Patient's Attitudes towards Trainee's Presence in Primary Care Clinic

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A medical student's training requires them to be present for medical appointments between a patient and a provider. A majority of patients are very comfortable with having patients in the room, but a small amount still feels discomfort with the student's presence. This discomfort may cause patients to withhold information from their provider and negatively impact the care they receive. This study seeks to confirm and measure the extent of these attitudes and to better categorize the information patient's prefer not to bring up.

Introduction

Patients feel a range of emotions in the examination room, which can show on their face and in their voice or through their posture and actions. Being a green medical trainee, I often sympathized with their nervousness with each new encounter raising my heart rate as I hoped to learn as much as I could. One of the things I quickly learned was that patients reciprocated my feelings. More specifically, patients were just as nervous about me as I was of them. Many avoided making eye contact with me and a few even asked me to exit the room after initially agreeing for me to be present. Some refused to allow me to be present for the entire duration of their medical visit. Thus, I began to wonder how patients felt about medical trainees being present for their visits and to explore the possibilities that came with the territory.

I wondered if students negatively impacted the medical visit. Did they make patients feel uncomfortable? Did they alter the medical consultation? The last being one of the chief concerns because it included history taking, which is often the source of many diagnoses. I speculated if patients omitted any information on purpose or accidentally because they were affected by the

student's presence and what exactly was it they did not mention. Hands-on teaching is essential in the training of a future health care provider, but did students do more harm than good?

These questions became more urgent in light of the population served by the community health center where I was stationed. CHCs are known to be health care safety nets for the poor and underserved. These at-risk individuals faced many challenges to get access to care and I did not want my presence as a trainee to be another obstacle. I set out to investigate the patient perspective and attitude towards trainees within the setting of a CHC in hopes of assuaging my concerns and shedding light on an under-researched population.

Background

Primary care in America is in a tenuous state. The American College of Physicians warned of its eventual collapse in 2006 due to a lack of manpower and financial support. [1] Fewer medical school graduates were electing to enter into primary care at the turn of the 21st century with reports of up to a 50% decline in the selection of primary care subspecialties in several studies done in 2007 and 2008. [2-4] Before the passage of the Patient Protection and Affordable Care Act (ACA), the country faced a projected shortage of 35,000 primary care physicians (PCP) by the year 2025. [5,6] A study done in 2012 by Petterson and colleagues raised this number to 52,000 PCPs after factoring in the increased utilization of the health care system with the passage of the ACA. [7] The enlarged burden on the health care system has not gone unnoticed by the federal government, which has also allocated funding for primary care delivery systems and education as a part of the ACA. $67 million of this funding is dedicated to supporting existing and constructing new Community Health Centers (CHCs), which have been designated with the responsibility of taking on the increased patient population.

CHCs were created in the 1960's to provide health care and social services to poor and medically unserved areas, acting as a primary care safety net for populations on the fringes of society. [8] Now, more than ever, CHCs are poised to deliver care on a sizeable population of newly-insured, vulnerable individuals and require a provider workforce to meet this demand. Provisions in the ACA are geared towards recruiting more primary care providers to train in community-based settings. [9] While this training will help to ameliorate the currently overtaxed health care delivery system, it also lends to the retention of an adequate workforce as residents and other health care providers have an increased likelihood of working in CHCs if they have trained in one as a student. [10-12] Therefore, the exposure of future health care practitioners to community based care settings is essential to the expansion of health care and the mitigation of the national primary care crisis.

While exposing students to patients in CHCs during training will benefit posterity, it is unclear how the presence of students affects vulnerable patients and their medical visits in the here and now. There have been studies investigating the trainee presence on medical visits, but there has not been one done with a focus on vulnerable populations. The last study to focus on the medical consultation and topics patients prefer not to disclose to their provider in the presence of a student was done by H.J. Wright in 1974 [13]. This study aims to compare if current views are comparable to those back in the 70's and how these views are expressed by those facing health care disparities.

Defined by the Center for Disease Control and Prevention as populations at risk for health-disparities [14], the patients served by the CHC where I worked in faced many difficulties in getting access to health care because they were largely uninsured, and low-income or at or below poverty level. Because the CHC offered specialty HIV services, there was also a substantial HIV

positive population who faced a greater burden of health-disparities on top of previously mentioned disadvantages due to their disease. This lent another layer of depth to the study because an investigation of this kind has never been carried out with HIV positive individuals. Therefore, the findings of the study are significant for medical teaching as well as medical practice.

Methodology

The study was carried out at one clinic of a chain of clinical health centers in the state of Texas. To be eligible, all study subjects had to be above the age of 18, literate in English or Spanish, and agree to have a medical student present during their medical appointment. A nurse asked all potential subjects if they would permit a female student to be present during their medical visit. All eligible subjects were then asked by the student to complete a survey in the language of their choice in the privacy of the examination room after their visit. The subjects were always given the option of opting not to do the survey and were fully informed that their personal identifiers and protected health information would not be attached to the surveys. Subjects were only allowed to complete one survey each.

The survey was a series of nine questions focused on the patient's experience with a medical student being present for their consultation and the topics patients prefer to not discuss when the student is present. A few of the questions were adapted from a survey issued by H.J. Wright and further expanded up on [13]. All the questions were multiple choice with the last question being open-ended to allow for commentary. The surveys were collected over the span of three weeks. At the conclusion of the three week, the data was recorded, saved in a password protected electronic database, and analyzed.

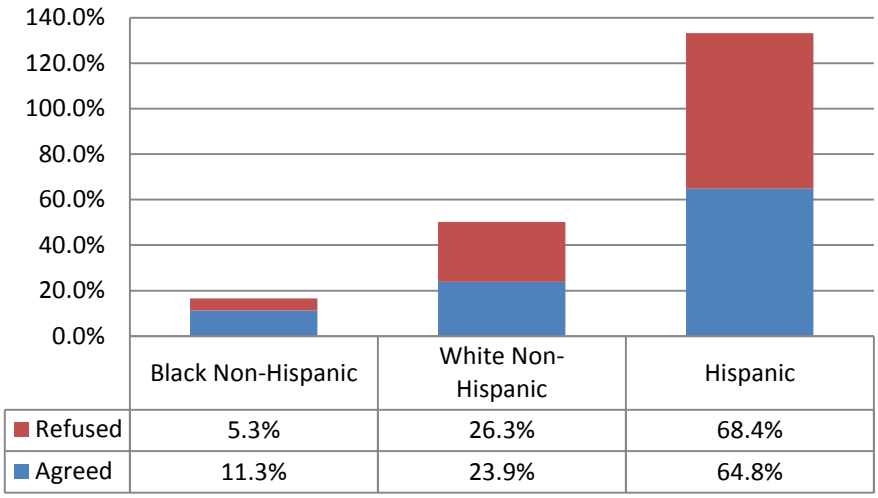
Results

Table 1. Demographics (%)											
	Ethinicity			Gender		Age					
	Hispanic	White Non-Hispanic	Black Non-Hispanic	Female	Male	18-29	30-39	40-49	50-59	60-69	70-79
San Antontio, Texas [15]	63.2%	26.6%	6.3%	51.2%	48.8%	21.9%*	18.7%	18.2%	16.1%	10.7%	6.0%
[redacted] Ryan White Clinic	65.6%	24.4%	10.0%	25.6%	74.4%	13.3%	20.0%	26.7%	24.4%	8.9%	6.7%
*this is an underestimation because only data from 20-29 yrs was available											

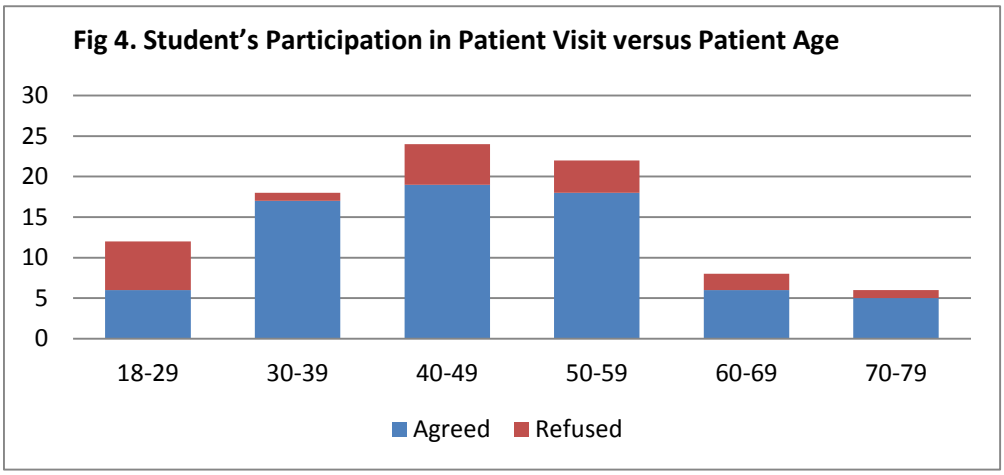
The breakdown in ethnicity of the study participants was very similar to the city of San Antonio with the exception of there being a slightly larger representation of black non-Hispanics among study participants (10.0%) than the city population (6.3%) (Table 1). Males were also over represented compared to females at the clinic because the prevalence of HIV is greater among men who have sex with other men than any other group of individuals. [16] 76 (84.4%) of the 90 patients approached were HIV positive. There were 23 females and 67 males who were asked by a nurse to allow a student to be present for their medical visit. Instead of there being 1:1 ratio of male to females, for every female patient that came through the clinic there would be three male patients. The age distribution of the study participants where comparable to the normal population after taking into consideration that there were no participants above the age of 80, which caused the 30-60 age ranges to be over weighted. 13.3% of study participants were 18-29 year olds compared to the 21.9% found in the normal population.

Overall, only 19 (21.15) patients declined to participate in the study out of the 90 patients approached. Race played a very small role in refusals as an almost equivalent amount of Hispanics and white Non-Hispanics refused or agreed to have a student present for their appointment with the physician. Black Non-Hispanics on the other hand were less likely to refuse allowing a student to participate in their care with rates of agreement (11.3%) doubling rates of refusals (5.3%) (Figure 2). Females were more likely to refuse than males with about 1 out of 3 refusing in contrast to 1 out of 5 men. There were refusals across the board for all age ranges, however, people in their thirties were the least likely to refuse (6%). The youngest patients were most likely to refuse with 50% of patients in the 18-29 age range opting to have a private appointment with their physician (Figure 4). When comparing the HIV positive patient to those who were HIV negative, those who were HIV positive were more open to a student's presence (82.9%) than those who were HIV negative (57.1%)

Fig 2. Student Participation in Patient Visit versus Ethinicity



	Black Non-Hispanic	White Non-Hispanic	Hispanic
Refused	5.3%	26.3%	68.4%
Agreed	11.3%	23.9%	64.8%



Of the 71 patients who agreed to participate in the study, 91% reported that they felt comfortable or very comfortable with having a student present for their medical appointment. Two (3.0%) patients were felt neutral about the experience, no one (0.0%) felt uncomfortable, and only 4 (5.6%) patients felt very uncomfortable.

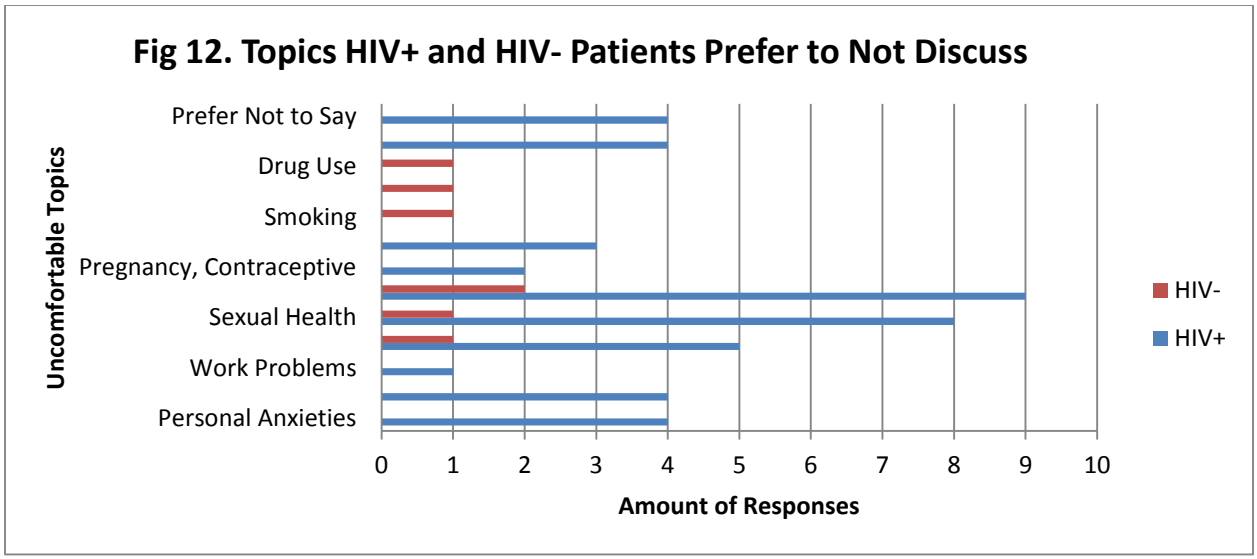
Anticipating that comfort level might be due to inexperience with students, comfort levels of patients were crossed with whether patients had prior experience with students. 41 (57.7%) of the patients had prior experience with a trainee while 30 (42.3%) did not. Regardless of their experience, most patients felt comfortable or better about a student being for their appointment. The 4 patients who felt very uncomfortable had never had a student participate in their care, but they were a minority (13.3%) among those who were inexperienced. Gender and HIV status showed little correlation with comfort levels.

Regardless of how they felt, 94.4% of patients would have a student be a part of their medical appointment. Even the 4 patients who felt very uncomfortable in the presence of a student would have a student be a part of their care again. A concern for patients was the student's gender. Many commented that on their next visit they would prefer someone of the same gender. This was particularly to true women as 43.8% of women preferred a student who was the same gender and 12.5% were unsure, commenting that their preferences extended to certain procedures. Men were

less selective, but a minority (10.9%) did prefer to have a male student and 10.9% of men were unsure at the time.

On the topic of communication, greater than 90% of patients did not find it difficult to discuss personal problems and were able to discuss everything they wanted with their physicians in the presence of a trainee. Even those who were very uncomfortable with trainees were able to do both of these actions with the exception of one subject who felt unsure if he could discuss personal problems in front of a student. When asked to imagine a scenario where the patient might withhold information due to the student's presence, the transparency reported by the patients declined to 76.1%.

The survey then further asked patients to describe the topics that made them feel uncomfortable. 47 (66.2%) patients reported that they had nothing that they felt uncomfortable discussing in front of a student while 24 (33.8%) did report that there were topics that made them uncomfortable. When the responses between those who were HIV positive and HIV negative were compared, HIV positive patients had more topics (35.5%) that made them uncomfortable to discuss than HIV negative patients (22.2%). In particular, HIV positive patients did not feel comfortable to discuss work, family or personal anxieties as well as mental health and pregnancy and contraceptive matters (Figure 12). They also had topics they preferred not to mention. HIV negative patients on the other hand, felt uncomfortable discussing drug, alcohol, and tobacco usage. Sexual practices, sexual health and finances were uncomfortable topics both groups shared in common. Sexual practices ranked first on the topics both types of patients did not feel comfortable to discuss in front of a student. Sexual health was a close second for HIV positive patients.



Discussion

While most patients (79.9%) are open to having a student be present for their medical appointment, 20.1% of patients would prefer to have private visits. Females (30.4%) were more likely to have a private visit than males (17.9%) even after being informed that the student was a female. Even patients who were open to letting the student participate in their care were wary about gender as 43.8% of females and 10.9% of males preferred to have a student who was the same gender as them. About 10% of both males and females were unsure if the student's gender was a concern with many of them remarking that it depends on the type of procedure and topic of discussion, which usually involved sexual health.

Refusals did not show a strong correlation with race or age with the exception of those in the youngest age range (18-29 y.o.) who tended to have a refusal rate of 50%. These young individuals were all HIV positive and probably adjusting to their new condition and did not want the additional factor of a student to be introduced to what can be a complicated time. For some, the appointment was also the first encounter with a physician after their diagnosis. The refusals might have also been based on the patients' desire to not be judged by someone close in age to

them. A student usually is perceived to be in his or her 20's and inability to face one's peers might have played a role in the youngest patients choosing a private visit.

Older HIV patients were very open to have a student care for them with less than 1 out 5 (18%) HIV patients preferring to have a private patient visit. HIV negative patients had much higher rates of refusals (42.9%). This might be related to the fact that HIV positive patients have a greater disease burden than those who are HIV negative, which might motivate HIV positive patients to be more open to receive care from different sources.

For the most part, having a student participate in the patient's care does not seem to harm vulnerable populations. First, the initial refusals are sign that patients do not feel pressured to allow students to be present and are able to independently make decisions in regards to their care. Second, 91.5% of patients felt at least comfortable or better when a student participated in their care. 94.4% of patients would have a student present for the next appointment regardless of their level of comfort. In addition to this, all patients who felt very uncomfortable in the student's presence would have a student present again at their next visit. At-risk patients as a whole are very open to students and their attitudes in the examination room and willingness see a student again are evidence of this.

Medical consultations were also largely unaffected by students. Most patients (90.1%) did not find it difficult to discuss personal problems and almost all patients (94.4%) were able to discuss everything with their physician with the student there. Greater than three quarters of all patients surveyed could not imagine a scenario where they would omit any information in front of a student. All of these were positive indicators that students do not pose as barriers to health care access. Most of the time patients considered the student as an extension of the physician and wanted to extend the same relationship and trust to the student.

The findings show that there is room for improvement because a minority of patients who agreed to have the student present had some reservations. A few patients asked the student to exit the room in the middle of an examination. 5.6% of patients were unsure about or refused to have a student present for their next medical appointment. 23.9% could imagine situations where they would withhold information from a student.

Gender and sexuality played a significant role in how the student was treated by patients who felt less than positive about the student's presence. Many patients cited gender and sexual health as being of great importance to them, which affected how they felt about the student. The patients who asked the student to leave the room mid-examination cited male health issues or not wanting to disrobe in front of the opposite sex. Some female patients also mentioned that they did not want males present for certain procedures though they were open to having a student participate in their care.

33.8% of patients did report topics that made them uncomfortable to talk about in front of a student. However, this is a not definite sign that there is information they would omit because as the previous data shows, despite how patients feel, 94.4% disclosed everything they wanted to their physician with the student present. Overall, HIV positive patients (35.5%) had more topics that made them uncomfortable to discuss than HIV negative patients (22.2%), but this is to be expected because of the greater burden of disease they carry. Sexual health and practices were the fore runners for both groups as topics that made them uncomfortable to discuss, but this is also unsurprising because most people tend to regard sexuality as a private matter shared with those they are close to and a student who they have just met for the first time cannot quickly enter into that role. HIV patients felt uncomfortable discussing many more things than those who were HIV negative with the exception of drug, alcohol and tobacco use, which HIV negative patients

preferred not to talk about. After living with a condition such as HIV, issues of drugs, alcohol and tobacco use might pale in seriousness and no longer be topics of contention that patients feel the need to keep secret in front of a student.

Though there have been attempts to explain the reasoning behind the action of patients, these are mere conjectures that need to be further delved into. A larger study done at more than one site and over a longer period of time needs to be carried out to flesh out the facts. More patients, especially women and those who are HIV negative, should be surveyed in order for the results to be more precise and applicable. Students of different genders should take part in the study to see if preferences for certain genders exist. The number of students present for teaching should also be examined to see if there is a cut off number for students where the risks would outweigh the benefits. Patients who refuse to have a student present should also be issued a survey in order for accurate comparisons to be made and for trends to be examined.

Recommendations

There are two recommendations that would improve the teaching experience for both the patient and the student. First, patients should be given more education on the role and purpose of the trainee and about the nature of the trainee and patient relationship. Patients should be informed about the benefits of teaching for all those involved. Not only is this beneficial to students and possibly the patient, but the experience will stay with the student to help future patients down the line. Someone should explain to the patient that the relationship of the trainee and the patient will be an extension of the physician and patient relationship in so far as everything made known within the examination room will be kept private and confidential. Students are trained to be non-judgmental and respectful of patient information and should be invited to participate in patient care.

The second recommendation is to better inform patients of their rights. Patients should be educated about their rights of refusal to any and all medical providers and students. Patients should know that they have the right to say, "No," at any time even if they have originally agreed to do something. Patient should also be encouraged to express what makes them uncomfortable and what a student can and cannot not be present for. This is so that a learning opportunity is not entirely missed and the student can learn as much as possible without harming the patient. Hopefully by empowering patients with their rights and educating them of about students, all parties will benefit.

Conclusion

According to the results of this study, vulnerable populations appear to welcome the presence of a student to be a part of their medical appointments. A majority of patients were comfortable with the student's presence and would have a student be a part of their next visit. While females and HIV positive patients ages 18 – 29 tended to prefer private consultations, most patients were still very willing to help in the learning process of the trainee. Regardless of how they felt, almost all the patients were able to fully discuss their concerns with their physicians in front of the students. The teaching of a trainee does not seem to interfere with the care of at-risk populations and should be encouraged because both patients and students are in favor of the experience. Hopefully, the recommendations suggested will be executed to increase teaching opportunities for students, which would be beneficial in garnering a future workforce for CHCs and increase the care provided to future generations.

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