Patients’ views and feelings on the community-based teaching of undergraduate medical students: a qualitative study

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Background. The 1993 directive Tomorrow’s Doctors recommended an increase in community-based teaching. In response, many new programmes have been established focusing on the teaching of clinical skills to pairs or groups of students in general practice, when patients are asked to see the students in the practice or in their homes, specifically to assist with teaching. This differs from the traditional model of teaching primary care, when one student sits with the doctor while s/he consults. Although current research suggests that patients are happy for one student to be present during a consultation with their GP, little or nothing is known about their views of this new method of teaching basic clinical skills in the community. If the new community-based teaching programmes are to be sustainable, continuing support from the patients is necessary. Students have been taught clinical skills in the community at University College London Medical School for several years. Research has demonstrated its effectiveness and its popularity with students. However, to date, patients’ views have not been explored.

Objective. Our aim was to determine the patients’ views and feelings on community-based teaching, in order to discover both the positive and negative aspects for participating patients.

Method. A qualitative semi-structured interview study was carried out in undergraduate teaching general practices in North London.

Results. Respondents felt very positive about participating in the community-based teaching programme. There were two underlying components to this: altruism and personal gain. Within altruism, reasons included: provision of a service to the community and repaying the system. Aspects of personal gain included: improved knowledge, improved self-esteem and companionship. Patient concerns included: embarrassment, reinforcement of the sick role and concerns about student access to notes.

Conclusions. Patients enjoy their involvement in community-based teaching and perceive themselves as making a valuable contribution. The findings of the research will be reassuring for doctors who presently are involved and those who plan to be involved in the future. Doctors need to be aware of the possible shifts in the doctor–patient relationship when actively seeking patients’ help in the teaching.

Keywords. Community-based teaching, patients’ views, qualitative research.

Introduction

In response to the General Medical Council’s directive, Tomorrow’s Doctors (GMC, 1993),1 most medical schools are increasing the amount of community-based teaching. This directive recognized that the community offers a wealth of teaching opportunities for medical students, since patients with chronic diseases and significant clinical signs, previously managed in the hospital setting, increasingly are being supported and cared for in the community. This move has also been supported by the findings that community-based teaching is as effective as hospital-based teaching of basic clinical skills.2–4 One feature common to these new programmes is the change from the traditional model of general practice-based teaching, of one student sitting in with the doctor while s/he consults, to pairs or groups of students being taught their basic clinical skills with the help of patients, who have been asked specifically by their doctors to assist in teaching.
The sustainability of community-based teaching is dependent on the ongoing willingness of all participants, i.e. patients, GP tutors and students, to take part. Previous work has demonstrated that GP tutors perceive substantial personal advantages from teaching, and the popularity of community-based teaching amongst medical students has been well demonstrated.

Research looking at the traditional teaching methods in general practice suggests that patients are happy for a student to be present during a consultation with their GP. In Newcastle, patients involved in a Medicine in Society course, where a pair of students visited the patient at home several times over 6 months, were positive about this initiative, seeing themselves as active teachers of the students. However, the University College London (UCL) model requires more intensive input by patients who may give up half a day per month for many years to participate in student teaching. GP tutors involved in this model have expressed concerns that patients will become fed up (or ‘fatigued’) by their repeated prolonged exposure to medical students and eventually will refuse to have further contact with them, so jeopardizing the future of community-based teaching.

The UCL Medical School has been running a community-based teaching programme of basic clinical skills for a number of years. The programme consists of a 5-week general medicine firm taught entirely in general practice. Most of the time is spent in the general practice, where the GP tutors concentrate on teaching the basic clinical skills of history taking and physical examination. The students see a wide range of patients with common medical conditions. GPs within the teaching practices identify these patients, who are then contacted either by their own GP or by a nominated member of the practice staff. This person then advises the patient of what the teaching involves, i.e. 1–2 medical students asking them questions and examining them either in their own home or in the practice. The patient is advised that each session will last ~2 h and that they are not attending for routine medical care. If the patient agrees to become involved in the community-based teaching, their names are held by the practice and they are then contacted a few weeks prior to the teaching session.

**Aims**

This study aimed to determine the patients’ views and feelings on community-based teaching, in order to discover both the positive and negative aspects for the patients participating and develop systems to ensure that the teaching benefits all the participants.

**Method**

**Recruitment**

Approval from the local research ethics committee was gained. Patients were recruited from four practices involved in the community-based teaching of basic clinical skills; each had a large intake of clinical medical students, i.e. 4–6 students every 5 weeks for 20–40 weeks of the year.

GP tutors were asked to identify a maximum variety sample of patients (Box 1). Once selected, the patients were sent a letter from their own GP, informing them of the nature of the project and inviting them to be involved. If they agreed to be interviewed, they were asked to return a reply slip to KC. On receipt of the reply slip, the patients were contacted by telephone. Tape-recorded interviews were organized and a consent form to be completed prior to the interview was sent to the patient.

Each of the four practices sent out six letters. Fifteen patients responded, of whom 13 were currently involved and two had previously been involved in the teaching and then stopped. Fourteen were interviewed in their own homes and one was interviewed at their GP’s practice at their own request. No patients who had declined to be involved in the teaching responded to the invitation to take part in the project. The two patients the GP tutors had identified as having stopped their involvement in the community-based teaching believed they were still involved.

**Box 1  Sampling strategy**

GP tutors were asked to recruit:

- Patients actively involved in the community-based teaching
- Patients who had declined to be involved in the community-based teaching
- Patients previously involved in the community-based teaching and now stopped

And to try to maximize the variability of the sample with respect to:

- Gender
- Age group
- Employment status
- Ethnicity
The interview

A semi-structured interview schedule was designed to address GP tutors’ concerns about the sustainability of the community-based teaching programme as well as perceived patient concerns. These concerns had been identified by GPs during a focus group of tutors to explore their concerns about the sustainability of the programme (Box 2). Eighteen tutors participated in this group, and the major concern identified was the risk of ‘patient fatigue’.

The interviews were carried out by KC. Patients were told that she was a doctor working in the Department of Primary Care at the Medical School who organized the community-based teaching programme. Patients were advised that any information generated during the interviews would not be passed to their GP.

Pilot interviews were carried out and did not result in any changes as the interview adequately covered all areas of interest and no new areas arose. After the first five interviews, the interview schedule was modified in order to cover a new emergent theme based on patients’ feelings about their notes being used in the teaching. This topic was then included in all the following interviews.

Data analysis

Interviews were audio-taped, and on one occasion when this method failed the interviewer took extensive field notes. All interviews were transcribed in full. A thematic framework was generated from the emergent data based on recurrent themes and issues. This was then applied to the textual data. The indexed text was then lifted and put into charts14 with the same themes, allowing comparisons to be made within and between the data. In order to ensure the accuracy of the analysis, the transcripts were read, charts checked and discussions were held with EM. Two patients were interviewed with their spouses. These are identified by number (of respondent) and letter, e.g. 10a.

Results

The overwhelming theme that emerged from the respondents’ experience of the community-based teaching was that they felt extremely positive about the teaching and, given the opportunity, would be willing to participate indefinitely. Two quite distinct underlying incentives for participating, altruism and personal gain, were identified and the data are presented in terms of these two dimensions. In addition, a number of other interesting themes regarding the teaching were generated and these are presented separately as patient concerns regarding the teaching.

Altruism

Providing a service to the community through training better doctors. Patients believed that their involvement with medical student teaching provided a service to the wider community as it broadened students’ experience, enabling the students to become better doctors in the future. They also felt that their doctors would become better doctors as they were getting the opportunity to learn more about patients’ feelings and experience of illness.

“[It] makes me feel good that I’m putting something back into the community.” (1)

“I think they’ll be more aware of the fact that what they suggest as a course of treatment is not necessarily viable for the person concerned. They may bear that in mind next time they have to make a diagnosis.” (9)

Repaying the system. Patients saw it as a way of repaying the NHS, as well as assisting their doctor who provides ongoing care. Many of the patients would not be able to contribute financially to the NHS, and were pleased to be able to help.

“I feel sort of slightly as if I’m giving a bit back, because I’ve had a lot out of the health service.” (11)

Providing a service for no financial reward. In line with the altruistic motivation, patients were against being paid for their help in teaching as they felt that:

(i) patients expecting compensation would be doing it for the wrong reasons;
(ii) the NHS is already financially challenged;
(iii) the service, i.e. involvement in community-based teaching, being provided is voluntary;

Box 2 Interview schedule

Areas explored:
• What patients felt about their involvement in the teaching with prompts for positive and negative aspects
• How the teaching affected the patients’ relationship with their doctor
• What the patients thought the doctors and students got out of the teaching
• How long the patients felt they may want to go on with the teaching
• Whether the patients would find it difficult to stop their involvement in the teaching and if stopping would affect their relationship with their doctor
(iv) the teaching programme is for the good of the wider community; and
(v) payment would make it more difficult to refuse future involvement.

Some patients felt that refunding travel expenses would be acceptable.

**Personal gain**

**Improved knowledge.** The close contact with the doctor and the medical students offered the patient the opportunity to learn more about their disease. This empowered the patients, making them more confident in the ability to cope with their own medical problem.

> “Even I can learn something from the students. It’s not just a one way system.” (15)
> “I know when something is wrong and I can do something about it.” (1)

**Enhanced self-esteem.** A number of patients involved with the community-based teaching suffered with chronic diseases, which had left them unable to work, with ensuing feelings of worthlessness. Involvement in teaching gave patients a sense of worth and pleasure.

> “It’s given him another outlet when he’s at home all the time and he’s got something else to think about.” (10a)
> “I just love doing it actually.” (1)
> “I felt I had something to offer as I was very unwell.” (2)

**Relief from social isolation/opportunity for companionship.** Many patients involved in the community-based teaching were elderly and lived alone. A visit from medical students and their doctor helped ease their isolation.

> “I have a visitor for half a morning; somebody different to talk to.” (9)
> “I’m always happy when they’re here.” (12)

**Reassurance of well-being (‘a good going over’).** Having agreed to participate in the community-based teaching, patients discovered that their involvement provided them with the opportunity to have frequent thorough examinations, which in turn provided them with a sense of reassurance of their well-being, and improved the chances of any new problem being identified earlier.

> “When they take your pulse and your blood pressure you know how you are getting on.” (2)
> “These kids they come along, and I’m undressed entirely, may find some little thing that’s not normally spoke about.” (12)

**A perceived better service.** The patients believed the teaching provided them with a direct improvement in their care through their GP gaining a better understanding of their medical condition. Patients also judged their doctor’s involvement in teaching as evidence of excellence. Moreover, they felt that this involvement would be of benefit to their doctor, as a way of keeping them up to date.

> “His doctors have got more understanding of him because he has multiple problems and where before he says he couldn’t relate, he couldn’t express himself, he can now a lot more easier and they understand him a lot.” (10a)
> “It would help them (the doctors) to keep more up-to-date with things going on in the hospital.” (5)

**Anticipated better service.** GP tutors had expressed concerns that their involvement in the teaching might make patients feel that they have a special relationship with the doctor that entitled them to out of the ordinary care. The general consensus from respondents was that this would not happen; however, the potential for this to occur was also apparent.

> “We’re just another patient really, aren’t we? I don’t see how we should have any priority.” (7a)
> “I do think maybe, if you need to see a doctor and you had to wait a long time, that they ought to be able to fit you in.” (5)

**Patients’ concerns regarding the community-based teaching.** Having received no responses from patients who had declined to be involved in the community-based teaching, it was difficult to identify the underlying reasons for not wanting to take part in the teaching. However, comments made during interviews with patients who were involved, as well as those patients whom the GP tutors had identified as having stopped their involvement, provided some insight into possible reasons for declining involvement.

**Source of embarrassment and anxiety.** Patients implied that the teaching generated feelings of anxiety and embarrassment, particularly during intimate examinations. This may have been prevented if the consulting doctor had asked the patient to re-consent to the student to be present during the examination.

> “It was embarrassing on one occasion when I went there—I had trouble going to the toilet and he thought I might have piles or something like that, and there was a woman student there and I thought this was a bit embarrassing, but he did pull the screen back, though I’d rather he’d done it on his own you know.” (3)
> “I know some people have refused. I suppose it’s just that they feel a bit embarrassed.” (7a)

**Reinforcing feelings of ill health.** Patients expressed concerns that repeated contact with doctors and medical
students reinforced their feelings of ill health and that this would be a reason for not increasing their involvement further.

“I wouldn’t want to increase my involvement. I have so many medical problems anyway, and I’m constantly needing to go up to the hospital and to the doctor’s surgery, I’d like to get away from it all—you know try to be well.” (13)

Providing a service as often as required. GP tutors had expressed concerns that patients may have felt unable to refuse to do the teaching. The responses given during the interviews indicated that this was not a problem and patients were happy to do it if and when asked, providing they did not have any other arrangements that took priority.

“As long as I don’t have anywhere to go, if I have somewhere to go I’d have to cancel it.” (2)

“As long as the day is free I don’t mind.” (6)

“Send them round the same day if you want.” (9)

Consent and confidentiality. Patients did not expect that consenting to see students is taken as consenting for students to have access to their medical notes. Indeed, several patients specifically commented when asked about students’ access to their notes, that they did not want this to occur.

“I think the patient should have some say in it, because that’s supposed to be private and confidential between my doctor and me, so the students aren’t allowed. I wouldn’t stop, but I would like them to stop using my notes.” (15)

Discussion

The main finding of this study is that patients enjoyed participating in this form of community-based teaching. They perceived both altruistic and personally beneficial reasons for involvement, and identified few detrimental effects from participating. Most would continue their involvement indefinitely if invited to do so.

There was a remarkable consistency of results, with few new themes emerging after the first five interviews, and none after the thirteenth, suggesting that we had sampled to the point of redundancy. Respondents felt able to raise new topics (e.g. access of students to their notes) during the interview, confirming that they perceived the interviewer as independent.

In order to address the concerns of the ethics committee, and respect patients’ confidentiality, recruitment was by ‘opting in’. Although this method tends to recruit fewer participants as it involves active consent, 62% of those approached agreed to be interviewed, echoing their altruistic motivation in participating in teaching.

Unfortunately, no patients who had declined to participate in teaching were prepared to be interviewed, and the two patients who had been identified by their GP as no longer participating in teaching perceived themselves as still involved. This prevented the study determining what prevented patients from initially becoming involved, or why they wanted to stop. Reassuringly, no interviewees felt that it would be difficult to cease their involvement and there were no suggestions that patients initially had felt coerced into participating.

There is an increasing body of evidence supporting active patient involvement in medical education.15–18 In our study, patients saw themselves as making a specific contribution to medical student education and deriving a number of personal benefits as a result of their involvement. This echoes Stacy and Spencer’s13 finding that patients involved in a different model of community-based teaching saw themselves as active teachers of students and also felt that they derived similar personal benefits. Not all the perceived benefits may be real, however; for instance, the reassurance provided by a ‘good going over’ by a medical student may be unwarranted and theoretically could prevent patients from seeking qualified medical advice when indicated. The similarity of our results suggests transferability to other environments, given that the nature of the educational initiative, in terms of both the amount of time patients committed and the objectives of the attachment, was very different in the two studies, as was the geographical location.

However, patients appear to have real concerns about student access to notes.19,20 Clinical teachers must note this, and consent for student access to notes can no longer be assumed. There may also be a broader issue here: to what extent are patients aware that information, and hence notes, is shared between the entire primary health care team on a need to know basis?

The relationship experienced between a GP tutor and his/her patient is unique. GP tutors, who actively have to seek help from patients, may feel indebted to the patient, with a resultant shift in their relationship.21 If so, could the real issue be ‘tutor fatigue’ rather than ‘patient fatigue’? Is ‘tutor fatigue’ a manifestation of some GPs’ discomfort with the potential shift in power toward the patient within the doctor–patient relationship? There is evidence that some GP registrars are still more comfortable with a model based on benign paternalism, rather than an egalitarian relationship.22

The findings will reassure doctors already involved in teaching as well as those who are considering getting involved in the future. They have highlighted training issues for GP tutors including recruitment of patients; strategies for clarifying patients’ desired level of involvement; and methods to ensure that patient consent for student access to notes is not assumed. A more fundamental problem is the difficulty some tutors appear to have with the change in the doctor–patient relationship inherent in this type of teaching. This may be a part of the
wider changes occurring with better-informed patients choosing to play a more active role in their health care. In the long term, will students who learn in primary care with autonomous patients feel more at ease with an increasingly egalitarian doctor–patient relationship?

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References