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Patients' Perceptions on Their Involvement in Medical Education: A Qualitative Pilot Study

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Abstract Patients' perception with regards to their use in medical teaching is an under-researched area in Pakistan. The objective of this qualitative, pilot study was to determine the perspectives of hospital admitted patients on their being used in the medical education of students in a private medical institution. An attempt to understand the dynamics of interactions between patients, students and doctors was also made and to see how this affected the doctor-patient relationship. A qualitative study with in-depth interviews was conducted in a private medical college of Islamabad, Pakistan with a total of 20 adult patients. The focus was on their experiences with bedside teaching. This pilot study reveals interesting findings about patient-physician interactions in Pakistan. Patients had a traditionally passive role in medical education putting more onuses on the doctor to impart knowledge to the medical students. Patients comforted themselves in the knowledge that they were following Allah's command when they were involved in the teaching of medical students. The apparent altruism of Pakistani patients in this study was influenced mainly by religious reasons, following the commandments of Allah to help develop future healers for humanity. The culture evident in the medical college where this study was conducted is reflective of the social power ladders that pervade Pakistani society. The positions of doctors and medical teachers in Pakistani society are hardly challenged to debate. Little attention has been paid to the values that influence the cultural and social frameworks within which Pakistani medical teachers, medical students and the patients function.

Keywords Patients · Teaching · Medical education · Ethics

This study was conducted a thesis requirement for a Masters in Bioethics from Sindh Institute of Medical Sciences. Ethics approval was taken from the Institutional Review Boards of Shifa College of Medicine, Islambad, Pakistan and Sindh Institute of Medical Sciences, Karachi, Pakistan.

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Introduction

"He who studies medicine without books sails an unchartered sea, but he who studies medicine without patients does not go to sea at all"

Sir William Osler
(1849–1919)

Patient contact in medical education is at the heart of learning which provides an opportunity for students and trainee doctors to learn and apply their knowledge and skills within existing settings. The educational benefits of patient contact are generally acknowledged to include motivation by emphasizing the significance of learning; development of clinical reasoning; appreciation of cultural diversity, and fostering empathy along with the development of professional and communication skills (British Medical Association [BMA] 2008).

In the undergraduate medical curriculum, patient contact can occur as part of clinical observation, supervised practice, real case based teaching or learning encounters with real or simulated patients (BMA 2008). These encounters mostly take place in hospital wards, outpatient clinics and community based settings.

Although patients may not benefit directly from the involvement of medical students in their care, educating these future doctors is essential for society. This forms one of the most inherent ethical dilemmas that medical educators face. The issues of informed consent, privacy and confidentiality and respect for persons are those that trouble not only the educator but also the trainee (BMA 2008). There may also be a "conflict of interest" on behalf of the medical students who are more focused on learning about the "disease" rather than the patient's "illness" (Shooner 1997).

The customary apprenticeship approach to training has depended critically upon patient contact. The role of the patient in medical education has been passive, with the patient acting as a teaching tool or interesting teaching "material" in a traditional paternalistic model (Spencer et al. 2000). There is now a paradigm shift reported in Western societies for example in the United Kingdom (UK), of the physician-patient relationship between the teaching doctors and the more empowered patient. With the increased awareness of patients' rights and informed consent, patients can now choose whether or not they wish to have medical students present in their consultation and care (Choudhury et al. 2006). The literature, from Western societies for example, the UK, USA, and Canada provides evidence to the fact that generally patients are favorable towards medical students' presence in their consultations and that patients show a greater level of satisfaction when involved in medical education. Work published by Choudhury et al. (2006), Sousa et al. (2009), Mavis et al. (2006), Walters et al. (2003), Westberg et al. (2001), Coleman and Murray (2001) and Stacy and Spencer (1999) demonstrate this.

The advantages that patients see in their participation in medical students training include reception of better care and a more thorough consultation (Sousa et al. 2009). Patients also visualize themselves in a more active and expert role and perceive their contribution as being valuable for the greater good (Stacy and Spencer 1999). The reasons reported for their altruism are providing a service to the community and giving back to the health care system (Coleman and Murray 2001).

Literature regarding patients' perceptions on being involved in teaching of medical students in the Eastern part of the world is almost non-existent. Limited data is available in Pakistan on how Pakistani patients perceive their involvement in medical education when being "used as teaching tools". Mahmud and Ahmad (2010) have reported that patients in

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their study, carried out in Pakistan were willing to be seen by medical students after informed consent. The determination of the factors which influence patients' perceptions on their involvement in medical education and how they differ from perceptions in the West was the prime objective of this study.

Methods

The General Medical Ward of a private medical college and hospital in a major city of Pakistan has been established to meet with the demands of medical teaching at the undergraduate and postgraduate level. Within this ward, there is a provision of quality services and medications at lower rates as compared to those who cannot afford the semi-private and private rooms offered by the attached hospital. It is occupied usually by patients belonging to the middle, lower middle and lower socioeconomic class of residents of the city and the surrounding suburban areas.

The General Medical Ward is a 40 bed facility and admits both adult male and female patients. The students of the fourth and final years visit the facility for at least 10 months during their Medicine rotations. There are daily teaching rounds of fourth and final year students within this ward.

A total of 20 adult patients, 10 male and 10 female were interviewed between the months of March-June 2011 with the focus being on their experiences with bedside teaching with the doctors and students while being admitted in hospital. This study was a thesis requirement for the Principal Investigator (PI) who was enrolled in a Masters in Bioethics program. The PI is a faculty member of the institution where this study was conducted and this was her first attempt at doing qualitative research with in-depth interviews. Keeping in mind, time constraints of the PI to conduct the interviews it was pre-decided to conduct an equal number of interviews in both genders. After gathering data of 14 patients (7 men and 7 women) we realized that similar themes were emerging. A further six interviews were conducted in the allotted time frame for data collection.

After receiving Institutional Review Board (IRB) approval and with permission of the Section Head of Internal Medicine the PI would go to the General Medical Ward for interviewing patients. The PI would approach the beds occupied by the patients and take an informed consent. All those patients who gave consent were interviewed. The PI would alternatively go to the male wing and female wing of the General Medical Ward.

An interview guide was developed prior to the study. It consisted of both closed ended and open ended questions gleaning information about demographics, the patients' understanding of their utility in medical education, what they gained from the clinical encounter with medical students present, their perceived role as facilitators and any problems or concerns they had. Questions explored the patients' perceptions on how the teaching affected the patient's relationship with their doctor and whether or not they would like to be involved in medical teaching in future. The questions were translated in the local language Urdu and available to the Principal Investigator (PI) prior to the interview. The questionnaire and interview guide is attached as Annexure 1 and 2 respectively.

All interviews were conducted by the PI. The interviews were audio taped after taking informed consent. If a patient refused audio taping then extensive hand written field notes by the PI were used. Interviews generally lasted from 45 min to an hour. Transcripts of the interviews were generated immediately afterwards.

The PI read and re-read the transcripts and field notes. The PI also shared these notes with her supervisor. The common and recurring themes which emerged from the transcripts and

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field notes were identified and scrutinized through constant comparative analysis (Glaser and Strauss 1967).

Results

A summary of demographic details of the patients is presented in Table 1. The names of the patients have been changed to protect their privacy.

From the conversations with the patients several consistent themes emerged. These are presented below and later on will be discussed in detail in the discussions section.

Language and the Patient's Role in the Teaching Round

During the interviews the patients described how the system of teaching medical students worked in the Ward. First the medical student would approach the patient on his or her allotted bed and ask for permission to interview and conduct a physical examination. Often there would be two or three students of the same batch approaching the patient at the same time. They would collectively interview and examine the patient. This interaction between student and patient would be in the local language Urdu. Most patients mentioned how students would ask the same questions several times or ask too many questions for that matter and would voraciously write each and every detail. This habit, particular to the

Table 1 Patient details (*Names have been changed*)

S. No	Patient ID	Sex	Age	Marital Status	Occupation	Education	Days spent in hospital prior to interview
1	Naima	F	31	Married	Housewife	Bachelors	1
2	Hidayat	M	82	Widower	Retired army officer	Middle (7th grade)	2
3	Masood	M	60	Married	Businessman	Illiterate	2
4	Younus	M	47	Married	Welder	Illiterate	3
5	Asif	M	64	Married	Retired army officer	Illiterate	9
6	Salman	M	50	Married	Businessman	Illiterate	3
7	Rashida	F	60	Married	Housewife	Illiterate	2
8	Maham	F	18	Unmarried	Student	1st year pre-engineering	13
9	Sanjeeda	F	32	Married	Housewife	Middle (8th grade)	3
10	Jan Mohammad	M	62	Married	Businessman	Middle (5th grade)	30
11	Sameera	F	58	Married	Housewife	Illiterate	3
12	Javed	M	54	Married	Businessman	Middle (8th grade)	14
13	Zafarullah	M	64	Married	Businessman	Matriculate	4
14	Liaquat	M	60	Married	Businessman	Intermediate	3
15	Khalid	M	46	Married	Driver	Middle (5th grade)	5
16	Farhat	F	48	Married	Housewife	Middle (5th grade)	2
17	Zarina	F	53	Widow	Housewife	Middle (5th grade)	2
18	Zubaida	F	34	Married	Housewife	Bachelors	3
19	Nadia	F	62	Married	Housewife	Illiterate	2
20	Sumbul	F	44	Married	Housewife	Illiterate	1

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students would cue the patients as to the importance of the task at hand in the eyes of the medical student. Then the teacher or facilitator who was usually a senior doctor or professor would arrive and conduct a teaching session by the patient's bedside. The student would present the history and findings of the examination in English and the discussion from there on between facilitator and student would be in English. During this time the patient is a silent observer who may or may not be following the discussion that takes place. If the patient needs to be addressed for more information by the student or teacher it would be in Urdu. This lack of involvement during the "intensive" teaching phase did not seem to bother any of the patients that were interviewed. They realized that the senior doctor was fulfilling his obligation to teach. At the end of the teaching round the patients were addressed by the senior doctor for issues relating to their management and care.

The "Majboor" Student

On being asked, how patients felt about the presence of medical students in their care, most patients interviewed felt compassion for the students because they saw them as "*majboor*." The word "majboor" is an Urdu term which means "helpless", or "without any choice". Patients' comments are shown in Table 2.

The issue of students being perceived as "*majboor*" was an intriguing finding and one not found as applied to medical students in Western literature. Pakistan exists as a hierarchical society and it was interesting to note that patients actually empathized with the students on perception of "shared *majboori"*, with the patients in front of disease and doctors, and students in front of their teachers. During conversations with the patients several of them talked about themselves being "*majboor*." When probed as to what made them so, they answered that they were helpless or "*majboor*" because of their illness and because their recovery was dependent upon the medical care provided by the doctors in hospital. The "*majboor*" student was not seen as an empowered figure by patients when compared to the doctors. This fits in with the hierarchical description of the teaching round mentioned previously.

The Family Paradigm

Almost all patients appeared to perceive students as extended members of a family, the elder patients referring to them as their "children" or "like their children" or "like sons and daughters". Rather than using the standard Urdu term "*talib alim/tulba*" which when translated in English means "student/students", the patients used the word "*bachchay*" which means "children". Generally, spoken Urdu in Pakistan is interspersed with English terms so patients would also use the word "student(s)" in their conversations but equate it with the term "*bachchay*". The use of the term "*bachchay*" for the medical students was consistent in most interviewed patents irrespective of their own ages. Rashida, a 60 year old lady and mother to 11 children actually appreciated the fact that students addressed her as

Table 2 Theme of the "majboor" or "helpless" student

"*It is the duty or obligation of the students to study*" (Patient 3, 4, 5, 12, 17, 18, 19, 20)
"*It is imperative upon them to learn, otherwise how will they treat patients in future?*" (Patient 1, 2, 6, 7, 9, 10, 11, 12, 14, 16, 18, 19)
"*I don't like refusing students because they are also desperate. If we don't co-operate, how will they learn*?" (Patient 6, 12, 15)

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"ammaan ji" (a respectful term in Urdu for mother/elder lady). She mentioned her own daughter being a nursing student and said

> "When I see these children approaching my bed I am reminded of my own daughter who is a nursing student studying at a nursing college in another city."

Masood, a 60 year old gentleman commented that he would never refuse medical students from being involved in his care. "If the students are getting what they want from my cooperation then let it be. They are also like my children."

The familial paradigm as expressed by the patients was not surprising as ethnographic research in Pakistan has shown similar findings (Moazam 2006). Relationships in Pakistani society extend beyond blood relatives to close friends who may also be referred to as *behan* (sister) or *bhai* (brother). Similarly, doctors or trusted health care professionals may be accepted into the family unit and termed as *maa* (mother), *baap* (father) or an older *behan* or *bhai.* The cultural pattern in Pakistan is such that people confide in and trust family members rather than strangers. Patients therefore feel more comfortable seeking therapy from someone they can perceive as a family member (Moazam 2006). Patients in this study therefore looked at the students as members of an extended family. That is why most patients referred to them as or like their children. The average age of our fourth and final year medical student was between the ages of 22–24 and as most of the patients were in their 50s and 60s this was understandable.

Religion as an Important Factor

Patients were probed about how they felt and what were their thoughts once students and their teacher left the bedside. No one reported any negative feelings. When asked if they were given a choice to be involved in medical teaching or not patients said they would never refuse. When asked why, most of them replied that it would never occur to them to refuse because this was a good deed in the eyes of God. Some patients' comments about this theme are presented in Table 3.

The youngest of the patient participants was an 18 year old girl and she commented

> "In our religion, (Islam) we are taught to be charitable and help those in need. If a beggar approaches our doorstep we do not refuse them and let them go empty-handed. So if students are in need for us (patients) to co-operate how can we refuse Allah's command?"

When patients were asked about their choice to be involved in medical education in future, all except one answered in the affirmative. When probed as to the reasons for this affirmation, they commented that it was in accordance to "Allah's will" due to the nobility of a doctor's profession and his work. Similar comments are shown in Table 3. Obviously, these patients saw the medical students as future physicians and healers although at present they may be "children."

Table 3 Theme of religion

"*Health is the hands of God or the doctor. The students cannot harm us"* (Patient 1, 2, 3, 4, 6, 8, 9, 10, 11)
"*Doctors can never be wrong. They do God's work.*" (Patient 1, 2, 4, 5, 7, 12, 13, 14, 15, 16, 19, 20)
"*If we become a hindrance in the learning process of students, God will not be happy with us.*" (Patient 6, 8, 17)
"*God helps them [students] because they do God's work.*"

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One patient remarked, "Allah expects this small sacrifice from us for the greater good of humanity and society.

Patients were asked if whether the type of illness that they had or sex of the students would influence their decision on involving students in their care. Most answered that this would not influence their decision. As one patient commented "*Doctors are above such things*."

Discussion

This pilot study reveals interesting findings about patient-physician interactions in Pakistan that seem to differ from the norms represented in literature. The Western literature reports on the emerging active role of the patient in medical education rather than the more traditional passive role (Coleman and Murray 2001; Stacy and Spencer 1999). However, in this study patients that were interviewed appeared to take on a passive role and accepted this fact unquestionably. The onus was on the doctor or consultant to impart knowledge to the medical students. This is perhaps related to the fact that in Eastern cultures, social hierarchy is more prominent and generally accepted. A doctor is perceived to be of a higher social status, the status being defined in terms of education and money, and therefore he or she is obligated with greater responsibilities to benefit those people belonging to a lower social status (Claramita et al. 2011). The use of a different language for patients (i.e. Urdu) and students (i.e. English) also seemed to emphasize this hierarchy.

Patients also looked upon the medical students as or like their children. They also thought that the students were helpless and could empathize with them as they observed how the students persevered for approval from their clinical teachers. An element of parental affection for a helpless child or appreciation of a student's predicament would influence the patient's cooperation on his or her involvement in medical education. This differs greatly from Coleman's (2001) study in the UK, where the patients' decisions on their participation in medical education were influenced primarily by altruism and personal gain. The altruism in Coleman's study was geared to providing service to the community and repaying the health system. Personal gain included an increase in knowledge about their medical condition and improved self esteem when contributing significantly to medical student education. The apparent altruism of Pakistani patients in this study was influenced by cultural (interaction between parent and child) and religious reasons such as following the commandments of Allah to help develop future healers for humanity.

With the increasing importance of "patient-centeredness" mostly in the United States and developed countries of Europe as mentioned by BMA (2008), Spencer et al. (2000), Coleman and Murray (2001) and Stacy and Spencer (1999), the applicability of this concept in Eastern countries like Pakistan has cultural, religious and practical nuances that warrant careful consideration. The doctor in Pakistan is considered to be an instrument of God (Allah) and therefore, held in high esteem by the society that respects authority and condones the hierarchal system (Moazam 2000). Therefore, the patients in this study believed themselves or maybe comforted themselves in the knowledge that they were following Allah's command when they were involved in the teaching of medical students, who will be doing God's work in future. The fact that these people were sick and admitted in hospital, vulnerable and dependent upon the doctors for treatment would likely influence their willingness on being involved in medical teaching. Also, Pakistani society is a collectivistic society, as opposed to the individualistic society of the West with greater emphasis on the family rather than the individual. Consent of the family is as important as

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consent of the individual. In majority of the patients that were interviewed, a family member was also present and actively participated in the discussions with the patients.

As this thesis was a qualitative pilot study, the findings cannot be generalized to represent a larger population. However a methodological attempt has been made to determine perceptions of patients, students and medical teachers with regards to the utility of patients in medical education. These findings are not unusual in the Pakistani context but this study needs to be expanded to include the perceptions of patients on being used for medical teaching among those who belong to a higher economic stratum and are paying more for health care services.

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Conflict of interest No competing interests declared.

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