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Stanford MedX|Ed offers a look into the future of medical education and what it might mean for patients

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Two members of the *diaTribe* team recently had the opportunity to attend the third annual Stanford MedX|Ed in sunny Palo Alto, California. A spin-off of Stanford's medical innovation initiative, MedicineX, the MedX|Ed event was founded in 2015 to gather stakeholders from every aspect of healthcare to discuss the future of medical education. The conference covered exciting innovations in technology for medical school (including the very trendy incorporation of Virtual Reality) and how to improve diversity in medical schools. The diaTribe team was particularly excited, however, to hear the consistent emphasis on improving the patient experience. The atmosphere was exhilarating with a real sense that people came to drive measurable change. Hope, creativity, and collaboration were key tenets of almost every talk. The many insights, innovations, and heart-wrenching stories throughout the weekend were tied together by five key themes.

1. Patient empowerment

MedX|Ed emphasized a commitment to including patients at every stage of healthcare and health education. Patient advocates and e-patient representatives were part of almost every panel and shared their stories in every series of talks. MedX|Ed also placed an admirable emphasis on access, with most talks livestreamed so everyone could participate and learn. If you are interested in hearing more feel free to check out the MedX|Ed Facebook or YouTube channels.

2. Shared decision-making

Speakers repeatedly highlighted the need for shared-decision making between providers and patients. Dr. Larry Chu, director of the conference, pointed out that this requires the healthcare system to empower patients to become experts in their own care. This doesn't mean everyone needs to go to medical school or memorize the side effects of various drugs. Rather, it involves recognizing that patients are the only true experts in their own experience, and empowering them to tell their stories and express their priorities. For example, and endocrinologist might be an expert in diabetes overall, but a patient should be seen as an expert in *her* diabetes. Only the individual patient will know what she values most, whether this means simplicity of management, increased tie in range, prevention of long-term complications, etc. The provider's responsibility is to deliver care that responds to these priorities, rather than just dictating to the patient what the priorities should be.

3. Interdisciplinary collaboration

Another key takeaway from this conference was the desperate need for collaborative teams with members from multiple professions and disciplines. Several speakers shared success stories from interdisciplinary medical education, bringing together students training to be doctors, nurses, pharmacists, psychologists, social workers, and more, and thus encouraging these students to break out of their traditional hierarchies and boundaries.

In one of the most interesting talks of the weekend, Dr. Neha Sangwan explained that she sees communication breakdowns and broken trust as the major barriers to successful interprofessional work. Disagreements and hierarchies frequently lead to low employee morale and poor patient care. Dr. Sangwan explained the concept of different "levels of agreement," ranging from the simple acknowledgment that someone spoke all the way to true agreement when specific details are acknowledge and agreed upon by those involved. Poor communication and broken trust and can be rectified with better communication of expectations for what constitutes an agreement.

4. The content and structure of medical education needs to change

Clay Johnston, Dean of Dell Medical School, explained that the structure and content for medical school was detailed by Abraham Flexner in 1910, and has remained largely unchanged since. Since then very little change has occurred; however, there are many proven ideas that could be implemented to improve the system. Dr. Rishi Desai of Stanford shared his finding that, on average, 15% of students attend their medical school classes. This statistics suggests that students feel they gain little from teachers that they can't already learn from textbooks. Presenters at MedX|Ed shared numerous possibilities for using technology to "flip" the traditional classroom and support medical student learning and engagement.

Two other key improvements are creating a culture of feedback and incorporating patient partnerships. In the opening keynote address, Dan Schwartz, Dean of the Stanford Graduate School of Education, argued that a lack of feedback is a key reason why there have been few changes to the structure of healthcare. Doctors may be unreceptive to feedback because they need to appear as confident experts, particularly to patients. Yet patients are the ones who can give the most valuable feedback about care methods. This paradox could be addressed by making feedback an early and constant element of medical education. Heather Davidson, an e-patient advocate, has participated in the Vanderbilt Program in Interprofessional Learning (VPIL). In this program she went into the medical school classroom and worked with students on self-designed improvement projects. This facilitates interprofessional work and accustoms students to shared decision-making and awareness of patient priorities.

5. Increased role of technology in health

Dr. Kunal Patel outlined six ways technology can be effectively used in healthcare systems: by improving healthcare workforce capacity, helping recruit and retrain healthcare professionals, creating collaborative learning, saving money on more context specific training, global e-mentoring, and finally creating a virtual community of practice with a way to exchange ideas. Later presenters offered concrete examples of these principles, including Virtual Reality programs to teach residents how to talk to vaccine hesitant families and help students practice laparoscopic surgery but is still not widely used.

Dr. Dhruv Khullar also proposed technology as a key to communicating science to general public. He noted a crisis of widespread scientific misinformation and a lack of public knowledge of new discoveries. Using social media or other mediums, the scientific community could dispel inaccuracies and increase general interest in research.

Lastly, we were particularly excited to see how patients could be empowered through technology. Claire Snyman, an e-patient scholar, was diagnosed with a rare condition and felt that she had hundreds of questions her doctors couldn't or didn't answer. She turned to Facebook and quickly found a group of people with the same condition. She found support and felt much more in control of her health. She also was able to get data on her rare condition from her group, which she took to her doctor and co-authored a paper on new best practices for treating her disease, a clear illustration of the power of social media for empowerment, community building, and even data collection.

MedX|Ed is an "Everyone Included" event, meaning that participants from a wide variety of backgrounds joined the conversation: healthcare providers, teachers, patients, caregivers, insurance representatives, medical students, technology designers, and even the adorable service-dog-turned-conference-mascot, Zoë. This Everyone Included principle, and the technologies, tools, and conference design elements that it involved, were a valuable demonstration of the collaborative nature of the next generation of health education and care.

Jacqueline Anders and Ben Pallant attended MedX|Ed and contributed to the writing of this piece.

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