

A Response to “Patient’s Perceptions and Attitudes Towards Medical Student’s Involvement in Their Healthcare at a Teaching Hospital in Jordan: A Cross Sectional Study” [Letter]

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Dear editor

We read, with interest, the study by Taha et al exploring patients’ perceptions and attitudes towards medical students to improve the training of future doctors.¹ Throughout our time at medical school, we, too, have experienced barriers in interacting with patients, and we appreciate the time and effort taken by the authors to improve both the medical training and level of healthcare provided to patients.

While the authors demonstrate significant results from their study, such as the need for informed consent and its impact on patients’ acceptance of medical students’ clinical input, there are several limitations which we will discuss and make suggestions for improvement.¹

Firstly, the authors’ use of a cross-sectional survey design is limited. Whilst Taha et al are able to determine associations between patient demographics and medical student demographics, they cannot fully establish causality.¹ This could be improved by utilising serial cross-sectional surveys, following the implementation of changes in medical school training.² For example, proposing more professional student attire, and surveying the consequent patient responses and attitudes. This would allow for investigation of aggregate change of the population’s attitude towards students and help to establish true causality.²

Secondly, Taha et al indicate that across all socio-demographics, more patients would approve of the presence of medical students during consultations than would allow medical students to perform clinical procedures.¹ The authors neglect to differentiate between procedures within the survey, which would be useful to determine the areas of medical education that hold significant barriers.¹ By contrast, Chipp et al surveyed patients’ attitude towards medical students performing different procedures, from joint examinations to cervical smear tests, and found that patient participation decreases as the invasiveness of the test increases.³ We propose that further research be conducted to investigate the reasons behind patients’ reluctance to allow medical students to perform procedures on them, and that by gathering open feedback on patient experiences, these barriers might be better addressed.

Lastly, we consider Taha et al’s method of data collection to be limited and somewhat biased.¹ The study consisted of medical students approaching every third patient in outpatient clinics to fill out the survey, without ensuring steps to reduce selection bias.¹ These medical students were associated with the study and would potentially be affected by the outcome of the patient responses. We suggest an approach similar to a study by Mwaka et al, which involved approaching patients who had already undergone random selection, to avoid selection bias, and using independent research assistants to carry out the survey, to avoid interviewer bias.⁴

Medical student training is an integral part of receiving care in a teaching hospital. Taha et al highlight that it is critical to understand patient perceptions and attitudes towards medical students. However, we propose that further research should be conducted to address these limitations, and in doing so, we can ensure that medical education and healthcare delivery continue to improve whilst evolving to meet the needs of patients.

Disclosure

The authors report no conflicts of interest in this communication.

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