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Teaching medical students

Ethical challenges

Aim

To explore ethical challenges for general practitioners teaching medical students in urban general practice.

Methods

Semistructured face-to-face interviews with 60 urban general practice teachers with diverse teaching loads and practice demographics. Interview data were analysed following member checking of interview records.

Results

Participants identified concerns in relation to a number of areas including: student assessment and professionalism; teaching support from colleagues; patient consent and confidentiality; and the effects of teaching on consultation dynamics, patient satisfaction and patient care. Participants with smaller teaching loads and with full fee-paying patients were more likely to express concerns about involving students actively in consultations.

Discussion

General practice teachers should consider modelling seeking informed patient consent in difficult circumstances, while being mindful that patients may be reluctant to refuse or withdraw consent. Arguably students themselves should seek consent. General practitioners should consider maintaining the confidentiality of previously divulged patient information. Concerns about active student involvement in teaching consultations should be discussed with teaching colleagues from similar practice demographics, with reference to pertinent literature about patient attitudes to teaching.

Keywords: education, medical/ethics; family medicine; doctor-patient relationship.

Although recent research has explored Australian general practitioner teacher workforce capacity and remuneration,[1] less is known about other challenges for Australian urban GP teachers, particularly those of an ethical nature.

A range of urban general practices offer medical student teaching placements. Some have longstanding, regular commitments and established teaching cultures. Others have been recently recruited due to increases in medical student numbers,[2] or accept a smaller teaching load. Teaching practice demographics, business models and academic affiliations vary, as may patient expectations. These factors may have an impact on the challenges and concerns GPs experience in teaching ethically. This study explored the ethical challenges for GPs teaching medical students in urban general practice.

Methods

General practitioners who accept medical students in the third year of The University of Queensland medical program for their 28 session general practice rotation placements were invited to participate in a 20–30 minute individual face-to-face semistructured interview. Interviews were conducted by the principal investigator, a GP teacher attached to the Discipline of General Practice at the university. General practitioners were sampled purposively to reflect the diversity of local urban teaching practices (*Table 1*), including GPs with a relatively small teaching load. The interviews took place between 2007 and 2009 at the participants' general practices.

Participants were invited to identify the perceived benefits ('Can you tell me about the rewards of teaching; what do you like about teaching medical students?') and the perceived disadvantages ('Tell me about the difficulties of teaching, the challenges') of their teaching, as well as preferred teaching strategies and their approach to student assessment. Questions were open ended and reflective listening techniques were used to clarify responses. No survey style questionnaire or pre-identified ethical themes were used. Hand written notes were taken by the interviewer; these interview records were typed and forwarded to participants for member checking[3] to confirm the accuracy of included data. Initial thematic and content analysis was performed by the investigator and validated by a second coder as described in a previous paper.[4] Analysis for this article was performed manually by the investigator using content analysis. Information about patient consenting processes were sought from practice staff. Results relating to teaching related rewards, costs and challenges were presented in a previous paper.[4] This article focuses on the ethical considerations raised at the interviews by participants.

This research was approved by the University of Queensland Ethical Review Committee.

Results

Twenty-eight of the 29 practices (97%) approached to participate in the study agreed to take part. The practice that declined to be involved cited a prohibitively high GP workload. One GP later withdrew from the study, leaving a total of 60 participating GPs.

Forty-eight participants shared the teaching of individual students with practice colleagues. A number of other participants reported being unable to persuade colleagues to accept a teaching commitment.

Many participants reported concerns in relation to assessing students fairly, including difficulties with benchmarking, 'how good are they meant to be?' [GP 16] and adequate opportunities for assessment, especially if students were less actively involved in consultations. A few had concerns about the professionalism of particular students, including their punctuality, courtesy, respect

Table 1. Sampling framework of participants

Sample requirements	Number of participants meeting requirement
Diversity of practice demographics using index of relative socioeconomic disadvantage[18]	Decile 1–2: 6 Decile 3–8: 10 Decile 9–10: 44
Diversity of practice teaching loads	1–2 students yearly: 34 3–4 students yearly: 20 >5 students yearly: 6
Diversity of practice billing models	Bulk billing: 13 Mixed billing: 47
Academic and nonacademic GP teachers	Employed by university: 7 Not employed by university: 53

and commitment. Participants also reported concerns in relation to patient consent; patient confidentiality; and the impacts of teaching on consultation dynamics, patient satisfaction and patient care. In some cases participants were reluctant to adopt teaching strategies that were embraced by other GP teachers because of ethical concerns. These strategies included student previewing patient medical records before patient consultation and consent; initial student history taking and examination before a doctor joins the consultation; student assistance with procedures including infant immunisation, 'I am uncomfortable with the student injecting a child, I'm mindful of the mother's anxiety ("don't hurt my child")' [GP 12], excision of lesions; and unsupervised student advice to, and counselling of, patients.

Consent

All practices had a patient consent process. Almost all participating practices prominently displayed a University of Queensland laminated poster, which identified their practice as a teaching practice. A number displayed the current student's name and often identified the gender of the student; one practice displayed a student identification photograph. Several participants reported concerns about a situation in which patients might initially consent then recognise the medical student and have difficulty extricating themselves. In almost all practices, the consent process involved a receptionist indicating to patients in the waiting room (and sometimes earlier at the time of booking the consultation) that their doctor had a student for the session, and seeking patient consent for the student to be present for the consultation. Various messaging systems were used to identify to the GP those patients who had refused consent. A number of participants reported confirming consent with patients before they entered the consulting room, where the student typically waited. The need to further consent patients more explicitly to more active student involvement in consultations was identified. No participants admitted to the 'ethical lapse'[5] of identifying students to patients as doctors, although one used the term 'colleague in training' to help the student 'step up to the plate'. In only a few cases did consent appear to be recorded formally in patient records, and in no cases did a written form appear to be signed by the patient. Only one participant described a consenting process which involved the medical student directly approaching the patient to introduce him/herself and seek consent.

Participants reported high levels of patient consent (typically over 90% of occasions on which consent was sought) to student participation (or at least presence) in the consultation. One GP participant mentioned a tendency for consent rates to increase over time as a practice teaching culture became more established. Consent appeared not to be sought by some participants if they anticipated patient embarrassment or refusal, or deemed that student participation was inappropriate; mental health and (particularly with male students) intimate gynaecological consultations were the commonest scenarios. Several study participants described trying to anticipate patient preferences, but acknowledged having been surprised at different times both by patient readiness and patient refusal to be involved in teaching consultations. A number of participants indicated that private fee-paying patients were less accepting of active student involvement than those in bulk billing practices, 'Patient expectations are different in a professional practice with patients paying top dollar.' [GP 4]

Confidentiality

A number of participants reported experiencing a dilemma about whether to maintain patient confidentiality in teaching consultations about pertinent but personal psychosocial issues which patients had previously divulged, 'It can be inappropriate to introduce the patient's issues during the consult – you know, "This is Mrs Blogs, she's got depression".' [GP 25]

Confidentiality was also mentioned in the contexts of its importance to patients, and of asking students to sign a practice privacy policy document. One participant reported that his student health practice had terminated its teaching commitment after a patient suspected a medical student breach of confidentiality. Another participant reported that student concerns about patient confidentiality made students reluctant to follow up patient results.

Positive and negative consequences of teaching

Participants also reported concerns, even in patients who have consented, about negative patient attitudes to particular teaching strategies, particularly those with more active student involvement, 'You may get away with it for some of the older patients, but most patients have come to see the doctor not the student.' [GP 20] Ethical concerns with the parallel consultation or 'wave'[6] teaching model of prior student history-taking before the GP joined the consultation, included: logistical difficulties consenting patients; the potential for patients to be managed inappropriately by the unsupervised student, especially as the reason for presentation is unknown at the time of seeking consent; and the potential to undermine the patient-doctor relationship, especially in the early rapport building phase of a consultation.

Participants identified both beneficial and adverse impacts on patients of teaching in

consultations, as well as impacts on the teaching doctor's clinical processes and decisions. Potential benefits included increased patient insight into clinical reasoning, longer consultations, and a welcome role as 'teachers of medical students'. Examples of adverse patient health outcomes reported included unravelling of student sutures, patients undergoing multiple student attempts at venepuncture, and reduced effectiveness of counselling techniques because of inappropriate student interjections. However, participants were also concerned about more subtle adverse effects on patient comfort and rapport in consultations, and about impositions on patient time and goodwill.

Participants who conducted fewer teaching consultations, who practised in higher socioeconomic locations and who charged privately, expressed more concerns.

Discussion

An intentionally diverse and relatively large sample of urban GP teachers was interviewed. However, theoretical saturation in terms of ethical issues may not have been reached because the study did not specifically focus on these. Unfortunately, interviews were not audiorecorded. Nevertheless, the study identified a number of GP teacher concerns which may contribute to GPs being reluctant to increase their teaching load. These concerns may be shared by GPs who decline a teaching commitment.

A duty to teach medical students and junior doctors has been identified as a professional obligation in a number of clinical codes from the time of Hippocrates to the present, including the Australian Medical Association Code of Ethics[7] and the Australian Medical Council's Good Medical Practice.[8] However difficulties recruiting teaching practices and GP teachers[9] suggest that for many medical practitioners altruism is not enough to outweigh perceived disincentives. To some extent, the teaching 'burden' also falls to other practice staff including practice nurses and practice managers, and nonteaching practice colleagues who may carry a greater patient and income generation load as a consequence of the reduced productivity of the practice's GP teachers.

The consent process reported by participants (and confirmed by the investigator with practice receptionists) is in keeping with The Royal Australian College of General Practitioner's admonition against 'ambushing' the patient.[10] However, The Council on Ethical and Judicial Affairs of the American Medical Association advised that students themselves should take responsibility for seeking patient consent in order to practise a clinical skill, establish student-patient rapport (potentially increasing consent rates), and to allow patients to ask questions and vet the student before consenting.[5] Written consent may be medicolegally advisable, but a United Kingdom study found that patients did not consider written consent necessary, and the investigators suggested that requesting written consent might discourage patient involvement.[11]

General practitioner preceptor decisions not to seek consent may miss opportunities to model the clinical skill of seeking consent in difficult circumstances, as well as teaching opportunities. However, GPs may be mindful of patient reluctance to refuse consent even if they do not want student involvement. There is evidence that patients may have difficulty refusing consent, and also that they may later regret having consented.[12] On the other hand, some patients may be willing to have greater involvement than that anticipated by the GP.[13]

The literature also suggests that many patients have altruistic motivations to assist with student training. In a 2004 UK general practice patient survey study, 80% of patients would see a medical student because 'they have got to learn somehow', and 34% to 'give something back'. Consent rates decreased with the invasiveness of medical involvement. Male patients were more likely to consent to procedures than women, and student proficiency and gender influenced consent rates.[11]

This study also found that 22% of patients would not consent to students reading their medical records.[11] A review of patient perspectives on medical confidentiality[14] quotes three studies indicating that the majority of adult patients expect medical students to have only limited access to their medical records, and other studies finding that many patients expect their practitioner to withhold sensitive information even when release forms have been signed. Confidentiality may be more important to patients in general practice than in the more anonymous hospital context.[15] This literature is pertinent to participant concerns about patient confidentiality in relation to teaching.

In a 2010 focus group/survey study, New South Wales general practice patients found it problematic to have students present during consultations that involved worrying test results, emotional upset, internal examinations, and sexual problems; patients were also much less willing to see the medical student without a GP present.[16] There is also evidence that hypothetical consent does not always reflect actual consent rates.[17] The literature does not explore whether patients who pay directly for medical services have different views about teaching from those who are bulk billed or of lower socioeconomic status.

Discussion in teacher training and other GP forums, particularly with teacher colleagues from similar practice demographics, and with reference to the increasingly nuanced literature on patient attitudes, may allay some GP concerns in relation to active student learning in consultations. Teaching GPs should be aware of a number of approaches to patient consent and confidentiality in teaching consultations.

Implications for general practice

General practitioner teachers should consider:

- identifying the student before seeking patient consent for teaching, or asking students to seek patient consent
- modelling the skill of seeking consent in difficult circumstances, while acknowledging that patients may be reluctant to refuse consent or later regret having consented
- maintaining patient confidentiality in teaching consultations of sensitive, previously divulged information
- discussing concerns about active student learning with colleagues in similar practice demographics, with reference to the increasingly nuanced literature about GP patient attitudes to teaching in consultations.

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