Liesbeth Verpooten
English transcript

(0:00 - 0:24)
Welcome to UAntwerp's podcast series on diversity and inclusion in education. Today's guests are Winny Ang and Liesbeth Verpooten, both of whom are teaching assistants at the Faculty of Medicine and Health Sciences. They're here to tell us about the importance of inclusive thinking and working within healthcare, where communicating with the patient plays a critical role.

(0:24 - 0:55)
Together with many colleagues, Winny and Liesbeth teach classes in the Bachelor and Master of Medicine, in the clinical and the doctor and society learning trajectories to be exact. Winny also conducts PhD research into the theme of diversity and medical education, with the assistance of Liesbeth. We hope that the way in which aspects of inclusion and diversity are addressed in the Medicine programme at the University of Antwerp will inspire lecturers in their own educational practices.

(0:56 - 1:11)
Tell us, what's the substantive focus of your clinical learning trajectory?

The clinical learning trajectory comprises two aspects. On the one hand you have the medical-technical skills and on the other the communication skills. That's what Liesbeth and I teach as well.

(1:11 - 1:34)
The common thread there is that it's experience-oriented education and self-directed. What topics are covered?

Active listening, informing, building relationships, diversity. We think it's very important to prepare students to communicate in a patient-oriented way based on those communication skills and that experience-oriented, self-reflective education.

(1:35 - 1:54)
We start out with basic skills, but in the master years we progress to delivering bad news, dealing with people who are psychologically vulnerable, and conflict management. And we start going into some specialised topics that are also important with respect to communication skills. We always work in small groups.

(1:55 - 2:07)
About twenty students. We also have practice sessions with simulated patients, where all students practice their communication skills. That's a group of eight people with a simulated patient.

(2:08 - 2:34)

So good communications and empathising with the patient are at least as important as theoretical knowledge. Do you apply the same focus to the doctor and society learning trajectory?

Good communications are always the common thread for us, also within doctor and society. But in this learning trajectory we obviously also zoom out a bit and look at macro concepts within society.

(2:34 - 3:02)
We introduce the students to groups and patients that sometimes have a different way of looking at diseases and health. We also discuss minority groups, people that sometimes fall behind because they're not involved in healthcare. We believe that in prevention and health promotion, it's important to also involve those groups and pay attention to them in medical education.

(3:02 - 3:33)
So would it be fair to say that a patient-oriented approach is central to both learning trajectories?

I think the common thread in our education is that we try to provide tailored assistance to patients. We don't believe in uniformity in this respect, but we really look at the needs of each patient. And it's also important to be conscious of what kind of doctor you are. That's why self-reflection is an essential element in our communication education.

(3:34 - 4:00)
Alongside the focus on patients, we of course also focus on our students. It's not only what we teach, but also the way in which we teach it. It's a whole parallel process to make sure students feel at home and feel heard within our education. We think it's very important to create this environment within a university.

(4:00 - 4:18)
We also continuously draw those parallels between student focus and patient focus. And within the latter, we also focus on the person behind the patient. In the past, you would typically talk about clinical pictures.

(4:19 - 4:39)
Now we talk about what kind of patients you have. And then we also look at the personal traits of that patient. We really try to apply that focus in the classes, at the micro level within communication, the macro level within doctor and society and then the meso level, where we integrate it in the curriculum, throughout the learning trajectory.

(4:39 - 5:18)
In the practice classes you work with simulated patients, so the doctors in training learn to have a good conversation with the patient. What advantages are there to working with simulated patients?

Perhaps it's important to say that for those classes we don't ask the simulated patients to play a part per se, they stay very close to themselves. Which means the students really feel

what it's like to ask personal questions, questions about identity or social background, to the person they have in front of them.

(5:18 - 5:44)
So that's not really roleplaying. We also evolved a bit in this respect, because we used to have a special pool of simulated patients for the diversity classes within communication. And those simulated patients themselves would ask: how come we're a special group that's selected for this? While one of the goals of our classes is to look at your own diversity and your own frame of reference as a doctor.

(5:44 - 6:05)
So it was a bit contradictory to engage people especially for this purpose. We therefore decided to try to make the general pool of simulated patients more diverse and more inclusive for everyone.

Great to hear that you were able to integrate authentic learning into those practical classes that way.

(6:05 - 6:29)
At the start of this conversation, you indicated students have to grow aware of their own professional development. Learning trajectories that incorporate skills trainings are, indeed, suitable for mapping personal growth. So how do you go about this in concrete terms within the Medicine programme?

On the one hand, in the communication training we teach there's a lot of room for feedback.

(6:30 - 6:43)
The students are taught to give feedback to one another. Simulated patients also receive training in giving feedback to the students. We really try to create a space where learning processes can be facilitated in safe ways.

(6:44 - 7:14)
If it concerns small-group education and if you as a lecturer try to frame everything correctly and give space to the students to practice and make mistakes, you automatically create a space where one can reflect and facilitate one's growth. In addition, we believe it's important that parallel to that, we as lecturers also continue to learn. That's why we regularly have reflection moments with our communication team.

(7:15 - 7:39)
What we also do, for example, is record our entire class and scrutinise our performance. This is what we expect from our students to. We believe that if we ask them to grow as professionals, we as lecturers should do the same. Even when it can be a bit uncomfortable to see and scrutinise yourself, to make space for that.

(7:39 - 8:03)
For us, that creates all kinds of growth and reflection opportunities as well.

I can imagine that following up on such a personal growth pathway requires proper guidance, both process-oriented and personal. What's the didactic approach for this with such large student groups? I can imagine that's tricky.

(8:05 - 8:45)
Yes, given the large groups of students in doctor and society we of course have to teach in lecture halls, but we still try to make it experience-oriented. For instance, in the first year we really send them to patients' homes, so they see their family situations. That's someone who, like everyone, has a diverse background, but also a disease or some other reason for being in the healthcare system. We then have students ask questions about that social background, but also about dealing with the disease.

(8:47 - 9:21)
We also have the students consult with the patient, making the learning process so self-directed that they themselves see in what direction they're going and what skills they could improve. And they're also welcome to come to class. So we think the patient's voice is very important and the students present the case to their fellow students in a small group, not to the entire lecture hall.

(9:22 - 9:42)
The patient is invited to share their reflections about the process. This is how we not only put the patient but also the person behind the patient centre stage. We also think this is a great example for students of how you can have students and patients participate in the classes from the outset.

(9:44 - 10:23)
That may be something we struggle with occasionally, because we like to involve experience experts as co-lecturers in every class, but at the same time we have to be careful that we don't devolve into the stereotype of the refugee, the person living in poverty or the person with gender issues. That it's not always the voice of one person. And that's a difficult balance to strike, because at the same time we feel that we should pay sufficient attention to all of those specific groups.

(10:23 - 10:46)
In the end, we want to keep seeing everyone for the unique human being they are, even if they're part of a certain minority. And if you invite an experience expert to a lecture hall, it's clear that students benefit a great deal from this. Like that's what reflects the truth.

(10:46 - 11:03)
So that's a difficult balancing act. That's the nice thing, we teach our classes both within small-group communication education and to the large groups. We have a metaphor or a concept, the kaleidoscope, which we introduce in the first year.

(11:03 - 11:21)
That's kind of the metaphor that sums up what Liesbeth said, that people consist of a great many aspects, many different identity dimensions. And in those doctor and society classes we can refer to this all the time. For example, we point out that if someone is coming to talk to the group who's from a poverty background, they're not just a poor person.

(11:21 - 11:40)
And that nuance, and the continuous reflection and awareness development, are very important to us within the programme. And because we are both teaching those two classes, it makes it easier to address this. It's interesting to home in on a certain dimension and it has consequences for structural inequalities in the healthcare domain.

(11:40 - 12:03)
At the same time, however, you have to stay vigilant and try not to reduce someone to that dimension.

It's great to hear that you are making so much time for reflection and constructive feedback about the way in which doctors communicate with the person behind the patient during a consult. And I can imagine this will undoubtedly lead to doctors entering the labour market with an inclusive mindset.

(12:04 - 12:27)
That's our hope, of course. We know from practice that when students start doing their internships, they are confronted with a world that's different from the one we've created. And that there are different kinds of situations and role models at different levels, too little time and other challenges, which means it can be quite difficult.

(12:27 - 12:59)
The advantage is that during the internship year, we have days when the students come back to university. This includes one for diversity, but also for all kinds of other topics, creating space to reflect on those things again. Because once you start using the knowledge and skills that you've acquired during your studies; on the work floor, that makes a different dynamic. Yes, we actually try to make those classes… Those sometimes lead to concepts that are more philosophical and less applicable to practice.

(12:59 - 13:27)
When students come back to university, those philosophical concepts are revisited and they really turn into practical tools. You take a real-world case or situation as your point of departure and then you think back to all of those concepts you've been presented with in the past six years and how you can practically apply those in the remainder of your internship. So then you actually track back by starting from something that's very much rooted in the real world.

(13:27 - 13:41)
Can I just add something? You asked how such a reflective process is facilitated with students. One of the projects we have within the clinical skills are the tutorships. Those play a very important role in this respect.

(13:41 - 13:55)
That started two or three years ago. It involves students receiving tutoring throughout the bachelor in groups of ten people, four or five times a year.

(13:56 - 14:28)

In the master years the same concept is used, but students are in a different group with a different tutor. That's a way to talk about various topics or things that affect students or are on their minds in as safe a context as possible.

Yes, I can imagine it's not easy to organise this from a practical point of view, but that's it definitely a major added value for the students' reflection processes.

(14:29 - 14:57)
You already briefly mentioned the doctor and society learning trajectory, in which attention is also paid to diversity amongst patients. What kinds of themes related to diversity-sensitive thinking come up in this trajectory?

We actually use the dimensions of the kaleidoscope as a basis. The concept Winny talked about before, the different identity dimensions.

(14:57 - 15:23)
What we do in each class is zoom in on one of those dimensions and also try to zoom out again. The subjects are religion, ethnicity, gender, sexual orientation, religion, philosophy of life, social class, handicap, talent, challenge. Yes, that's all of them.

(15:24 - 15:35)
Life phase might also be an important one.

An extraordinarily broad, varied and interesting range of themes you discuss.

Yes, that's actually a conscious choice.

(15:36 - 15:47)
For a long time there was a tendency to discuss diversity purely in terms of ethnicity or people with a migrant background, which of course is an important aspect. We also notice that when we do outreach. Liesbeth and I go to a lot of different places to do outreach.

(15:47 - 16:00)
Those are the main things people ask questions about. But we try – and I think that's key – to have a broad outlook from the start, thereby making all of the other aspects just as important as migrant background.

(16:01 - 16:19)
It's also a conscious choice to position the project we were talking about before, with those patient interviews Liesbeth mentioned, in the first year. That's actually students' first acquaintance with our doctor and society diversity learning trajectory. It's a very experience-oriented exercise right away, simply embedded in society.

(16:19 - 16:33)
And for us that's a great stepping stone to zoom in on those dimensions in the following years. Yes, it's built up very nicely throughout that learning trajectory. It's of course a process of trial and error.

(16:35 - 16:44)

We of course also try to engage in self-directed learning ourselves and evaluate our own classes every time. There's a lot to do still.

(16:44 - 16:54)
If the sky were the limit, I think there would be many other things we could do. But yes, we really try to make that our common thread.

(16:54 - 17:36)
One final question perhaps. Based on your approach, how would you describe inclusive education to doctors in training?

As we said just now, for us it's a constant search to make both the patients and students, as well as ourselves as lecturers and the university, feel at ease with what we do and to give everyone a voice in one way or another. Which of course requires a very tailored approach on the one hand, but there's also the challenge of creating that space for reflection and awareness. Which then kind of creates the need for the university to also create a safe space somewhere, where students feel at home or feel like they belong, as we like to call it.

(17:37 - 17:55)
In that respect, I think it's very important to look at the person behind the patient and also to look at the person behind the student. And the person behind the lecturer. We do outreach in this area in different places, which makes it an experience for us as well, and gives us the opportunity to finetune the outreach programme.

(17:56 - 18:16)
And that also makes us realise – and we also teach our students that – that there's also a person behind the doctor. A doctor also has a frame of reference and norms and values. We often assume – and perhaps students also do – that a doctor is a neutral entity moving through a vacuum, but that's of course not the case.

(18:17 - 18:51)
We believe developing an awareness of your own frame of reference and your frame of reference as a future doctor is very important in not focusing on the other person, but on your own frame of reference and to connect to it, or explore it in further depth to find the connection with the frame of reference of the other person, of the patient or student. But that's a continuous search, which involves covering the same ground over and over. And not avoiding the areas of tension Liesbeth mentioned before.

(18:51 - 19:18)
We see every area of tension as a kind of beginning of a possible transition. Sometimes, we as people are inclined to smooth over those areas of tension, because diversity isn't always an easy theme. Although we feel that too, it's precisely that feeling of discomfort and talking about it and reflecting where it comes from and – possibly – how to deal with it.

(19:18 - 19:34)
I'd like to thank you both very much for this interesting conversation. I'm convinced the communication training you deliver to these Medicine students will provide society with

empathetic and open-minded future doctors, who pay ample attention to the person behind the patient, but also to the person behind the doctor.