

Patients' Attitudes Towards the Presence of Medical Students In Family Practice Consultations

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Key words: family medicine, medical education, patients' attitudes, consent, consultation

Abstract

Background: Patients' consent to being part of medical education is often taken for granted, both in primary and secondary care. Formal consent procedures are not used routinely during teaching and patients are not always aware of teaching activities.

Objective: To investigate patients' attitudes and expectations on issues of consent regarding participation in teaching in general practice, and the influence of a student's presence on the consultation.

Methods: The study took place in 46 teaching practices during the sixth year clinical internship in family medicine. Patients completed questionnaires at the end of 10 consecutive eligible consultations. The questionnaire contained data on the willingness to participate in teaching, the preferred consent procedure and the effects of the student's presence. The doctors were asked to estimate the sociodemographic level in their clinic area.

Results: A total of 375 questionnaires were returned; the response rate was not affected by the clinic's sociodemographic level. Overall, 67% of the patients had come into contact with students in the past; 3.2% of the participants objected to the presence of a student during the consultation; 15% would insist on advance notification of the presence of a student, and another 13.9% would request it; 4% stated that the presence of students had a detrimental influence on the physical examination and history; and 33.6% would refuse to be examined by a student without the doctor's presence.

Conclusion: Most patients agreed to have a student present during the consultation; some would like prior notification; a minority refused the student's presence. A large minority would refuse to be examined without the tutor's presence. Our findings need to be taken into account when planning clinical clerkships.

IMAJ 2001;3:903-906

and clinic physicians we found that formal consent procedures are not used during teaching. Patients are not always aware of teaching activities [1] and there is ignorance among staff regarding their obligation to patient confidentiality [2]. Previous studies that examined the effect of videotaping [3-6] and direct observation [7-10] of the consultation found that 5-15% of patients would refuse to participate in such teaching activities. Editorials on consent and confidentiality have mainly though not exclusively addressed research issues [11-13], and juridical literature does not address issues of teaching in general practice. Guidelines have mainly addressed the issue of recording the consultation, such as who is allowed to observe, how recordings should be stored, and whom and what should not be recorded [14,15].

In 1996 the Law of Patient Rights was legislated by the Israeli parliament, defining issues of confidentiality, consent and record-keeping [16]. The law details new standards for healthcare provision and research, including appropriate sanctions, but it does not mention teaching. The Minister of Health later issued a statement regarding the participation of students in clinical teaching [17]. The statement defines six areas of importance: the provision of information, the right of refusal, proper identification, the presence of the teacher, the right to request the presence of a third party, and the rights of disabled people.

In a small-scale study [18] we found that 15% of women and 20% of men refuse to be part of teaching. Most patients would agree to be interviewed by a student in the presence of a supervisor, but not to being audio- or videotaped, or observed through a one-way mirror. Most patients indicated that they were uninterested in obtaining either an advance explanation or a request for consent.

The aim of the present study was to investigate patients' attitudes and expectations towards participation in teaching in general practice, and the influence of a student's presence on the consultation.

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The patient's consent to participate in medical education is often taken for granted. In an informal survey among hospital

Methods

The study was conducted in 46 teaching practices during the sixth year clinical internship in family medicine. In this compulsory internship, students are attached for 3 weeks to a family practice affiliated with our department and are supervised by an accredited tutor.

Students were instructed to distribute an anonymous questionnaire to 10 eligible patients at the end of consecutive consultations during an ordinary working day. The patients were asked to complete the form after leaving the consulting room and to deposit the form in a closed box. Excluded from the study were patients who were unable to read or write, those under the age of 18, seriously ill patients for whom it would be difficult to reply, and confused or cognitively impaired patients.

The questionnaire contained questions concerning: patient consent to the *presence* of students; the need for *prior notification*; whether the student's presence had any *influence* on the consultation either during the history-taking or during the physical examination; and whether the patient agreed to be *examined* by the student, either in the presence or absence of the tutor. For these six items the patients were asked to answer on a scale of 1 (strongly disagree, or strongly negative statement) to 5 (strongly agree, or strongly positive statement).

For further analysis of the results we developed a "scale of disagreement." We gave a score of one point for each negative reply (1 = a strongly negative statement or 2 = a negative statement) and 0 for all other answers for each question. We gave a total score to each patient's attitude, which was the sum of the scores above, and obtained a "scale of disagreement" from 0 (a strongly positive attitude) to 6 (a strongly negative attitude).

The patients were asked to note their age and gender, and previous exposure to student teaching (either in hospital or in an ambulatory care setting). We also investigated the *type of visit*: urgent, chronic, administrative, and for family or personal reasons. The doctors were asked to estimate the sociodemographic level in their clinic area.

Descriptive statistics were used to characterize the participating patient population and to assess the questionnaire. Chi-square tests were used to compare proportions, and Student's *t*-test to test differences between means. One-way ANOVA was used to test the analysis of variance when needed and a multiple regression model where the "score of disagreement" was the dependent variable, and age, gender, type of visit, and prior exposure to students were the independent variables. Due to incomplete data on a number of forms, there was some loss of data in the sub-analyses.

Results

A total of 375 questionnaires were returned, representing a response rate of 81%. Due to technical factors in collecting the questionnaires, most non-responders belonged to seven practices. Socioeconomic levels of the clinics as estimated by the family physicians were: 15% lower class, 35% middle class, 15% upper class, and 35% mixed. The patients' response rate was not affected by the clinic's sociodemographic level.

The patients' mean age was 53.1 ± 17.9 years (range 18–85); 44% were males. Most consultations were for acute conditions (41%) or chronic diseases (27%), some for administrative purposes (15%), a few for personal problems (3%), and 14% were not characterized. Sixty-seven percent of the patients had come into contact with students, 24% had no experience, and 9% did not remember.

Table 1 summarizes the patients' attitudes and expectations regarding issues of consent to participation in teaching. As to the presence of a student during the consultation, 3.2% of the participants objected or strongly objected while 76.8% agreed or strongly agreed; 15% would insist on advance notification of the presence of a student, and another 13.9% would want it sometimes, but the majority did not express strong feelings either way.

Four percent stated that a student's presence had a detrimental influence on history-taking and physical examination, while the rest indicated a positive influence (26%, 21% respectively), or no influence. Thirty-four percent of the patients stated that they would never be prepared to be examined by a student without the tutor's presence, while only 7.2% would refuse with the tutor present. On the other hand, 59.7% were prepared to give their medical history in the presence of the tutor vs. 21.6% without the tutor's presence. It is interesting to note that "no answer" was in the range of 1.1–6.1%, but on the items about physical examination it rose to 14.9–20.3%.

The results of the "scale of disagreement" are summarized in Figure 1. We found no influence of age, type of consultation, or previous exposure to students on the global score of disagreement.

Table 1. Patients' attitudes and expectations regarding issues of consent in teaching (375 questionnaires)

Question	Disagree/Strongly disagree (%)	Did not answer (%)
1. I am happy for a student to be present during my consultation	3.2	2.1
2. I would be interested in knowing about the student's presence in advance	29.9	1.1
3. The student's presence had a positive effect on the doctor's interview	4.0	3.5
4. The student's presence had a positive effect on the physical examination	4.0	14.9
5. I would agree to be examined by a student with my doctor present	7.2	6.1
6. I would agree to be examined by a student alone	33.6	20.3

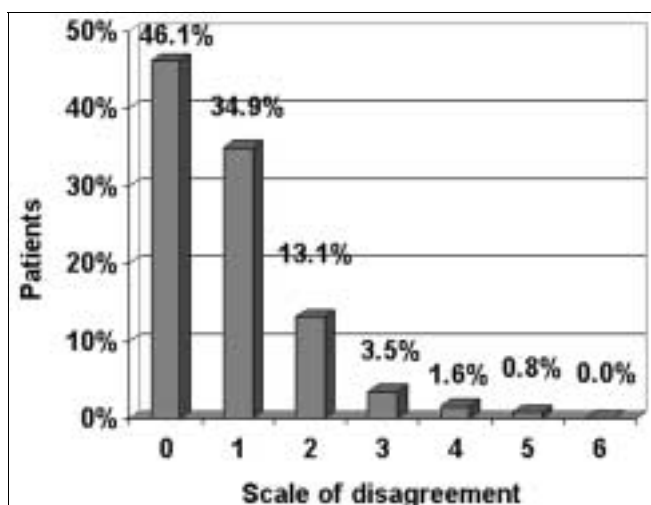


Figure 1. Patients' disagreement to a student's presence (375 patients). Scale from 0 (a strongly positive attitude) to 6 (a strongly negative attitude).

Discussion

Our results indicate that most patients do not consider the issue of prior consent important with respect to teaching. In fact, in the additional comments, some patients wrote that they were proud to be part of teaching, or pleased to be part of the advancement of medicine. Nevertheless, a minority of 15% insisted on prior consent. Furthermore, most patients did not feel that the student's presence had any influence on the consultation, although a third would object to a "physical" without the tutor's presence, and 4% thought that the student's presence had a detrimental effect on the consultation.

Previous research has indicated that patients with negative attitudes to being involved in teaching were likely to be younger [3,6,8], to be women [3,7,8], and to have stated psychological problems [3,6,7]. They were also less willing to discuss intimate and emotional problems, or to be videotaped and observed [10]. Social class had no influence, and previous experience with students had an inconsistent influence [6,8,19]. Refusal rates varied from 3% to 14% [6,10] for direct observation, and up to 35% for being videotaped [3]. Our refusal rate of 3% accords with this, and our tutors estimated this quite accurately [20]. In this respect, Israeli patients seem to be no different from patients in other countries.

In 1974, Wright [8] carried out the most detailed analysis to date of a student's presence on the consultation, and found that patients were prepared to talk about smoking, physical illness and drinking, but not about sexual problems. Though previous experience with teaching had a negative effect, social class did not. Unfortunately, these categories allowed for "don't mind" or "not," but they did not examine the beneficial effects of a student's presence. In a questionnaire study, O'Flynn et al. [7] found that women were less inclined than male patients to discuss emotional and sexual problems and to undergo a physical examination. In a further study [21] they found that

30% of the patients found it difficult to talk about personal matters. On the other hand, 95% of the patients said that students "had an important part to play in general practice." In our study, the vast majority of visits were for medical conditions while only 3% were for personal problems; further study on this issue is needed.

Devera-Sales et al. [19], in a questionnaire study, found that 90% of patients would agree to students taking part in their care. Those who were unwilling expressed concerns about confidentiality. Thirteen percent of their patients who had previous contacts with a student, and 22% who did not, would be troubled if a physical examination were to be *repeated* by either a doctor or a student; and 31% and 42% respectively would be uncomfortable if a student of the opposite sex examined an intimate body part. In our study, 33% would refuse to be examined by a student alone. Although the response rate in our study was high, and the number of total visits studied compares well with the literature (sample sizes of 128–480 visits), a few patients did not answer all the questions. Specific omissions were the influence and performance of the physical examination (14.9% and 20.3% respectively). Possibly the patients were uncomfortable with these issues and "didn't see" these items on the questionnaire. If this were true, one could speculate that even more patients would refuse to be examined by a student.

In our study 15% insisted on prior consent. In their questionnaire study, Shier and colleagues [2] found considerable ignorance among students on the confidentiality issue. In O'Flynn's study [21], 64% wished to know about the student's presence, but 32% did not think it necessary. The important question is how patients perceive confidentiality: does it mean being asked intimate questions? Is it being examined? Is it about writing in the file? In O'Flynn's study, patients expressed concern that students would talk about them *after* work. This is something that should be discussed with both the patients and the students. Another concern is the extent to which the patients feel pressured to consent to the student's presence. Research indicates that this amounts to over 10% of patients [5,6,10]. Patients are apparently unwilling to "disappoint" their physician, or they may fear retribution.

On the positive side, 25% of our patients said that the presence of students improves the consultation. Devera-Sales and colleagues [19] found that three-quarters of their patients perceived the involvement of students in their care as beneficial. They "appreciated the attention they got from students." Frank and coworkers [9] found that the length of the consultations did not change but that more attention was given to the patient's expectations and to discussion of family members.

Thus, it seems that for some patients a student's presence results in receiving more attention during the consultation, having more opportunities to raise concerns (though perhaps not intimate ones), and they appreciate participating in the teaching process. The students' influence on the consultation is

complex. Some patients dislike it, others are not concerned by it, and still others enjoy it.

The issue of consent and confidentiality must be an integral part of teaching in medical schools. A clear explanation should be given to patients about the need for student participation, its advantages and disadvantages. Patients should understand that they are free to choose, and that refusal to have a student present will in no way influence their care or the doctor-patient relationship. Students must be instructed not to discuss patients in a careless manner, and should be made to understand that if a patient does not wish to be examined by him or her, no personal element is involved.

Conclusion

Most patients agreed to have a student present during the consultation; some would like prior notification, while a minority refused the student's presence. A large minority would refuse to be examined without the presence of the tutor. Our findings need to be taken into account when planning clinical clerkships.

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