

To Cite: Jiwa M. Clinical and Research Insights to get you started on the road to thoughtful practice. *JHD* 2017;2(1):2–4. <https://doi.org/10.21853/JHD.2017.23>

Corresponding Author:

Prof Moyez Jiwa

The University of Notre Dame, Australia Melbourne Clinical School

300 Princes Highway, Werribee, VIC 3030 Australia
moyez.jiwa@nd.edu.au**Copyright:**© 2017 The Authors. Published by Archetype Health Pty Ltd.. This is an open access article under the [CC BY-NC-ND 4.0 license](https://creativecommons.org/licenses/by-nc-nd/4.0/).**SUMMARY**

The Journal of Health Design seeks to stimulate clinicians to be involved in health innovation by publishing their insights into clinical practice and pilot studies. We especially welcome papers that describe attempts to improve the patient experience of health care. Three types of contributions are now welcome: Clinical Insights, Research Insights, and Design Insights. Each will report the lived experience of clinicians or innovators based on their ideas or intuitions and will be published alongside a commentary of what another practicing clinician thought about what was described.

Key Words

Research; publishing; pilot projects; patient care; innovation; health design

INTRODUCTION

A major challenge for clinicians in primary care is to maintain an active interest in developing their practice. By active we mean regularly reviewing what is done for patients, why this is important, and how this is supported by current literature. Perceived lack of time is one reason clinicians cite for this relative lack of engagement with practice development. Practitioners pressed for time may well find themselves too busy to be involved in research and development.¹ Unfortunately, the less you exercise

your muscles, real or figurative, the more they atrophy.

With a particular focus on the patient experience, *The Journal of Health Design (JHD)* has introduced two new types of contributions that aim to engage clinicians in critical thinking. *Clinical Insights* offers the chance to reflect on patient experience innovations that seem to make an impact even though they have not been evaluated in a formal experiment. In addition, *Research Insights* is an opportunity to report on formal studies that have ethics approval but may have encountered unexpected outcomes. It is often just as informative to understand why an approach didn't work as well as the aspects that did.

Clinical Insights

In the *Clinical Insights* section of *The JHD* we are inviting colleagues to share their ideas and approaches to practice that they believe are making a difference for their patients. Such practices can then either stimulate research, or be framed with reference to what we already know from the literature. There was an example of one such practice reported recently. I started to offer patients the "big chair" in the consulting room. I was startled at the patient response to this rearrangement of the furniture in my room and I believe that such an approach may contribute to a better patient experience.² There is supportive evidence for this from the psychological literature.² Of course, we need more robust evidence if we are to consider redesigning the furniture in doctors' offices, but it is certainly a start and the practice can be adopted by clinicians who may wish to try it. These are the types of insights we are looking to publish in this section of *The JHD*.

As another example, shaking the patients hand may be a very powerful ritual at the start of a consultation. Writing about the perceived impact of that ritual may be possible and helpful to others if the matter is framed within the context of what we know about the pros and cons of

handshakes.

The editor will reject reports for projects that require, but have not prospectively sought, formal ethics committee review. Ethics approval must be sought for research involving human participants.

To clarify:

A 'participant' is someone who actively provides research data. For example completes surveys. Participates in interviews, discussions or observations. Undergoes psychological, physiological or medical treatment or testing. Tests software. Grants access to personal collections of records, photographs, etc. The participant is the person from whom tissue has been collected (including blood, urine, saliva, hair). Is identified in a record, e.g. employment record, medical record, education record, membership list, electoral roll or is identified or de-identified in data banks or unpublished human research data, e.g. an analysis of existing unpublished data collected by another researcher or collected for a different research project.⁵

Therefore, *Clinical Insights* reports the intuitions or ideas of the clinician who writes the report and describes what they think has improved the experience of the patient by the change in their practice. It is unlikely that prescribing something for a chronic condition can be presented in the context of a “clinical insight” even if it appears to benefit the patient. This is more appropriately presented as a research project, and because it involves human participants it requires the necessary ethics approvals and safeguards. However, removing a desk from the consulting room may have an important effect and something for which there may be reasonable grounds for improving communication. As long as the person reporting their experiences is the clinician involved and is not reporting the recorded views of another person, then the paper can be presented as an insight.

What do you do that you feel makes a difference to patients? Do you time how long before you ask the first question at the beginning of the consultation? Do you shake the patient's hand? Have you removed the reception counter from your waiting room? Do you use a diffuser with aromatic oils in your waiting room? Do you

play music in the practice? Do you provide any reading material in your waiting room? Why and how do you think this makes a difference with reference to the literature? We want to read about how you are improving the patient experience.

Research Insights

Our *Research Insight* section reports ethics committee reviewed experiments. Here researchers can report the outcomes of studies that failed to recruit.³ There is something to learn from such experiments. In the publication, the reviewer of a research insight will also offer a published view from a practicing clinician, which may shed light on the matter. Small pilot studies and protocols for research are also welcome as these provide a rich source of information that tell us about planning research or why something works, and more importantly, why our intuitions sometimes mislead us.

These two new sections of *The JHD* and the soon-to-be-introduced *Design Insights* offer the opportunity to begin the work of improvement, starting locally with the people who are directly involved in health care redesigning aspects of the patient experience. Health care policy rarely takes account of this experience because it is seldom framed in an academic context and because it is rarely available in such a forum alongside descriptions of larger formal experiments.

We encourage clinicians to engage actively in developing their practice. Clinicians are put off research due to the perception that without “grants” it is not possible to do good work. This is patently false, especially in primary care where clinicians often have complete autonomy over their practice and can introduce practices to improve the patient experience at minimal cost. What one practice discovered by offering telephone consultations changed practice not only for their patients but for countless others across an entire country.⁴ Large randomised controlled trials are necessary to generate data for robust interventions, but they are costly and should be led by experts with appropriate skills and the relevant approvals. However, many adjustments to practice are locally relevant and don't need a huge budget. They can be tested locally as practice policy.

In the coming editions of *The JHD* we welcome

contributions to these new sections where we can gain inspiration to innovate based on the experiences of clinicians, and describe learnings from formal studies to improve the patient experience.

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ACKNOWLEDGEMENTS

None

PEER REVIEW

Not commissioned. Not externally peer reviewed.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

FUNDING

None

ETHICS COMMITTEE APPROVAL

None