Patients and students in general practice

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A SIGNIFICANT trend in undergraduate medical education today is the extension of clinical teaching from hospital to general practice. More medical schools are arranging for senior students to be attached to general practitioners, a development that will be encouraged by the Report of the Royal Commission on Medical Education and facilitated by the declared policy of the Royal College of General Practitioners. That many improvements are, or were, required in some of these attachment schemes was shown by Pearson, Eimerl and Byrne (1968) who found the British schemes current in 1965–66 to be "amateur, haphazard, and to have little academic supervision". I think, however, that an up-to-date survey would reveal substantial betterment in both the quantity and quality of present arrangements.

On one important aspect of student attachment little information is available. The reaction of the general practitioner's patients to the presence of a student at consultations does not appear to have received systematic attention, perhaps because it has been assumed that patients do not mind a student accompanying their family doctor. From a previous survey of student opinion on general-practice attachment (Richardson 1965), and from more recent experience with the compulsory scheme whereby all Aberdeen students undergo a four-week full-time programme of general practice teaching, there certainly does not appear to be any difficulty in getting most patients to accept the presence of a student at consultations. However, even with adequate explanation to the patient, once he or she is in the consulting-room and confronted with the student, it can be argued that preference for an exclusive interview with the doctor might be embarrassingly difficult to express. Moreover, as Ogston and McAndrew (1967) showed in their study of hospital patients, ignorance of the right of the patient to refuse to be examined by students was at that time prevalent.

This paper presents the results of a small study designed to explore patients' response to the presence of a student in their doctor's consulting-room.

Method

During March, 1970, while two female and one male student were attached to three practices, each patient reporting to the surgery for consultation by appointment was handed the following slip by the receptionist:

> A senior medical student is meantime attached to the practice to learn about the work of your family doctor. With your permission the student will be present at the consultation. If, however, you wish to see your doctor alone, please make this known to the receptionist."

The name, address and age of each patient was logged on recording sheets, together with the patient's decision to accept or decline the presence of the student. At the end of each surgery the doctor entered the diagnosis and any additional comment he felt appropriate. The forms were then returned to the Department of General Practice for analysis. It is important to emphasize that the patient's decision was made before meeting either doctor or student; thus a refusal enabled the student to withdraw prior to consultation.

Results

Table I shows the results. In all three practices the exercise covered consulting sessions throughout the day, included patients of two or more doctors, and was applied

to unselected series of patients. Out of 703 patient attendances (the number of individual patients was less, due to repeat consultations in the period of observation) the number of refusals was 43 but, since one patient refused on three occasions and another patient, having refused on the first and accepted on the second attendance, the actual number of

TABLE I

RESPONSE OF PATIENTS TO ADVANCE INFORMATION ON STUDENT ATTACHMENT

	Practice A	*Practice B*	*Practice C*	*Totals*
Number of patients refusing	14 *13.9*	4 *1.3*	25 *8.7*	43 *6.1*
Number of patients accepting	87 *86.1*	311 *98.7*	262 *91·3*	660 *93.9*
TOTAL	101 *100*	315 *100*	287 *100*	703 *100*

individual patients declining to be seen by the student was 40. Thus, in round figures, some 94 per cent of patients accepted the presence of the student. The tabulated data show that the acceptance rate varied from 99 per cent in practice B to 86 per cent in practice A.

In only one practice were patients told in advance the sex of the student, so the effect of this factor on response cannot be evaluated. It was, however, possible to examine the age, sex, and diagnosis of those who refused compared with those who accepted. This showed that refusals tended to come from younger rather than older people, and that female patients were a little more liable to decline than males. As expected, patients with genito-urinary and psychological complaints were much more likely to request a private consultation with their doctor; of the 40 who declined to be seen with the student present, 15 had disorders of the genito-urinary system and 19 were suffering from some form of mental illness or stress due to a personal problem. Why the other six declined is not directly known, but the fact that four were either members of the medical or nursing professions or belonged to the family of such a member, probably influenced their decision. Another was described by the doctor as " a difficult patient who was expected to object".

Discussion

Every patient, wherever he or she consults a doctor, has the right to opt in or out of a student teaching situation; this right, and the hospital circumstances in which it should be exercised, have been explicitly stated and in 1969 (see *Lancet*) the Secretary of State for Social Services again assured the House that no teaching hospital makes treatment conditional on the patient consenting to participate in teaching.

The question confronting general practitioners who take undergraduates (and, to some extent, postgraduates) into their consulting rooms and into patients' homes is not so much whether they should ask patients to approve of a student's presence—that is surely a moral obligation as well as a courtesy—but rather how the request can be made in such a way as to ensure genuine choice. Though there seems no doubt that the big majority of patients seen in general practice either do not object to, or welcome with understanding, students learning from their cases, it seems wise and fair to operate a system of consent which allows of full and free decision. Several methods can be suggested:

1. All doctors probably exercise their own judgment on the reaction of patients to students and protect both by asking the student to withdraw before certain patients are seen. Other patients are introduced to the student and asked if they mind his being present; this may embarrass a patient with a new complaint of an intimate nature and may occasionally inhibit a patient from disclosing the true

nature of his or her complaint. Furthermore, this procedure is probably the most feasible when students are taken on home visits.

2. A system of advance information, either by a notice in the waiting-room or by the slips used in this study, does give the patient attending surgery the opportunity to ask for a private consultation without embarrassment to any of the parties involved.

3. All patients in a teaching practice might be sent a letter of explanation, and a consent form for signature, which would be filed in the patient's record so that, whether the patient attends surgery or is seen at home, the appropriate action can be taken.

Experience of student attachment prior to this little experiment suggests that the first (and most common) method of obtaining patient consent leads to the lowest refusal rate. The effect of a notice in the waiting-room has not been tried. Advance information via a note handed to each patient on arrival at the surgery—the method most favourable to free patient choice—produced a refusal rate of only six per cent. It is worth recording that two of the three teaching practices have decided in future to use the slips described here when students are attached to them.

The doctor–patient relationship in general practice is such as to suggest, to me at any rate, that the selection of method of seeking patient consent to undergraduate teaching should be left to individual doctors. Whatever method is used, this enquiry indicates that, in the circumstances most favourable to free patient decision, there need be no concern about co-operation. There is, however, at least one important and obvious proviso; practices should not be so saturated with students as to leave little opportunity for patients to consult their doctor alone—an unlikely event if medical schools recruit (and reward) sufficient teaching doctors to spread their attached students out at intervals.

Finally, it is hoped that this paper may stimulate more teaching practices to experiment with different methods of obtaining patient consent and to report their findings.

Summary

Patient consent to student attachment to their general practitioner was measured by issuing a notice of student presence in advance of actual surgery consultation. Given this free choice, in three practices, about one in 20 patients asked for an exclusive consultation with the doctor, and this appeared most commonly to be due either to the intimate nature of the complaint or to a personal association with the medical profession. The question of methods of patient consent is discussed and the conclusion reached that choice of formal versus informal means is a matter for the individual doctor teacher.

Acknowledgments

I gratefully acknowledge the interest and help of Drs D. S. Allan, B. W. Duthie, G. B. Farquharson, F. A. Forbes, D. R. Grieve, S. G. Marshall, A. Robertson and S. A. Silver.

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