Teaching medical ethics symposium

Patient involvement in clinical teaching

Valerie J Grant *Auckland School of Medicine, Auckland, New Zealand*

Abstract

This paper presents findings from a longitudinal study of patient refusals (as reported by graduating medical students) to take part in the teaching function of public hospitals. Results from a smaller study of non-patients' attitudes are also reported. Findings are discussed in terms of patients' rights, issues of personal privacy, medical education, and the public good.

Introduction

In New Zealand, as in the United Kingdom, patients usually expect to be involved in the teaching function of public hospitals. Requests to patients to take part in the teaching are set in the context of patients' rights agreements. For example, the Auckland Area Health Board's *Ethical Guidelines for the Involvement of Patients in Clinical Teaching* begins with the following statements:

'1. Every patient has the right to decide whether he or she wishes to agree to an interview, examination or other specific procedure carried out by a student, and to withdraw from the teaching situation at any stage. Patients have the right to have a support person present. These rights should be brought to the attention of all patients who are asked to become involved in a teaching situation.

'2. Every patient must receive a clear prior assurance that refusal to participate in teaching or withdrawing from teaching will not jeopardise his or her care in any way' (1).

Overall these guidelines, or ones very similar to them, appear to have been accepted and adopted by most people involved in the care of patients in teaching hospitals in New Zealand. If it were not for new pressures and initiatives there may have been little need for further analysis of the ethical issues underlying these procedures.

The very existence of the revised guidelines can be traced back to the vigorous public debate in New

Zealand following the publication of the Cartwright Report (2). As Campbell has observed: '... it could be argued that a side effect of the Cartwright Report has been a serious attention to ethical theory and practice ...' (3).

Although the chief area of concern was the right of patients to be fully informed about their clinical treatment, several related issues also came under the spotlight. One of the more important of these was the right of patients to refuse to take part in the teaching function of the hospital. On the one hand, some argued that the patient's right to refuse should be given far more prominence in the hospital settings. In contrast it was pointed out that: '... beliefs that patients should not be exposed to students against their wishes need to be contrasted with the expectation of all patients that their own doctor has been trained on somebody' (4).

Since the availability of a sufficient and secure clinical base appears to be a *sine qua non* of clinical medical education, and since the uncoerced co-operation of sick people with the teaching process is equally fundamental, it appeared the time had come to re-evaluate the underlying arguments for patient involvement in clinical teaching.

There were additional reasons for addressing this issue. As opportunities for clinical teaching in hospitals steadily shrink, clinicians have become increasingly concerned that the smaller numbers of patients available to take part in the teaching programme might jeopardise the clinical competency of graduates. Thus medical educators were concerned to establish, with hard data if possible, whether or not there was also an increase in the numbers of patients refusing to let students take their histories or to examine them. At the same time teaching staff responsible for training in communication skills and medical ethics needed to know whether more specific tuition was needed to help students handle the problems they would encounter on the wards.

At the theoretical level, questions that needed review were: What reasons would a (sick) ethicist give for co-operating or not co-operating in a clinical teaching programme, and associated with this, Why do patients usually agree to co-operate in medical

Key words

Informed consent (teaching); medical education.

teaching; Are patients sufficiently aware of their right to refuse to co-operate? At the practical level, some of the questions that needed answering were: At what rate and in what context are patient refusals occurring?; Are patient refusals more common in some specific settings or amongst some groups of students?; and Do students perceive a need for further education in either approaching patients with requests to interview or examine, or in coping with patient refusals?

Changes in the provision of health resources are imminent. Hospitals are to tender for patient care. This means that both public and private hospitals will be competing for the government's 'health-dollar'. The big teaching hospitals are already reducing staff numbers as new therapeutic and diagnostic technologies are introduced, and reduced hospital stays are the goal of both administrators and medical personnel. Today's hospital patients tend to be both older and sicker than those of former times. These, and a number of other factors, mean that the clinical teaching base has diminished to the point where alternatives must be sought if a well trained work-force is to be maintained.

It was in this context of both radical and rapid change that further data were sought on whether or not patients were refusing to be interviewed or examined by medical students in teaching hospitals. Since one of the things researchers were interested in was the possibility of change in patient attitudes over time, the research was planned to run for three or four years.

Method

Two studies were carried out. The first involved asking medical students about their experiences (The Student Study) and the second involved asking members of the public for their opinions (The Open Day Study).

1. THE STUDENT STUDY

A questionnaire seeking information about refusal rates was administered to students completing their fifth year of training at the Auckland School of Medicine in 1989, 1991 and 1992. Questionnaires were anonymous, the only information sought about the student respondents being their sex. Students were asked: 'For any four week block during your clinical training (wards, clinics or general practice), please estimate the number of patients you asked to allow you to interview them and/or to take their history. Please enter the total number of patients asked in one box, and the total number of patient refusals in another box'. They were then asked: 'Would this estimate apply equally to all specialty areas? (general practice, medicine, obstetrics and gynaecology, paediatrics, psychiatry, surgery, sexually transmitted diseases clinics). If not, please give details below'.

Next they were asked to give the same details for both full-system examinations and single-system examinations. The third section of the questionnaire listed possible reasons for refusals and students were asked to indicate which were the most common in their experience. Examples of such reasons were 'too tired or ill', 'embarrassment', and 'pain or discomfort associated with repeated examinations'. Students were also given the opportunity to give reasons other than those specified or to indicate if patients refused without giving a reason. A last possibility was 'nurse requested permission and did not divulge reason'.

The fourth and final section of the questionnaire asked students if they would have appreciated more help or training in approaching patients to request permission to interview or examine, or in coping with refusals.

2. THE OPEN DAY STUDY

The student studies were followed up by a small opportunistic survey of opinions from members of the public visiting the Auckland Medical School on Open Day, 20 September 1992. People who stopped for more than approximately two minutes to look at a display entitled 'Teaching Medical Ethics' were invited to complete a questionnaire on 'Patient involvement in clinical teaching'.

In the resulting group (n=71) ages ranged fairly evenly from late teens to 60s, and both sexes were equally represented in all age-groups except the 50s where men predominated. The questionnaire was designed so that items on which most agreement was expected were offered first, and those which were expected to be more controversial were offered last (see Table 3).

Results

1. THE STUDENT STUDY

Table 1 gives a summary of the results. With one exception, basic rates do not appear to have changed significantly over the four-year period. That is, the majority of students report doing about the same number of interviews and full- and single-system examinations on all occasions. Refusal rates have shown a slight decline in two areas. In the third (single-system examinations) there has been a statistically significant decline in the refusal rate (Kruskal-Wallis one-way analysis of variance by ranks $p < 0.007$).

Table 2 shows the numbers of students in each year who said that one or more departments were exceptions to the general refusal rate across all three types of interactions. Two specialties (obstetrics and gynaecology and the sexually transmitted diseases clinic) appear to provide the most difficulties for students; two others (paediatrics and psychiatry), a moderate amount of difficulty. By contrast, no

Table 1
Numbers of interviews, full-system examinations and single-system examinations and numbers of patient refusals in each category, reported by medical students in any four-week block during 4th and 5th year training

Student cohorts	1989	1991	1992
No of students in class	111	104	108
No of students responding to questionnaire	90	84	81
Mean number of interviews done (in any four week block) [Range 2–99; 90 per cent of students between 7–23]	12.55	13.34	12.60
Mean number of refusals to be interviewed [Range 0–11; 90 per cent of students between 0–3]	0.83	0.77	0.58
Mean number of full-system examinations [Range 0–40; 90 per cent of students between 4–20]	9.40	9.18	10.08
Mean number of full-system examination refusals [Range 0–10; 90 per cent of students between 0–2]	0.68	0.61	0.59
Mean number of single-system examinations [Range 0–40; 90 per cent of students between 4–24]	12.96	11.44	11.14
Mean number of single-system examination refusals [Range 0–12; 90 per cent of students between 0–2]	0.93	0.65	0.55

students reported difficulties in medicine, in any of the three years.

So far as sex of student effects were concerned, male students were significantly more likely ($p<0.004$, chi square) to experience patient refusals in obstetrics and gynaecology. This difference did

not apply to the sexually transmitted diseases clinic in which both male and female students were equally likely to experience patient refusals.

Reasons given for refusals were also consistent across years. The most frequently offered reason (indicated by almost half the students on each occasion) was that the patient was 'too ill or too tired'. The second most frequently marked was 'too embarrassed'. About one third of the students said there were occasions when no reason was given.

Nearly half the students refrained from answering the question on further education. Of those who did, a small majority said they did not wish to have further training in this area.

Table 2
Numbers of students saying a specialty was an exception to the general refusal rate. (In every case, an 'exception' means higher refusal rates)

Year	No of students responding	Specialty	No (%) of students saying specialty was an exception
1989	90	O & G	56 (62%)
		STD clinic	17 (19%)
		Paediatrics	13 (14%)
		Psychiatry	9 (10%)
1991	84	O & G	37 (44%)
		STD clinics	36 (43%)
		Paediatrics	11 (13%)
		Psychiatry	16 (19%)
1992	81	O & G	44 (54%)
		STD clinic	48 (59%)
		Paediatrics	14 (17%)
		Psychiatry	12 (15%)

2. THE OPEN DAY STUDY

With one exception, results were strongly in favour of taking part in clinical teaching no matter what the setting. The exception was item five: 'As a patient at an STD (sexually transmitted diseases) clinic at a teaching hospital'. In this setting, 44 per cent of respondents said 'yes'. The least difficult was item three: 'As a patient in a diabetic or asthma clinic in a teaching hospital', where 96 per cent said 'Yes'. All other items range from 73–90 per cent 'Yes'.

More women than men said they would refuse in the STD clinic although the difference did not reach statistical significance (chi squ.p=0.051). Contrary to expectation there was a marked sex difference, reaching beyond the probability measures, on item 12. 'If some public hospital consultants with responsibility for teaching were to begin teaching in private hospitals, would you expect to be told this when booking in?' All except one woman (34 out of 35) said she *would* expect to

Table 3
Number of Open Day visitors saying they would not agree to take part in clinical teaching

1. As a patient in the medical ward of a teaching hospital	9 out of 71 (13%)
2. As a patient in the surgical out-patients' department of a teaching hospital	9 out of 71 (13%)
3. As a patient in a diabetic or asthma clinic in a teaching hospital	3 out of 69 (4%)
4. As a patient in a community-based general practice run by the university	7 out of 70 (10%)
5. As a patient at an STD (sexually transmitted diseases) clinic at a teaching hospital	38 out of 68 (56%)
6. As a parent on behalf of your four-year-old child in the paediatric ward of a teaching hospital	12 out of 70 (17%)
7. As a patient in a private surgical hospital where the surgeon also held a part-time position in a teaching hospital	16 out of 71 (23%)
8. As a patient in a rest home where the visiting consultant was also a consultant at a teaching hospital	11 out of 70 (16%)
9. As a patient in a private psychiatric hospital where the consultant was also a consultant at a teaching hospital	18 out of 70 (26%)
10. As a client at one of the Family Planning Association's clinics where the doctor was also a member of the university teaching staff	15 out of 71 (21%)
11. As a client at a private fertility clinic where the doctor was also a member of the university research staff	19 out of 69 (28%)

Number of Open Day visitors replying 'No' to the following two questions

12. If some public hospital consultants with responsibility for teaching were to begin teaching in private hospitals, would you expect to be told this when booking in?	14 out of 70 (20%)
13. Would this affect your decision to go to this hospital?	53 out of 70 (76%)

be told, but more than one third of the men (13 out of 35) said they would *not* expect to be told.

Discussion

The results of these studies raised a number of issues, three of which are discussed below. The first has to do with the difficulties most patients experience in submitting a private part of the body for examination. The second has to do with alternative interpretations of refusal rates. In the third section some more general issues are raised relating to patients' reasons for taking part in teaching programmes at all.

1. Privacy, embarrassment and consent to take part in teaching

Open Day respondents were not only a non-representative sample of the population, they were also more likely to be drawn from amongst those who have benign attitudes towards medicine and its practitioners. The fact that a majority of them declared themselves to be willing to take part in teaching programmes is perhaps therefore not surprising. What did surprise, however, was the fact that the strongest, and in fact the only negative response, even amongst this group of respondents,

was to taking part in teaching in the STD clinic. This was in the context of marked support for taking part in teaching in all other settings. (We had expected the strongest differences to emerge on the issue of public versus private settings, see below.)

This finding did, however, corroborate the students' reports of high numbers of refusals in the STD clinic. Students' unsolicited comments on this problem were both stronger and more numerous than their comments on any other problems in 1992. (This did not apply in 1989 when students' comments on problems in O and G were equally strong.) For example, one student wrote that the problem of refusals was 'terribly bad in STD - was it worth going?' And another, 'only saw one patient, therefore *won't* be able to diagnose STDs'.

Clearly, no matter how close the similarities, most people appear to perceive the dissimilarities as stronger when it comes to an examination of a rash on the forearm as opposed to an examination of a rash on the foreskin. The data reported here, from both studies, indicate a highly significant difference in the public mind.

Invasion of privacy, embarrassment and possibly shame may all contribute to the difficulties experienced in this setting by patients, clinicians and students. It appears, however, as though the issues

surrounding this difficulty are qualitatively different from those surrounding the general issue of patient willingness to take part in teaching programmes. In this area, patient sensitivities and the need to respect these, appear to be so strong that clinicians might want to put more emphasis on alternative ways of educating students in this specialty.

First, more use might be made of technological advances in audio-visual and computer-based learning. Increasingly available are vivid, highly accurate reproductions in either print or screen mode of the various clinical conditions. It makes sense to use these to their fullest extent in areas of patient sensitivity. Funding for such educational aids might be given priority in these areas.

Secondly, more use might be made of volunteers for training in the examination of normal organs. Work in this area has already been going on for several years in some settings, particularly for students at the beginning of their clinical training. Gynaecological teaching associates have provided an excellent model in O and G.

It is possible that the small decline in the single-systems-examination refusal rates reflects an overall improvement in procedures in O and G following the recommendations of the Cartwright Report (2). These included the necessity for improved communication with all patients and improved availability of information. In particular, the report recommended that 'prior consent must be sought from patients for all procedures conducted under anaesthetic, be they for the benefit of that patient and/or for teaching purposes. No more than two students (present with the patient's consent) may participate in a vaginal examination on an individual patient' (5).

The international reporting of the results of the Cartwright enquiry gave rise to a review of procedures in many other hospitals. A group from the O and G department of a British hospital wrote to *The Lancet* (6) saying that consent to medical student teaching was a 'neglected area'. They conducted their own survey of patient attitudes, finding 'high objection rates' and suggested that the 'excellent patient co-operation we enjoy in our clinics is often accompanied by reservations'. They too said they intended in future to seek the patients' consent for students to do vaginal examinations under anaesthetic.

2. *Alternative interpretations of low refusal rates*

There are several ways of interpreting the possible decline in overall refusal rates. First, it might be argued that since the decline in rates, although consistent, is non-significant in two of the three categories (ie, for interviews and full-system examinations) it is not yet clear whether there is an overall decline. Further data, collected over an additional three-year period, would be needed to clarify this issue.

Secondly, if there is a real decline, differing interpretations are possible. For example, it may be that in the immediate post-Cartwright period patients felt empowered to refuse; but that since then, with the passage of time doctors may once again be pressuring patients in subtle ways to take part in teaching programmes against their wishes. Or it may be that the additional, new programmes in medical ethics and communication skills have led to an improvement in medical student behaviour.

At the Auckland School of Medicine, after lengthy and sometimes heated debate, it was finally agreed that 'students must seek the agreement of patients allocated to them to be interviewed and examined, or to be the subject of specific learning procedures, and must explain clearly what is involved' (1). The controversial aspect of this directive was the emphasis placed on the student. Some wanted the responsibility for asking to be given to a third person (a nurse, patient advocate or senior clinician) on the grounds that it would be easier to refuse a neutral intermediary. Students were finally given this responsibility themselves on the following grounds.

First, training in communication skills and medical ethics was seen as requiring a strong practical component in addition to the theoretical one. If students had not been given the opportunity actually to use these newly acquired skills in the wards they might have come to undervalue, and even lose, them. Secondly, some felt that the proposed intermediaries, being senior experienced people, might be even more difficult to refuse than medical students.

Most important of all, however, it was felt that the more information a patient had about the person he or she was actually saying 'yes' to, the more the patient was being empowered. In initiating a conversation with the patient, prior to asking permission to take a history or examine them, both the patient and the medical student have the opportunity to see one another, albeit briefly, as human beings. Saying 'yes' in principle about an unknown medical student may have resulted in a patient occasionally being required to co-operate with a person he or she did not feel comfortable with. Having the student come and ask personally, puts a patient in possession of further relevant facts which enable a more informed decision to be made.

Notwithstanding any of the above, what would constitute the ideal refusal rate? It could be argued that a small refusal rate would be best. A low refusal rate could be said to demonstrate that patients can and sometimes do refuse when they feel unable, for whatever reason, to co-operate with the teaching programme. A high refusal rate might indicate one of a number of things, including inadequate communication skills, inadequate knowledge of patients' rights or lack of sensitivity to a patient's general condition, ie, the situation which arises when a patient is too ill.

Thus medical educators, patient advocates and patients themselves might consider that the system was working well and that adequate safeguards were in place if refusal rates continued at their present level.

3. Reasons for co-operating in teaching programmes

In the Open Day survey, those respondents who said that their decision to go to a particular private hospital would be influenced by the knowledge that they might be asked to take part in a teaching programme, were asked to give their reasons. Of the small number of respondents in this category ($n=18$), six gave reasons which appeared to indicate that if they were paying for their treatment, they would not expect to be asked to contribute in any way. For example, one respondent wrote: 'As it is a private hospital I would be paying a sizeable sum of money' and another: 'I would want a fee concession'. Other respondents emphasized privacy, confidentiality and inconvenience as reasons for refusing.

These comments all raise questions about why any patient should consent to take part in the teaching process. Five reasons have been offered. One is that some patients enjoy the additional attention. They argue that having another member of the medical team review their case in depth can result in benefits to the patient. There is a further opportunity to reveal and discuss worrying problems (especially problems which may have seemed too trivial for a busy consultant) and there is also the possibility that previously overlooked signs or symptoms may be revealed.

Another group of patients see co-operation with the teaching programme as a reasonable return for kindnesses received, especially kindnesses that are seen to be above and beyond the call of duty. Such a patient may say: 'Well, they've been very good to me. It's the least I can do in return'.

For those patients who do not particularly enjoy or seek the additional attention, or feel obliged to return kindness, three further reasons to take part in teaching have emerged. Some patients see it as an obligation or duty done in return for free or subsidized hospital care. Other public hospital patients see this as untenable, claiming that such patients have thought insufficiently about how the hospital is funded in the first place. These patients say they feel no such burden of gratitude since they have paid in advance for their care through their taxes.

A further group of patients see their co-operation as a *quid pro quo* for having one of the best consultants. Finally, some see it as the duty of the good citizen to ensure there will be properly trained doctors for future generations.

In situations where patients see advantages in taking part in teaching programmes, there is no problem; nor presumably is there a difficulty if patients wish to return a kindness, except perhaps where a patient's distorted sense of obligation

outweighs what is reasonable. And who could object to the altruism inherent in the thinking of the patient who contributes to the welfare of future generations because he or she sees it as the duty of the good citizen to do so.

But what of the remaining reasons? Are these equally moral? In the context of a just society, one could argue that being poor ought not to bring further disadvantages in terms of unwelcome obligations to take part in teaching programmes against one's wishes. On the other hand, if the majority of patients in public hospitals were to take this view, it is entirely possible that future clinical training would become inadequate or even deficient.

The data presented here show that patients in public hospitals are usually willing to co-operate with the teaching process. There is also some evidence to suggest that patients might be willing to co-operate with teaching in private settings. But their reasons for doing so remain a matter of conjecture. Further information is needed in this area, the source of which would optimally be patients themselves.

As the public hospital teaching-base declines in size it may become necessary to investigate these reasons in greater depth. With so much treatment now being provided outside the teaching hospital, extension of the teaching arena into both community and private settings is already taking place. The advent of students into such settings may sharpen the issues further. Since medical students carry with them into medicine the attitudes commonly held in the communities they came from, some of them will have thought that the patient's co-operation with the teaching process is a fair return for 'free' care. This in turn could lead to students thinking that patients' co-operation is less altruistic than it actually is. A slight, subtle but important shift in student (and consultant!) attitude might become apparent if students were to request permission of patients in private hospitals. A theoretical prediction, this is at least partially supported at the practical level by a study from the United States.

Cohen *et al* (7) conducted a national survey concerning the ethical aspects of informed consent and the role of medical students. In a large ($N=1,596$) random sample of all medical students graduating in 1985 in the United States of America, they found that students whose training had been predominantly in 'non-public hospitals' and who had cared 'primarily for private patients' were more likely to introduce themselves as students and to explain that they were not yet physicians. Conversely, students who had been 'caring for non-private patients in public hospitals' were more likely to introduce themselves as doctors without giving any information on their professional or educational status.

In countries where medical training has so far been largely confined to public hospitals, it may be that moves towards broadening the teaching-base

will need to be preceded by further investigation and analysis of patient rights and patient duties in the area of co-operation with teaching.

Valerie J Grant, PhD, is Chair of the Interdisciplinary Teaching Committee in Medical Ethics, Auckland School of Medicine, Auckland, New Zealand.

References

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News and notes

Access to health care

Charity, Justice, and Rights: Philosophic and Religious Perspectives on Access to Health Care, a conference jointly sponsored by Mount Sinai School of Medicine, CUNY, University of Notre Dame, Saint Mary's Hospital, will be held from 1-3 February, 1995 at Jupiter Beach Resort, West Palm Beach, Florida.

This conference will include both invited and submitted papers. Abstracts on the following topics are being considered: The right to health care; Justice and health care; Charity and health care; Religious positions on the provision of health care; The history of health

care delivery in the public, private, or religious community; Rationing health care; Allocating health care to the terminally ill, to the aged, to neonates, to people with end-stage organ failure, to the HIV population, to legal and illegal aliens, to prisoners; Worthiness and access; Access to organ transplantation, and The nursing or medical tradition on access.

For further information contact: Rosamond Rhodes, PhD, Box 1108, Mount Sinai School of Medicine, One Gustave Levy Place, New York, NY 10029. Telephone: (212) 241-3757; fax: (212) 427-7862.

News and notes

Health Law and Ethics in a Global Community

The organisers of The Fourth International Conference Amsterdam '95: Health Law and Ethics in a Global Community are calling for abstracts.

The conference will be held at the University of Amsterdam in the Netherlands from 16-20 July, 1995.

The four themes for abstracts are: Health and human rights; The death debates; Genetics and reproductive technology, and Health, ecology, persons and planet.

Abstracts, in English, should be between 200 and 250 words and should be typed, double-spaced, single-

sided and submitted as soon as possible to: the American Society of Law, Medicine and Ethics, 765 Commonwealth Avenue, Suite 1634, Boston MA 02215, USA. Telephone: (01) 617-262-4990; fax: (01) 617-437-7596.

For further information contact the Amsterdam '95 Abstract Committee at the above address.

The conference organisers are: The American Society of Law, Medicine and Ethics, The University of Amsterdam and The Dutch Society of Health Law.