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The individual care plan as a learning tool

PERSPECTIVES

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Learning to use an individual care plan in medical studies can help students prepare for a reality in which interdisciplinary collaboration, holistic thinking, advocacy and service user involvement are becoming increasingly important.

The Norwegian health service faces considerable challenges in the years ahead. Demographic changes are leading to a major increase in the older population, there is a shortage of healthcare personnel and a shift is taking place from institution-based to more home-based care (1, 2). These changes will require increased collaboration between the specialist health service and primary health and care services. Ensuring coherent patient pathways and continuity of care across services with different organisational structures is challenging – even when the willingness is there. Patients who require services from multiple agencies are particularly vulnerable, and inadequate collaboration can mean they do not receive the care they are entitled to (1). Today's medical students are taught the importance of pattern recognition; however, when caring for people with complex lives and long-term health problems within a pressured health service, it is not enough to solely consider diagnoses and medical history. Medical students need to shift their focus: from disease to patient resources, from treatment to coordination of care, and from seeing individuals as patients to seeing them as active participants in their own lives. An individual care plan is a personalised plan developed collaboratively with the patient and their healthcare providers. It serves as a tool to increase collaboration between different services and provide a coherent service provision to patients with chronic conditions (3–8). The individual care plan

was therefore introduced as a mandatory component of medical studies at the University of Oslo ten years ago. In this commentary, we wish to share our experiences with this, in the hope of inspiring others.

Patient case: Anna (44)

Anna has had substance use problems for over 20 years. In recent years, she has consumed alcohol daily and used benzodiazepines intermittently. Some of these were prescribed by a doctor, while others she obtained illegally. After many years of life challenges, including financial problems, mental health issues and physical health complications, she is now nearing completion of an in-patient treatment programme in the specialist health service. She is set to return to her home municipality, but many loose ends remain: she has no permanent housing, a small social network, financial challenges and an ongoing need for medical, psychosocial and practical follow-up. She requires assistance from multiple agencies, which do not tend to communicate with one another.

Collaboration and service user involvement

For patients like Anna – and most patients with chronic conditions who require help from multiple agencies – the most important question is not the one most commonly asked by doctors: 'What is wrong with you?' but rather, 'What is *important to you*?' What Anna wants most is to live safely, have structure in her daily life and receive support to stay substance-free, or at least gain more control over her substance use. Through an individual care plan, Anna can, together with her support team, formulate her goals and suggest measures that support her going forward. This may include contact with an addiction counsellor in primary care, follow-up with her general practitioner (GP), an application for local authority housing, discussions with NAV regarding finances and potential employment initiatives, referral to specialised treatment for substance abuse disorders (SUD treatment), and perhaps most importantly, a dedicated *coordinator* – someone who knows her, follows up with her and ensures progress and coordination.

> ***«Learning to develop an individual care plan is an exercise in empathy and understanding of the system, in multidisciplinary thinking, and in recognising that health is shaped by more than biological factors alone»***

An individual care plan is not primarily about medical diagnosis or treatment options: it is about *goals*, *measures* and *responsibilities* – from the patient's perspective – and how the support system can work together to achieve these goals. The plan should address the questions: What is important to you? What is needed to achieve your goals? Who does what – and when? Learning to

develop an individual care plan is an exercise in empathy and understanding of the system, in multidisciplinary thinking, and in recognising that health is shaped by more than biological factors alone.

A statutory responsibility

According to the Norwegian Health and Care Services Act (section 7 - 1) and the Specialised Health Services Act (section 2 - 5), developing an individual care plan for patients and service users who require long-term and coordinated services is a statutory responsibility (9, 10). The relevant local authority or health authority must provide a coordinator to ensure coordination and progress. A patient's GP is expected to offer their medical expertise and help develop the plan (General Practitioner Regulations, section 19) (11).

The individual care plan is thus anchored in comprehensive legislation (4), but laws alone do not ensure better services – practical training in developing and implementing individual care plans is also needed. Unfortunately, individual care plans are still underutilised (3, 12). Evaluations show that many patients entitled to a plan are not offered one (3, 13). This may be due to challenges with the health service's digital systems, which often do not communicate with each other. One of the main reasons, however, is that healthcare personnel do not regard work on individual care plans as part of their professional role, and may not even recognise the benefits (3). Service user organisations argue that professionals do not adequately promote the individual care plan as 'the service user's own plan and as a tool for their involvement' (14).

Having the right to an individual care plan does not in itself guarantee that the measures will be implemented. The plan therefore needs to include suggestions for specific measures and clearly state who is responsible for follow-up. Failure to do so risks reducing the individual care plan to a purely rhetorical exercise. Medical students receive training in individual care plans through the practical components incorporated into the teaching. Devising an individual care plan based on a realistic case developed in collaboration with service user organisations helps students gain a better insight into how the plan can serve as the tool it was intended to be. It also fosters a deeper understanding of their professional role and promotes engagement with a patient group that many feel powerless to help.

Why the need to learn about individual care plans in medical studies?

We do not expect medical students to master the administrative process involved in an individual care plan (7); the responsibility for assisting the patient in devising the plan lies with the coordinator, who is usually not a doctor. The aim is for students to gain an in-depth understanding of the individual care plan, for the following reasons:

To clarify collaboration and service user involvement

Authorities have repeatedly emphasised that the individual care plan is a key tool in the coordination of services (1). Healthcare personnel play an important role in informing patients about and recommending the individual care plan – and this starts during their education. An individual care plan requires collaboration between multiple actors, often across different sectors. By preparing an individual care plan, students gain insight into how collaboration works in practice and the challenges that arise when responsibilities and roles are not clearly defined. An individual care plan also helps students gain a clearer understanding of why service user involvement and collaboration are necessary, as well as their potential benefits. They learn that it is the patient, rather than healthcare personnel, who defines the goals in an individual care plan. This patient-centred approach is important for all harm-reduction efforts. Preparing an individual care plan also gives students insight into what meaningful service user involvement entails and demonstrates the attitudes, language and communication required of support teams. Because doctors often choose to study medicine out of a desire to help, and the helper role does not necessarily provide the best foundation for an equal collaboration, this training is valuable for developing skills relevant to the full scope of the doctor's role.

To deepen understanding of patient agency and resource-oriented work

Working with an individual care plan helps students focus on patients' strengths and resources, rather than just their symptoms. Rather than asking, 'What is wrong with you?' they learn to ask, 'What do you want to achieve, and how can we support you?' This approach is important when working with patients with chronic conditions, including chronic obstructive pulmonary diseases, schizophrenia and SUD. An individual care plan requires a different language and mindset than that used in medical records. The goal is not merely to describe problems, but to mobilise the patient's own goals and resources. This can be challenging for medical students accustomed to thinking in a problem-focused way, but it is nonetheless crucial.

To highlight the structural and social determinants of health

Housing, finances, social networks and dental health are important determinants of health and are particularly significant for marginalised patients. When working with people with substance use or mental health disorders, these factors can determine whether treatment is effective. Devising an individual care plan for SUD patients gives students insight into how structural factors, such as the unequal distribution of power and resources, affect health. This provides a concrete context for understanding otherwise abstract topics in medical studies, such as *structural and social determinants of health*.

To provide insight into the everyday lives of patients with complex needs

Many patients, like Anna, encounter a fragmented support system. A well-constructed individual care plan can make the difference between chaos and coherence. Throughout their studies, medical students receive thorough training in medical knowledge and clinical care; however, they gain less insight into what it is like to live as a patient navigating a fragmented and complex support system. Trying to understand the life of someone with substance use challenges in order to draft an individual care plan, and receiving personal feedback from an instructor with personal experience, gives students a valuable perspective. This is particularly important in relation to patient groups whose voices are seldom heard and who often fall outside established structures.

Engaging with the service user's voice

People with personal experience as a service user participate as instructors in medical studies. They also review and provide feedback on students' draft individual care plans. This represents a unique learning experience that cannot be gained from textbooks or lectures.

Through this feedback, students learn how language and attitudes can lead to either empowerment or helplessness. The involvement of instructors and evaluators who have personal experience with substance use, alongside lecturers and clinicians, allows students to see how contributors with professional and experiential knowledge can engage on an equal footing within interdisciplinary collaboration. Guidance from individuals with personal experience of substance use helps students see them in a different light, which in turn can reduce stigma.

> ***«Feedback from students indicates that working with individual care plans is often perceived as one of the most educational and challenging aspects of the social medicine component of their education»***

A common misconception among medical students is that an individual care plan is similar to a medical record. However, the medical record documents symptoms, diagnoses and treatment, whereas an individual care plan is a collaboration and coordination tool. The language used should be accessible, respectful and resource oriented. This shift in language is an important part of the learning process in itself. It requires students to reflect on power, values and attitudes, as well as on what it means to treat a vulnerable person with respect.

Feedback from students indicates that working with individual care plans is often perceived as one of the most educational and challenging aspects of the social medicine component of their education.

A practical tool

The individual care plan in medical studies is more than just a pedagogical tool: it brings to life the concepts we often discuss in general terms, which can be difficult to teach because students feel they are self-evident. Concepts such as holistic care, person-centred care, equity, collaboration, service user involvement and the principles of social medicine may sound straightforward in theory, but are far more challenging in practice.

When working with patients like Anna – and many others who require long-term, coordinated care – a doctor who understands the value of collaboration and the individual care plan is better positioned to make a meaningful difference, both for the health service and for the patients themselves.

The patient case is fictional.

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