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Chapter

Patient Feedback to Enhance Residents’ Learning: A Patient and a Resident Perspective

Mana Nasori, Lindsay Bank and Fedde Scheele

Abstract

Patients are becoming more involved in healthcare, however, their involvement in postgraduate medical education (PGME) is often less prominent. We provide insight into patients’ and residents’ perspectives regarding possible topics for patient feedback, to increase its use and effectiveness in PGME. Semi-structured interviews with 20 purposefully sampled patients were done and 15 residents filled out a fully qualitative questionnaire. The sample size was not calculated as we aimed for data sufficiency. Content analysis was inspired by grounded theory. Topics mentioned by patients and residents were communication skills and communication of medical knowledge. While patients find organizational matters and personal aspects important topics, residents do not. Patients intend to provide feedback on task-, process-, and self-level, whereas residents do not wish to receive feedback on self-level. Topics mentioned by patients corresponded with various CanMEDS roles, that is, communicator, collaborator, professional, and leader. Feedback directed on task- and process-level would be of residents’ interest, including feedback on the physician-patient relationship and communication of medical knowledge. Patient feedback should not only focus on communication skills but also on other CanMEDS roles. To provide effective feedback and ensure that it remains at the level that enhances residents’ learning, patients should avoid giving feedback on self-level.

Keywords: patient feedback, residents’ learning, postgraduate medical education, feedback levels, CanMEDS roles, patient feedback topics

1. Introduction

The healthcare system has put emphasis on patient-centered care [1] by empowering patients to have an active role, for example, by being involved in their personal care [2] and by contributing to improvement in the care process [3, 4]. Although patients have become increasingly involved in healthcare, their involvement in postgraduate medical education (PGME) is often less prominent. Whereas, patients’ perspective and feedback on residents’ performance could be valuable for enhancing residents’ learning as well as the quality of healthcare in general [5]. Furthermore, expanding the involvement of patients in PGME would be in line with the current trends in healthcare. This study builds on the conception that patients are obvious
members of the educational team in workplace-based learning. We aim at finding topics for patient feedback that patients and residents agree on.

Obviously, feedback and reflection are crucial aspects of residents’ learning [6]. Residents receive feedback in the workplace-based learning environment, in which the relationships between patients, residents, and medical supervisors are essential [7]. Feedback is the result of observing performance and has the purpose to minimize the gap between the current performance and the desired goal [8]. Current feedback guidelines within PGME have put an emphasis on providing effective feedback for medical supervisors in order to enhance residents’ learning [6, 9]. Medical supervisors give residents feedback on different competency roles based on the competency framework of the Canadian Medical Education Directives for Specialists (CanMEDS), to ensure that residents possess a range of various competencies [10]. On the other hand, Lai et al. noted additional feedback from patients as an educational tool to enhance the consultation skills of medical students as well [11]. Additionally, research has shown that patients can enlighten blind spots and suggest new opportunities for learning [12]. Furthermore, Crotty et al. reported the importance of patient feedback by means of OpenNotes in graduate medical education (GME) [13]. Whereby patients were able to look into the residents’ notes and provide feedback. Although residents considered OpenNotes in GME effective, some concerns were made about the patient-doctor relationship [13].

Despite the value patients’ feedback could potentially have for residents learning, there have been no studies to our knowledge that focused on the feedback topics that patients actually wish to provide feedback on in order to enhance residents learning. Studies so far have mainly focused on patient feedback regarding the communication skills of residents [3, 14–16], while medical training includes more competencies than communication skills alone [10, 17]. Even so, the current feedback systems that are in place within PGME also involve other dimensions/areas of clinical practice rather than communication skills only. Feedback from patients on other aspects of the medical profession might be valuable for learning as well. Additionally, little is known about both the patient feedback topics for resident enhancement and the effectiveness of feedback from patients.

The purpose of this study is to improve PGME by means of patient feedback. This study provides insights into both patients’ and residents’ perspectives regarding patient feedback topics, in order to increase its use and effectiveness in postgraduate medical education. Therefore, the research question answered in this study was: What are the feedback topics patients and residents provide for the development of patient feedback into PGME for the purpose of enhancing residents’ learning?

2. Methods

2.1 Study design

In order to explore the potential content of patient feedback, a qualitative approach was chosen to investigate the perspectives of both patients and residents regarding patient feedback topics. Two different qualitative methods were used. The first perspective was gathered by means of semi-structured interviews to enable patients to explain their thoughts on patient feedback more in-depth as knowledge of patients’ perspectives is limited [18, 19]. Whereas the perspective of residents was collected with the use of fully qualitative questionnaires. Qualitative questionnaires
are used to collect qualitative data. The qualitative questionnaire consisted of a set of open-ended questions which allowed residents to write responses in their own words, instead of choosing from fixed response options. By means of this, residents’ ideas on patient feedback topics were explored, while not investigating the depth [19, 20].

2.2 Setting

In order to ensure that residents possess a range of various different intertwined competencies, the CanMEDS competency framework is integrated with all PGME programs in the Netherlands [10, 21]. This framework consists of seven medical competency roles: medical expert, communicator, collaborator, health advocate, scholar, leader, and professional (Table 1) [10]. Residents receive feedback on these roles in order to become competent physician. This study was conducted at OLVG hospital in the Netherlands. This hospital is one of the largest teaching hospitals in the Netherlands facilitating more than 20 different PGME programs.

2.3 Sampling and recruitment

During the study period from January 2017 to May 2017, both patients and residents were sampled purposefully. Patients visiting the outpatient clinic of several departments were informed about this study and asked to participate by the main researcher (MN). After informed consent was given, the interview took place after

<table>
<thead>
<tr>
<th>Competency roles</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Expert</td>
<td>Disclosing patient history, performing physical examination, investigations, and setting up patient-centered management plan.</td>
</tr>
<tr>
<td>Communicator</td>
<td>Establish a relationship with their patients and their families in order to collect and share essential information for effective health care.</td>
</tr>
<tr>
<td></td>
<td>Determine patient perspectives regarding their fears and thoughts about the disease/treatment.</td>
</tr>
<tr>
<td></td>
<td>Inform patients with the best available evidence and support patients in considering the best option.</td>
</tr>
<tr>
<td>Collaborator</td>
<td>Collaboration with patients, families, physicians, and other medical staff.</td>
</tr>
<tr>
<td>Leader</td>
<td>Contribute toward improving health care delivery by being involved in new developments.</td>
</tr>
<tr>
<td></td>
<td>Demonstrate leadership in professional practice, manager planning, finances, and practice.</td>
</tr>
<tr>
<td>Health Advocate</td>
<td>Physicians are accountable to take responsibility for putting effort in order to improve patients’ health and well-being.</td>
</tr>
<tr>
<td>Scholar</td>
<td>Engagement to excel in practice by continuously learning, teaching others, reflecting on evidence, and contributing to scholarship.</td>
</tr>
<tr>
<td>Professional</td>
<td>Demonstrate clinical competence devotion to continuous professional development.</td>
</tr>
<tr>
<td></td>
<td>Commit to its own health and well-being in order to provide optimal care toward patients, including professional performance and managing influence on personal well-being.</td>
</tr>
</tbody>
</table>

Table 1.
CanMEDS competency roles examples.
their consultation with their medical doctor. During a resident lunch meeting, residents working at the OLVG hospital were also recruited face-to-face by the main researcher (MN). The researcher had no personal or professional ties with the participants or the medical doctors whose patients were approached. The sample size was not calculated prior to the study as we aimed for data sufficiency, which means that the data should be rich enough to answer the research question [22]. We determined data sufficiency by reaching a consensus with the research team.

2.4 Data collection

All in-depth interviews were performed with an interview guide, including example questions and probing questions (Appendix I). Frames were used in order to understand a patient’s reasoning on feedback topics [18]. During the interview, the patient had the freedom to discuss their perspective on the topics they considered valuable to be discussed. Afterward, the interviews were summarized for member checking by the participants. All interviews were performed, audiorecorded, and transcribed verbatim by the main researcher (MN). After transcription, the audiorecords were erased and the transcripts were anonymized.

To understand what feedback topics residents would like to receive from patients, qualitative questionnaires were handed out during a resident lunch meeting at OLGV hospital (Appendix II). The main researcher (MN) was present to ensure completion of the questionnaires. The qualitative questionnaire consisted of six questions and took approximately 5 minutes to fill in. All questionnaires were anonymous as they did not require to fill out names.

2.5 Data analysis

A content analysis inspired by the grounded theory was used. Both the interview and questionnaire data were analyzed separately before comparison. To allow new insights, open, inductive coding was used. All transcripts were coded by the main researcher (MN). The analysis started immediately after the first interview. The transcripts were coded by attaching keywords (“codes”) to all text fragments that were considered relevant to help answer the research question, subsequently, the codes were categorized. To enhance reliability, two interviews were analyzed by a second researcher (LB) using open coding and then discussed extensively. During this discussion, differences in interpretation were discussed and some codes were refined which led to the creation of the first version of the code tree. After coding 15 transcripts, no new codes were derived. The answers to the open-ended questions of the questionnaires were analyzed by the use of open coding as well. Subsequently, the derived codes were categorized, creating a separate code tree. Thereafter, the derived key themes from the interviews and questionnaire were discussed and compared in depth within the research team until a consensus was reached. All coding was performed using qualitative data analysis software (MaxQDA, version 12). We followed the consolidated criteria guidelines for reporting qualitative studies (COREQ) when writing the article [23].

After identifying the different feedback topics described by the participants, these topics were then categorized depending on which feedback level it is aimed at. Feedback can be aimed at a task level, which describes feedback about specific procedures and how well certain task is performed. Feedback on the process level is more specific to processes related to accomplishing a certain task. This self-level feedback
describes feedback on the person’s self, whereas self-regulation feedback includes interaction between control, confidence, and commitment [8, 9].

2.6 Ethical considerations

The study was approved by the ethical review board of OLVG hospital (WO 17–050). All participants received an information letter explaining the purpose and procedure of this study as well as the voluntary nature of participation. Informed consent was obtained from all patients.

3. Results

3.1 Participants

Between January 2017 and May 2017, 20 patients (n = 20) from OLVG hospital participated in this study. The participants were between the age of 21 and 74 years old, recruited from 12 different departments (Table 2) and half of them were female. The interviews lasted between 10 and 40 minutes. Four patients refused to participate due to lack of time or interest. A total of 15 residents, recruited from eight different departments, filled in the questionnaire (Table 2).

Below, the findings will be presented in two sections; patients’ perspective and a residents’ perspective, after which the two will be compared.

3.2 Patients’ perspective

Generally speaking, all patients were able to put forward several topics for providing feedback to residents. However, it became apparent that patients who had mainly positive experiences with residents or other physicians had more difficulties providing topics compared to patients with rather negative experiences. Patients did not mention topics they prefer not to provide feedback on.

<table>
<thead>
<tr>
<th>Involved department patients (n = 20)</th>
<th>Involved department residents (n = 15)</th>
</tr>
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<tbody>
<tr>
<td>Cardiology</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Ear, nose, and throat</td>
<td>Ear, nose, and throat</td>
</tr>
<tr>
<td>First aid</td>
<td>Internal medicine</td>
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<td>Internal medicine</td>
<td>Lung disease</td>
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<td>Lung diseases</td>
<td>Neurology</td>
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<td>Neurology</td>
<td>Obstetrics &amp; gynecology</td>
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<td>Obstetrics &amp; gynecology</td>
<td>Oncology</td>
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<tr>
<td>Orthopedics</td>
<td>Psychiatry</td>
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<td>Pulmonary medicine</td>
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<td>Radiology</td>
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<tr>
<td>Sport medicine</td>
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<td>Surgery</td>
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Table 2.
Departments patients and residents were involved.
3.2.1 Involvement in medical decision making

Patients expressed that they wish to provide feedback on how a resident involves them in the process of medical decision making during which the resident gives them advice on the best options for treatments. They reported that they find it important that the final decision is up to them. This topic was explicitly mentioned because patients currently experience little room for shared medical decision-making.

“The specialists must have all the knowledge to communicate what is best for the patient. And the patient, I think, must listen very carefully to what is being said. And weigh up the advice. [...] So yes, it is up to the patient I think to decide what he [or she] wants to do.” (Male, cardiology department, interview 3).

3.2.2 Organizational matters

Patients mentioned waiting time as feedback residents can learn from. They have the feeling that the schedule is too tight. Ideally, patients also wish to provide feedback on making appointments and the hospital experience in general.

“Well, I think there are a few key points which should be dealt with such as simple things like waiting time. Isn’t the planning too tight? [...] there was a sign which said that the waiting time was approximately one hour, one and a half hours.” (Male, pulmonary medicine department, interview 2).

3.2.3 Personal aspects

Additionally, patients wish to provide feedback on personal aspects such as a resident's representativeness, including a resident's personal hygiene. Furthermore, patients also mentioned their general attitude as well as their tone of voice and kindness.

“No, not the appearance, but grooming. Yes, you could say something about that. Yes. It is very disturbing if a physician sweats a lot or smells, that's just unpleasant. You could say something about that.” (Male, orthopedics department, interview 14).

3.2.4 Communication of medical knowledge

Patients also desire to provide feedback on a resident’s ability to explain a diagnosis. The resident should be able to do this in understandable words and avoid medical jargon as much as possible. Patients also described transparency about medical uncertainties and guidance through the medical process as important topics for feedback. Patients would like to understand their medical condition and take its uncertainties into account when deciding on treatment options. However, residents do not need to explain everything in detail but should pay close attention to the information that concerns the patients and be honest about it. Furthermore, they find it important that physicians guide them and explain every action step by step in order for them to know what to expect.

“They couldn’t find anything on the MRI scan and they didn’t explain further. I was overwhelmed by this. [...] I still had a lot of pain. [...] I don't think that’s providing an explanation. [...] it is my body and I feel the pain.” (Male, orthopedic department, interview 15).
3.2.5 The physician-patient relationship

Lastly, patients wish to provide feedback on the continuity of care. This involves topics such as seeing the same physician every visit and communication between physicians because it clearly influences the physician-patient relationship. Patients stated that residents should be aware of a patient’s personal situation and take this into account when providing medical advice. In order to do that, residents should communicate well with each other in order to prevent patients to have to repeatedly explain their stories. Furthermore, patients find it important to provide feedback on how residents approach their patients, for example, whether a resident listens to them, takes them seriously, takes time during the consultation, and shows a real interest. In addition, patients preferred that a physician sees them as a human and not as a disease or a problem to be solved.

“It is very alienating when a physician looks at you as if you are a problem. As if you are not really there. As if the soul or the self in the body is not of interest anymore. But you are dealing with living creatures. […] It is a human who has a problem and not a thing that’s broken. I find that important.” (Male, orthopedics department, interview 14).

3.3 Resident’s perspective

3.3.1 Desired feedback topics

The residents mentioned physician-patient relationship and professional performance as an area they wish to receive feedback on from patients. This includes whether patients trust the resident, how the residents approach patients, and whether the patients feel the resident takes time for them. But also, whether the resident takes a patient seriously, listens to, and shows empathy toward the patient. Another area mentioned was the communication of medical knowledge, which involves giving understandable medical advice and if patients have the feeling that they can ask questions. Communication skills were also seen as a feedback topic residents would be interested in, such as information transfer, providing clear explanations, and breaking bad news.

3.3.2 Undesired feedback topics

While residents mentioned a variety of areas, they wish to receive feedback on, there are also a few areas they preferably wish not to receive feedback on from patients. These areas include feedback on their medical knowledge and personal aspects, such as the residents’ kindness. Other areas mentioned were organizational matters, such as waiting time, facilities of the waiting room, the process of making appointments, and general aspects of the hospital they are working in such as the restaurant and interior design. Residents felt that these particular topics do not concern them.

3.4 Patients’ feedback topics versus residents’ feedback topics

When comparing both patients’ and residents’ perspectives regarding patient feedback topics clear similarities were seen (Table 3). For instance, communication of medical knowledge and the physician-patient relationship was desired feedback topics for both. However, differences between the two groups were identified as well.
While patients wish to provide feedback on organizational matters, such as waiting time, facilities of the waiting room, and process of making an appointment, residents wish not to receive feedback on any of these matters. Furthermore, patients also wish to provide feedback on personal aspects, such as kindness, representativeness, attitude, and tone of voice, whereas residents wish not to receive feedback on kindness either. Additionally, residents put forward their professionalism and medical knowledge as topics they would and would not like to receive feedback on, respectively. Both these topics were not pointed out by patients altogether.

### 3.5 Feedback level

For the purpose of residents’ learning, the level of feedback provision has been identified as well (Table 3). Generally, patients intend to provide feedback at the task level, process level, and self-level, whereas residents do not wish to receive feedback at the self-level. Providing or receiving feedback at the self-regulation level was not mentioned by the participants altogether.

### 4. Discussion

#### 4.1 Discussion

In this qualitative study, insights were gathered about both patients’ and residents’ perspectives regarding patient feedback topics. These insights may direct the development and involvement of patient feedback in PGME.

#### 4.1.1 Feedback topics

Topics patients wish to provide feedback on, touch elements of the current competency framework of CanMEDS used in PGME. For instance, the communicator...
role (Table 1) which includes among others, listening to patients, taking a patient seriously, and taking enough time for patients are topics mentioned by both patients and residents as possible feedback topics [10]. Furthermore, both patients and residents put forward the value of feedback on the physician-patient relationship, including establishing trust, empathy exhibited toward a patient, and the ability to clearly explain medical knowledge and attitude toward the patient. Moreover, these topics were also identified by physicians as areas that could be changed and improved on when receiving feedback from patients making them suitable feedback topics to enhance a resident's learning [24].

In line with current trends in healthcare that put emphasis on shared decision-making and patient-centered care, the CanMEDS communicator role clearly describes that residents are ought to provide the best available evidence and support patients in their decision-making [3, 4, 10]. Indeed, patients have stated they would like to provide feedback on their involvement in the medical decision-making process. The fact that none of the residents mentioned shared decision-making or related topics in the questionnaire may be explained by cultural issues and their early phase in the development of professional identity [25].

Indeed, studies so far have either focused on residents’ communication or interpersonal skills in light of patient feedback, assuming that patients can only provide feedback on these topics [3, 16, 24, 26, 27]. However, the results of this study have shown otherwise. For instance, patients also mentioned the continuity of care, which involves communication between physicians as well as seeing the same physician each visit, as an important topic to provide feedback on. Indeed, the importance of this subject is recognized in the collaborator role of CanMEDS. This role involves, among others, handing over patients’ care safely to other physicians, whereby a sufficient transfer of written or verbal communication is used [10]. Although residents are trained in achieving this role, topics related to the continuity of care were not mentioned altogether. This might be explained by the fact that residents think that this could only be assessed and judged by their peers.

Although this study showed similarities between the desired feedback topics mentioned in both groups, a difference between the groups was found as well. Organizational matters, such as waiting times and the process of making an appointment, are something patients intend to provide feedback on to residents, while the latter wish not to receive feedback on this particular topic. At first glance, it may seem obvious that these topics do not concern a resident as it might not always be his or her responsibility alone. However, when looking at the leader role of CanMEDS (Table 1) it could be stated that residents are ought to take responsibility in organizational matters in order to improve healthcare delivery in general, which according to the CanMEDS framework involves management, financial matters and organizational matters (Table 1) [10].

Additionally, personal aspects were mentioned by patients to provide feedback on, that is, representativeness, tone of voice or attitude, and kindness. These aspects can be recognized in the CanMEDS role of professional as well as the role of communicator. The role of a professional particularly reflects on society’s belief in physician’s professionalism, which requires them to commit to their own personal health and well-being. Moreover, physicians are ought to demonstrate accountability toward society [10]. However, residents mentioned personal aspects as an undesired feedback topic. It might be argued that based on the CanMEDS roles as well as their accountability toward the public, residents should accept some feedback on personal aspects [10].
4.1.2 Feedback levels

The effectiveness of feedback depends on the level of feedback aimed at, and whether the given feedback is indeed similar to the feedback level a recipient wants to receive feedback on [8]. This study has also led to insights into what level patients intend to provide feedback and thereby helps to determine its effectiveness. First of all, patients intend to provide feedback at the task-level, which describes how well a certain task is performed, which is in line with what residents wish to receive feedback at. From the literature, we know that providing corrective feedback at this level enhances learning [8]. Therefore, patients’ feedback at the task level might be effective to enhance residents’ learning. Patients also intend to provide feedback at the process-level which describes the process needed in order to fulfill certain tasks [8, 9]. Residents wish to receive feedback at this level as well, suggesting patient feedback at this level may enhance residents’ learning as well. Moreover, Hattie and Timperley (2007) argue that receiving feedback at this level enhances deeper learning as it is an effective way of shaping one’s strategy [8]. Lastly, patients also intend to provide feedback at the self-level, which involves feedback at a personal level and includes statements about a resident, such as feedback on his or her attitude, representativeness, kindness, or tone of voice. However, providing feedback at this level generally contains little task-related information and has too little value of enhancing learning [6]. Indeed, residents in this study did not wish to receive feedback at this level, suggesting that patients providing feedback at this level might not enhance residents’ learning. As expected, feedback provision at the self-regulation level was not identified. This level describes the way residents learn, direct, and have applied previous feedback, something patients are unable to monitor over time.

4.1.3 Effectiveness of patient feedback

Residents did not wish to receive feedback on the self-level. Kluger and Denisi (2000) have shown that feedback directed on the self-level negatively affects one’s performance [28]. If negative feedback is directed at the self-level, one may redirect attention to the self and become distracted from what matters, the task at hand [28]. Besides, it is important to take into account that the effectiveness of feedback might even be more influenced by the way it is delivered. Among others, effective feedback is delivered in an appropriate setting, specific, based on observation, and in nonjudgmental language [29]. Additionally, results have shown that patients who have had positive experiences with residents or physicians had difficulties providing feedback topics. Paternotte et al. (2017) also argued that patients who think positively about their physicians have difficulty reflecting on the consultation at a deeper level and provide feedback for improvement [28]. Others have also shown that these patients are not capable of providing critical feedback and are therefore less crucial to enhance change in a resident’s behavior [30]. This suggests feedback from patients with rather positive experiences might be less effective in order to enhance residents’ learning. Nevertheless, to ensure that residents obtain a variety of both positive and negative feedback from patients, it is recommended to involve a range of patients when seeking patient feedback. This could be achieved by assigning, for example, an assistant to collect feedback from patients instead of the residents or collect feedback regularly on a specific part of the day, for instance, a morning per month.
5. Conclusion

To our knowledge, this is the first study that explores which feedback topic patients wish to provide. In PGME, residents are medically trained based on the CanMEDS framework which includes seven different roles. Patients in this study were able to point out feedback topics that corresponded with various CanMEDS roles. It showed that patients and residents see possibilities to use patient feedback for competence development of residents on subjects other than the communicator role alone. To ensure that patients provide effective feedback, it is recommended to avoid feedback on the self-level and collect a diversity of feedback by involving a variety of patients when seeking feedback.

Currently, when patient feedback is sought, this is mainly focused on communication skills. However, in this study patients have provided potential feedback topics corresponding with four CanMEDS competency roles. This insight provides ground to extend the subjects on which feedback is sought from patients rather than a focus on communication skills alone. In order to provide effective feedback to residents and ensure that such feedback remains at the level that enhances residents' learning, it is recommended that patients avoid giving feedback at the self-level. To ensure that residents obtain a variety of both positive and negative feedback, it is recommended to involve a variety of patients when feedback is sought.

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Conflict of interest

The authors declare no conflict of interest.

Appendices and nomenclature

PGME  postgraduate medical education
GME  graduate medical education
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