# PATIENT PARTICIPATION IN, AND ATTITUDES TOWARDS, COMMUNITY-BASED MEDICAL EDUCATION

Short title: Patient participation in medical education

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**Abstract**

Introduction

Community based medical education in Australian health care settings other than general practice has been limited by a perception that patients would be unwilling to accept the presence of medical students.

Methods

A survey was developed and administered anonymously to patients attending private specialist and general practices in southern Adelaide.

Results

Almost all patients surveyed (96%) either had, or would, agree to a student's presence during their care. The majority (72%) agreed that the presence of a student was acceptable whether in private or public health care settings. One-third of patients were happy to be asked to attend a doctor's clinic for the purpose of teaching students. Patients viewed teaching clinicians very positively.

Discussion

This study clearly demonstrates that private health care is not a barrier to clinical teaching from the patient perspective. It confirms previous findings regarding the need for clear consent, the acceptance of a student's need to learn, and the high regard patients have for doctors who teach.

Conclusion

Patients are willing to allow medical students to be involved during their health care in private practice settings whether general or specialist practice. There is therefore potential to develop more learning opportunities in Australia's private health sector.

**Introduction**

The training of future doctors relies heavily on their learning in real clinical environments. In Australia the dominant clinical training sites are public teaching hospitals that have strong reciprocal relationships with medical schools (Ash et al, 2012). These teaching hospitals are usually tertiary hospitals funded by state governments. While general practice has a long history of providing clinical teaching placements, until recently these placements have been more as an adjunct to training in teaching hospitals rather than providing substantial training across the core clinical disciplines. Over the last two decades however, clinical education in Australia has expanded beyond the teaching hospital environment, with recognition of the importance of community-based medical education (CBME) (Ash et al, 2012; Mahoney et al, 2012; Thistlethwaite et al, 2007). This demand has been driven by the rising number of medical students and the limitations of teaching within tertiary- and quaternary-care hospitals, as patients in these institutions have shorter lengths of stay and more care devolved to the community setting.

The future of CBME is constrained by a number of factors, including clinical supervisor workload and funding arrangements to support clinical teaching. In the Australian health workforce culture there is another constraint: the perception that patients are not happy to have students involved in their private health care.

The funding arrangements for health care in Australia are complex. Around 46% of all funding is provided by the Commonwealth Government, 26% by state or territory governments and the remainder funded by patient contributions and insurance schemes including private health, motor vehicle and workers' compensation insurances (Productivity Commission 2005).

The Australian public hospitals constitute most of the teaching hospitals, and these are funded predominantly by Commonwealth and state/territory governments with state/territory governments having responsibility for operating and regulating the hospitals in their state. People who attend or are referred to public hospitals are not able to choose their treating doctor, but rather are allocated to an appropriate service or care team.

Most of the remainder of Australian health care is through privately provided services in specialist and general practice. The majority of community-based medical services attract a Medicare rebate: in 2004-2005 the Commonwealth Government contribution to funding of services through the Medicare Benefits Schedule (MBS) was $9,923 million (Department of Health and Ageing). Of this, around 33% was for GP services, 30% for imaging and pathology services, 25% for specialist services and the remainder for optometry and unspecified 'other' services. Private health insurance provides the bulk of funding for private hospitals and for private patients in public hospitals.

While teaching is recognised as a professional responsibility and part of good professional conduct (Medical Board of Australia 2010), the only funding available to support it in the private practice setting is the Practice

Incentive Payment (PIP) for accredited general practices (Medicare Practice Incentives Program – Teaching Payments guidelines 2012). There is no equivalent for specialists or other health care services, and the GP community widely regards the PIP payment as inadequate to compensate for the costs of teaching (Laurence et al, 2010). In the context of time-driven fee-for-service medicine this is another disincentive for teaching in private practice. In the public hospital system, a responsibility for teaching is usually written into work contracts, along with University and medical school arrangements that contribute to staffing and funding.

The structure of the current PIP for GP teaching is also a disincentive for teaching, as it has a narrow definition of what activities attract the payment (Laurence et al, 2010), thereby limiting opportunities for innovative models of teaching, and it rewards the practice, but not necessarily the motivated GP who provides the teaching.

Although funding is an important consideration, particularly when teaching incurs a real cost to a practice or individual, many clinicians teach for altruistic reasons (Dahlstrom et al, 2005) as part of their commitment to the profession and to the community. However, because of the long-standing public and private divide in health care, some doctors in private practice are unsure whether their private patients, who are usually paying an extra dividend to see the doctor of their choice, would agree to the involvement of medical students in their health care. Thus the common ethos of Australian private practice, particularly specialist practice, is that private patients would not accept the presence of medical students during their care. The aim of this study was to determine whether in fact this is true and whether or not patients object to medical students being involved when they are seeing a doctor in a private health care setting.

Previous studies have reported willingness as well as positive perception, expectations and acceptance from the majority of patients who have had medical students involved in their consultation (Hudson et al, 2010; Sweeney et al, 2010; Chipp et al, 2004; Salisbury et al, 2004). Patients are willing to have students present although this may depend on the nature of the medical consultation, with fewer people being prepared to have a student present for more intimate or personal consultations. (Sweeney et al, 2010). It has also been objectively shown that patients' enablement and satisfaction with the consultation is not impaired by students' participation (Benson et al, 2005). These studies have been undertaken in general practices in urban (Salisbury et al, 2004; Chipp et al, 2004), regional (Sweeney et al, 2010) and rural areas (Hudson et al, 2010) of Australia as well as in the United Kingdom (Benson et al, 2005; Chipp et al, 2004; Coleman et al, 2002). In another setting, patients in hospice were also found to be willing to participate in medical student education (Arolker et al, 2010). One qualitative study reported that patients participate for at least two main reasons (Coleman et al, 2002). Firstly some participate for altruism – the intention to provide a service to the community and repaying the system "They have to learn, don't they?" Secondly there are some who do so for personal gain reasons – improved knowledge of their own medical condition, improved self-esteem and companionship.

However less is known about patients' view of the presence of medical students in specialist private practice, and whether or not this accords with the understanding of private practitioners. This study seeks to

determine patients' views about medical students learning in settings outside of public teaching hospitals. The findings of this study will help to determine if there is scope for further expansion of CBME, or whether clinical teaching should remain in the public teaching hospital and general practice arenas. This is important information for new urban CBME programs such as the Onkaparinga Clinical Education Program in suburban Adelaide, which relies heavily on clinical placements in private specialist practice as well as in general practice (Mahoney et al, 2012).

**Methods**

The researchers designed a survey instrument aimed at providing information about patient acceptance of, and views about, medical students in private specialist and general practice.

All specialist and general practice services located in the urban section of the (then) Southern Division of General Practice's catchment area were identified using the most recent version of the Telstra Telephone Directory for Adelaide (Yellow Pages). No attempt was made to single out practices or services known to provide clinical teaching. Principals, or owners, of these private practices were sent a letter describing the research and requesting permission to recruit participants by the placement of information about the research, questionnaires and collection boxes in their waiting rooms. Sixty four sites were contacted and fourteen sites replied agreeing to allow their sites to be used for recruitment of participants. The 14 sites included five general practices and nine private specialist clinics. The Emergency Department at Noarlunga Hospital, a public, community-based hospital in the same catchment area, also agreed to the placement of the questionnaire in the waiting room, giving a total of 15 collection sites. All 15 sites completed a signed consent form. The researchers then sent these sites a copy of the questionnaire and information for practice staff to assist with any questions about the research. The study was approved by the Flinders University Social and Behavioural Research Ethics Committee. The self-administered questionnaires were delivered to each site along with participant information sheets and collecting boxes. These were placed in the waiting rooms of each site. Each location was supplied with 50 questionnaires; two sites, both general practices, had rapid uptake by participants during the four week collection period, and took a further 50 questionnaires, resulting in total distribution of 850 questionnaires. Participants were asked to place completed questionnaires in a sealed box in the practice waiting room. There was no identifying information on the questionnaire. One of the researchers collected the completed forms on a regular basis.

The questionnaire asked whether patients had previously agreed or would agree to the presence of a medical student during their care. Those who said no were invited to describe their reasons, while those who said yes were asked to complete the remainder of the questionnaire. Questions asked were aimed at clarifying the constraints or limitations to acceptance by patients of student involvement in their health care. Some questions required selection of one or more options using tick-boxes, while other requested free-text responses. The questionnaire also specifically enquired about the any distinctions in the settings where patients would accept student participation in their health care.

Data was expressed as frequencies and corresponding percentages. With categorical data, comparisons between groups were analysed by chi-square where appropriate. All statistical analyses were performed using SPSS statistical software, version 18.0 (SPSS Inc., Chicago, IL).

**Results**

A total of 681 completed questionnaires were returned (80% return). The age distribution (Table 1) is consistent with general age distribution of adult patients attending health care services (Britt et al, 2010). Most are in the age group between 36 and 75 years. Female patients made up nearly 70% of those surveyed.

Table 1: Characteristics of patients who participated in this survey

| Age groups, years | Number (%) N= 681 |
|---|---|
| 18-25 | 32 (4.7) |
| 26-35 | 62 (9.1) |
| 36-45 | 127 (18.6) |
| 46-55 | 133 (19.5) |
| 56-65 | 149 (21.9) |
| 66-75 | 102 (15) |
| Over 75 | 75 (11) |
| No response | 1 (0.15) |
| Gender | |
| Male | 205 (30.1) |
| Female | 473 (69.4) |
| No response | 3 (0.44) |
| Previous experience with medical students' presence | |
| Yes | 430 (63.1) |
| No | 247 (36.3) |
| No response | 4 (0.6) |
| Have agreed or would agree to student presence | |
| Yes | 656 (96.3) |
| No | 22 (3.2) |
| No response | 2 (0.3) |
| Would accept female student only | 1 (0.15) |

Of all respondents, 430 (63%) have had previous experience with a medical student during a medical consultation while 247 (37%) had not. Four people did not respond to this question. Of those with no previous experience, the vast majority 234 (95%) said that it was because they had never been asked to do so. Only 8 respondents (3.2%) said they had been asked and had declined, while 5 people did not respond. Of the 247 people who had not had a student present, 226 (91.5%) said that they would agree to a student being present if asked. Thus, of the total number (681) of respondents 656 (96%), either had agreed, or would agree, to the presence of a medical student during their health care consultations. Twenty two people, or 3% of respondents, stated that they had declined or would decline to have students present during their consultations. All 22 were female (compared with 451 out of 656 who agreed to participate; $p$ = 0.0037), and none of the 22 was aged over 65 years (compared with 500 out of 656 who agreed to participate; $p$ <0.001) Three people of the 22 had previously had a medical student present but said that they would decline if asked to do so again, and one respondent would allow a female student but not a male.

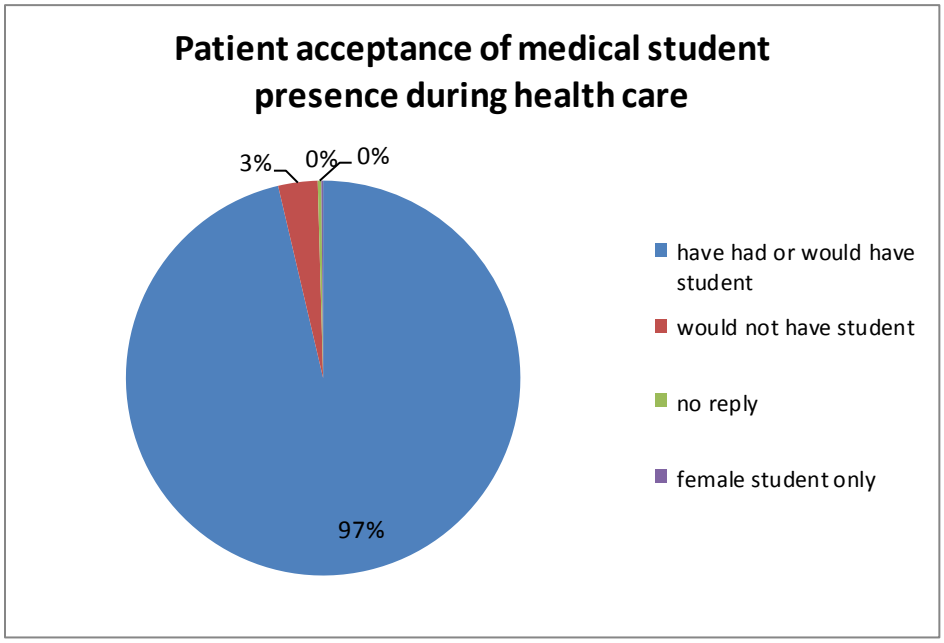


Figure 1: Patient acceptance of presence of medical students during their health care

Most patients (96%) will agree to have a student present during their consultation and only a small number (3%) expressed that they will not have any students. Among those who declined student involvement during their consultations, some of the reasons given are as follows:

- "mainly because I prefer my privacy"
- "I prefer one on one with my own GP"
- "don't like a lot of people around me"
- "if it was an embarrassing or evasive problem I would not be as willing to have a student come in. I would probably also be interested in the sex and age of the student"

The commonest location in which respondents had previously had a medical student present during their health care was in general practice, with 331 (77%) stating that a student had been present during GP consultation only, consultation and examination, or for a procedure. The teaching hospital was the next commonest location, with 171 (39.8%) of respondents having had a student present during care there. Students had been present during consultations, examination or procedures with private specialists in their consulting rooms for 162 (37.7%) respondents, and in private hospitals for 59 (13.7%) of respondents.

Table 2: The locations in which medical students had been present during respondents' health care (N= 430)
Note: total > 100% because respondents had students present on more than one occasion.

| Location | Number (%) who have had student present |
|---|---|
| GP consultation only | 137 (31.9) |
| GP consultation and examination | 155 (36.1) |
| GP procedure | 39 (9.1) |
| Total GP | 331 (77) |
| Teaching hospital | 171 (39.8) |
| Private specialist consultation only | 49 (11.4) |
| Private specialist consultation and examination | 81 (18.8) |
| Private specialist procedure | 32 (7.4) |
| Total private specialist | 162 (37.7) |
| Private hospital | 59 (13.7) |

The extent to which respondents were prepared to allow students to participate in their health care was then questioned. Of the 656 who either had agreed or would agree to the presence of a student, 510 (77.7%) said they would always be happy to have a student present as the students need to learn, and 306 (46.7%) said that they enjoy, or would enjoy, contributing to the student's education. The majority of respondents (473 or 72.1%) agreed that the presence of a medical student is okay whether in private or public health care settings, while only 40 or 6.1% agreed with the statement "The presence of a medical student is okay in public hospital or bulk-billing practice but not okay in a private specialist practice or GP who charges a gap".

Table 3: Extent of patient involvement and their attitude towards medical education (N=656)

| Statement | Number (%) |
|---|---|
| I am (or would be) always happy for a student to be present as they need to learn | 510 (77.7) |
| I am (or would be) happy to talk to a student but not to be examined by them | 138 (21) |
| I am (or would be) happy to talk to a student and to be examined by them, but would not allow them to practice a procedure under supervision | 184 (28.1) |
| There are some things that I would be uncomfortable about having a student present | 176 (26.8) |
| I enjoy (or would enjoy) contributing to the student's education | 306 (46.7) |
| The presence of a student is (or could be) a nuisance because everything takes longer | 6 (0.9) |
| The presence of a student is (or could be) enjoyable because things get explained in more detail | 186 (26.4) |
| The presence of a student is (or could be) neither enjoyable nor a nuisance | 143 (21.8) |
| The presence of a medical student is okay in public hospital or bulk-billing practice but not okay in a private specialist practice or GP who charges a gap | 40 (6.1) |
| The presence of a medical student is okay whether private or public | 473 (72.1) |
| I would prefer not to be involved (in medical student education) | 28 (4.2) |
| I am happy just to let the doctor explain things to the student when I am there for an appointment | 478 (72.9) |
| I would be happy to be asked to go to my doctor's clinic at a convenient time to help a student or group of students to learn about my health condition | 215 (32.8) |
| I would be happy to be more actively involved in the education of medical students | 87 (13.3) |

Note: total >100% because respondents agreed with one or more statements.

Respondents were asked whether the fact that a doctor teaches medical students would influence their opinion of the doctor. In response, 436 (66.5%) agreed that it would not change their opinion of the doctor while 187 (28.5%) said it would influence their opinion. Those respondents who indicated that it would influence their opinion were asked to describe *how* it would influence them; 172 comments were received of which 165 (95.9%) were positive.

Table 4: Response to the question "Would the fact that a doctor teaches medical students influence your opinion of the doctor?"

| **Response** | **Number (%)** |
|---|---|
| Yes | 187 (28.5) |
| No | 436 (66.5) |
| Yes and no | 1 (0.15) |
| Total number of "yes" responses with written comments | 172 (92% of those who replied "yes") |
| Positive comments | 165 (95.9% of all comments) |
| Other comments | 7 (4.1% of all comments) |

The themes of the comments received in response to this question fell into three broad categories. A major theme was increased respect for the doctor, who was seen to be caring and patient, sharing and passing on knowledge. One comment said simply 'I'd be proud of my doctor.'

Another theme in 19% of responses was that teaching was an indication of the doctor's knowledge, ability and credibility and showed that the doctor was up to date with latest information and research. A further 15% of responses related to the doctor's altruism in giving back to both the profession and the community by helping to train future doctors. There were no completely negative comments, although one person thought that a good doctor may not necessarily be a good teacher, and another said that it is a two-way process and doctors learn from students as well.

Table 5: Themes and examples of written comments in response to the question:

| **Themes of written comments** | **Number (%)**<br><br>**(N= 172)** | **Examples** |
|---|---|---|
| Supervisor would be a better doctor, up to date, capable, knowledgeable, patients would have more confidence in doctor and benefit from more detailed explanations during the consultation | 33 (19) | It is a compliment to the doctors own capability.<br><br>(shows) that (they) are keen to update/continue their professional development and share their knowledge with students.<br><br>I feel he's very capable and trustworthy to do the job.<br><br>More confidence in the doctor as he must have the knowledge to teach others.<br><br>Makes me assured he/she is abreast of up to date information and procedures.<br><br>Doctor appears more credible - if they have a student – they must be good!<br><br>Indicates knowledge and reputation of doctor.<br><br>Doctor may actually be more up to date with new procedures.<br><br>To me that means they are interested in keeping up with the latest research.<br><br>It means the doctor is well regarded and so may raise my opinion of the doctor.<br><br>Shows professionalism and that they are recognised as clinically proficient.<br><br>It would make me feel that my doctor must be very well educated to be able to be teaching others.<br><br>I'd hope it means the doctor is up to date with current practice and also benefits from having to describe in detail his/her diagnosis or consultation. |
| Giving back to the profession and community by passing on knowledge to students and helping to train future doctors | 26 (15) | Pleased that they view it as important and contributing by training future doctors.<br><br>Positively. They had to be taught, so it is giving back to the medical community by teaching the next |

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| | | generation.<br><br>Reassures me of the dedication of my GP to further educate and influence future doctors.<br><br>Altruistic, giving to others, knowledgeable.<br><br>Indicates his/her commitment to the profession and self-confidence.<br><br>They are willing to help others learn which is good professional conduct, a bit like teaching an apprentice 1 on 1. |
| Increased respect for doctor, shows doctor to be caring and patient, benefits for medical students, passing on knowledge | 106 (62) | I would think very highly of the doctor for teaching the student.<br><br>Encourages my respect for his sharing nature.<br><br>I believe in sharing knowledge. If a doctor is willing to do this it shows they care.<br><br>Good that student is getting hands on learning and knowledge from an experienced professional.<br><br>I think higher of the doctor. As there is only so much you can learn from a book.<br><br>Just the fact he takes time to teach - very patient and caring.<br><br>It would show that my doctor was willing to teach others and this puts him/her in a positive point of view.<br><br>Teachers are valuable in countless ways.<br><br>I'd be proud of my doctor.<br><br>It would demonstrate that he is a caring doctor and willing to assist students in their development.<br><br>Increased respect; community service aspect terrific.<br><br>It shows professional responsibility, which I respect.<br><br>Underscore my respect for my GP. |

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|---|---|---|
| Doctors have a duty to teach | 3 (1.7) | I would be unimpressed if I knew my doctor had refused a student.<br><br>Knowing it was voluntary to take students: that they be monitoring them; - because I feel they should be sharing their knowledge + skills anyway.<br><br>All doctors should be willing to help students. |
| Other comments | 4 (2.3) | We all have to learn. Experience is the best teacher.<br><br>Doctors learn from students too. Two way process often.<br><br>Only if woman - men can only do one thing at a time.<br><br>A good doctor may not be a good teacher. |

Respondents were asked how they would like to be involved in helping medical students to learn. Of all 681 respondents, 28 (4.1%) said that they would prefer not to be involved, 478 (70.2%) agreed that they would be happy just to let the doctor explain things to the student when they were there for an appointment, 215 (31.6%) agreed that they would be happy to be asked to go to their doctor's clinic at a convenient time to help a student or group of students to learn about their health condition, and 87 (12.8%) said they would be happy to be more actively involved in the education of medical students. Fifty people (7.3%) did not respond to this question.

Respondents who said they were happy to be more actively involved in medical education were asked to describe how they would like to do so. Forty seven people replied to this question. The theme of almost all responses was aiding the students in their learning; 12 responses (25.5%) highlighted giving the patient's perspective and understanding and knowledge of their condition.

At the end of the questionnaire respondents were invited to make any other comments. A total of 90 comments were received. Of these 47 (52.2%) were supportive of clinical teaching in community / private settings, while 14 (15.6%) were conditional comments, mostly about requiring prior consent, or opportunity to decline if the consultation was of a personal nature. There were 25 (27.8%) non-specific comments, and 4 (4.4%) comments describing a previous bad experience relating to medical students. Two of these negative comments relate directly to student behaviour, one is related to not being informed or offered an opportunity to decline, and one highlights the importance of following through with any promises or undertakings that are made to patients. Examples of comments in each category are given in table 6.

Table 6 General comments

| Category | Number (%) N=90 | Examples |
|---|---|---|
| Supportive of students learning in private / community settings | 47 (52.2) | I think this is a great idea and I would fully support it.<br><br>Everyone has to learn. Learning from a great GP is of benefit to the student which in turn produces a great doctor in the future.<br><br>It is important for medical students to have opportunities to learn in "real" situations and give them skills/strategies when dealing with patients.<br><br>Agree with broadening the learning experience past the public health system.<br><br>The greater the exposure to patients, hopefully the greater the learning experience - I think it's a great program.<br><br>I think it is very good idea for trainee doctors to receive wider training at all different levels especially dealing and interfacing with patients (under supervising doctor). They can gain valuable communication experience when dealing with patients directly.<br><br>It is high time this teaching is taking place. I feel it would help give students confidence and experience they would otherwise miss. |
| Consent required / conditional approval | 14 (15.6) | I reserve the right to say "no" if appropriate.<br><br>I think the presence of a medical student is only an issue when the reasons for seeing a doctor are not embarrassing.<br><br>I think it would be a good thing to be asked (about having a student present) at the time you are making the apt.<br><br>I think it is important to maintain the students esteem so asking the patient prior to their appointment with the Dr would be best so that the student doesn't feel "rejected" or the patient "pressured" to have them present.<br><br>Wouldn't be happy to be charged for a long consult without being bulk billed if it was delayed due to the students' questions. |
| Negative previous experiences with medical students | 4 (4.4) | 20 years ago I used to allow medical students to do some research on my son when he was little. Some students promised to let me see their finished assignments (or some type of research outcome) But it NEVER happened. I also got caught out with parking tickets. Some hospitals say you can claim parking costs but the paperwork was |

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|---|---|---|
| | | extremely complex and time consuming and not worth the headache. So I stopped helping students.<br><br>Students at the flinders medical centre should be taught that it is not a meeting centre: to have fun.<br><br>The event happened many years ago but I still find it traumatic to remember. My private specialist had referred me to a teaching hospital for infertility treatment and suddenly when I was on the examination table a group of students were ushered in.<br><br>I did have one experience with a student/intern at Flinders. They need to learn manners as much as the medical side of things. |
| Non specific | 25 (27.8) | Programs need to be well structured as many GPs are under large workloads and need to be supported if extra time and resources are required to support students.<br><br>I would trust my GPs knowledge of my medical conditions as to when to involve a student. It would depend on the years of medical school as to whether I would be happy to have the student involved other than in a passive role.<br><br>Just don't have the time with work commitments.<br><br>Some diseases, like polio in my case, are not seen now and many older doctors have not seen the effects, or the splints used to support paralysed limbs; or results of aging of a disabled person<br><br>I think that medical students need to practice their skills both in a hospital and practice setting. |

**Discussion**

This study has shown that patients are almost universally (96% of respondents) accepting of medical student involvement in their health care, at least to some extent. This acceptance extends to specialists and to private medical care where the patient is paying some out-of pocket contribution to the cost of care. While previous surveys have shown that patients are generally willing to accept medical students in general practice consultations, this study shows that such acceptance is not limited to general practice or teaching hospital and publicly funded health care.

Consistent again with previous findings are that acceptance of the presence of a student requires patient consent, and may vary with the type of clinical activity to be undertaken (hence consent is not global, and is required for every occasion). Some patients are less willing to accept students during health care involving private personal matters and intimate physical examination and procedures.

While this study has focused mainly on community-based patients, other studies have reported relatively high levels of willingness to participate in consultations with the presence of medical students in a variety of subspecialty settings (Birkinshaw et al, 1996; Graber et al, 2003; Grasby et al, 2001; Shann et al, 2006; Simons et al, 1995). One study has also evaluated patients' comfort levels and attitudes regarding medical student involvement in family medicine, obstetrics and gynaecology, urology, general surgery and paediatrics, and found no difference in these parameters across the different subspecialties (Passaperuma et al, 2008).

Koehler and McMenamin (2012) found that individuals with prior experience with a medical student and who had been hospitalised previously were more likely to permit medical students to examine them. However of the 36% of the patients in this study who had no previous experience of student involvement in their consultations, the large majority (91.5%) said that they would agree to a student's presence if asked.

This study also revealed reasons for which patients felt comfortable with the presence of medical students. Those reasons were consistent with other reports in the literature and included the desire to contribute to medical education, the extra time spent with the patient, and the opportunity for the patient to learn more about their medical problem (Haffling et al, 2008; Prislin et al, 2001).

In our study, over 96% of participants indicated that they were willing to have medical student involvement in their consultation, 72% agreed with the statement 'the presence of a medical student is okay whether private or public' and only 6% agreed with the statement 'the presence of a medical student is okay in public hospital or bulk-billing practice but not okay in private specialist practice or GP who charges a gap.' This suggests that there is high acceptance of the presence of medical students regardless of the setting in which it occurs. Recently another study has also reported that patients treated in an Australian private hospital are as receptive to medical students as patients in a public hospital (Tiong et al, in press). Similar results were reported among patients treated in a non-teaching private hospital in Brazil (Sousa et al, 2009). The willingness of patients to participate in medical student education in private practice settings is an encouraging finding because this can open new opportunities for clinical education.

In addition to the majority of people being willing to accept the presence of medical students during their health care, one third of the respondents in our study (32.8%) indicated a willingness to be asked to attend their doctor's clinic at a convenient time to help a student or group of students in their learning. This is an important factor for the design of different teaching methods in private practice. It allows some structure to

be placed in the content of sessions, rather than relying on the presentations that happen to occur when a student is present. It would also allow teaching sessions to be structured so that the clinical supervisor does not need to be physically present in the consultation room for the entire duration of the learning episode. It would give both patients and students more involvement in the clinical education process, provided there was sufficient infrastructure (room, computer, examination equipment etc.) in the premises to support such sessions.

**Strengths and limitations**

The mixed methodology strengthens the study as it informs the interpretation of the quantitative findings with qualitative data. The high response rate to the questionnaires is also a strength, as is its setting encompassing patients attending outer metropolitan general and specialist private practices.

One limitation of this survey is that patients do not actually have to commit to student involvement in their care and there may be a difference in real life response and that given in the questionnaire. Although the questionnaire was completed anonymously, some participants may still have a tendency to choose what they would consider as the correct or socially desirable answer. As this questionnaire was written in English, patients who are unable to read English may have been excluded from the survey. Ascertaining their willingness and attitude will also be important with the increasing ethnic diversity in the Australian population.

**Conclusion**

Patients are willing to allow medical students to be involved during their health care in private practice settings whether general or specialist practice. The fact that the care is offered in the context of private health care does not affect this acceptance for most patients. The study has reinforced previous research showing that patients often think more highly of doctors who are involved in teaching and respect them for their knowledge, professionalism and commitment.

This acceptance by the community therefore offers the potential to develop more learning opportunities for medical students in Australia's private health sector, knowing that it is largely accepted by patients and reflects very positively on those doctors who teach.

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