Comment

Doctors do not risk being swamped by their patients' complaints if they listen until a patient indicates that his or her list of complaints is complete. Even in a busy practice driven by time constraints and financial pressure, two minutes of listening should be possible and will be sufficient for nearly 80% of patients. We gathered data in a tertiary referral centre that is characterised by a selection of difficult patients with complex histories.[4] Patients in less selected groups might need even less time to complete their initial statement.

We thank our colleagues at the outpatient clinic for providing the data and the administrative staff for collecting patient questionnaires.

Contributors: WL participated in the design and conducted most of the analyses. AKe contributed to data collection and analyses, MD was the project manager. AKi was involved in design and analysis. SR (then head of the outpatient clinic) organised data collection and coordination with standard routines in the clinic; BW provided training in patient centred communication. The paper was written mainly by WL and MD. WL is guarantor.

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Women's attitudes to the sex of medical students in a gynaecology clinic: cross sectional survey

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In *Tomorrow's Doctors* the General Medical Council recommended that medical schools construct a list of procedures in which students should show competence by the time they qualify.[1] There is general acceptance that such core skills include passing a speculum, taking a smear, and performing a competent pelvic examination. Anecdotal evidence from medical students, particularly male students, is that experience in this area is difficult to obtain. This is not a problem confined to the United Kingdom. In response to a similar perception among their male students, staff at the University of California studied patients' views on the involvement of medical students in the women's visits in an outpatient gynaecological and obstetric setting.[2] They found that 81% of patients accepted the involvement of students during a gynaecological visit, with no preference for a particular sex. However, the study did not directly address the issue of intimate examinations. We surveyed women attending a gynaecology clinic in an inner London teaching hospital to examine women's experience of and attitudes to the sex of medical students.

Methods and results

We surveyed women attending a gynaecology clinic in the academic year 1999-2000. Women were approached only when a student was working with the doctor they had seen. Questionnaires were given out by nursing staff after the consultation. Two hundred questionnaires were distributed and 181 were returned. The age range of respondents was 17-79 years (mean 40 (SD 13) years). Just under a quarter (44) of the women were attending a gynaecology clinic for the first time. Ten women had never been sexually active, and 64 had no children. In the sample 166 women had interacted with students. Six women who saw more than one student at the same consultation were omitted from the analysis. Ninety seven women had interaction with male students and 63 with female students.

Students had low levels of interaction with patients. Just under half (73) of the women reported that students asked questions, 25 that students did general examinations, and 31 that students did intimate examinations. There was a trend towards female students being more actively involved in examination: in 12 of the 63 visits (19%) involving female students the student did a general examination, compared with 13 of the 97 visits (13%) involving a male student, and the corresponding figures for intimate examinations were 14 (22%) for female students and 15 (15%) for male students.

The women were asked to consider the potential involvement of a student during a consultation. Their attitudes differed according to the sex of the student, with a preference for female students in all types of interaction. More women said they would allow a female student than a male student to observe their genital area (140 *v* 93 of the 181 women; χ^2=45, $P<0.001$), and more said they would allow a female student than a male student to do an intimate examination (114 *v* 72; χ^2=63, $P<0.001$).

Numbers (percentages) of women responding to the question "Would you allow a student to do an intimate examination?"

Respondents	Yes to male or female students	Yes to female students, no to male students	No to both male and female students	χ^2
All respondents (n=170)	72 (40)	41 (23)	57 (31)	—
Respondents who had had children (n=105)	53 (50)	25 (24)	27 (25)	10 (P=0.007)*
Respondents aged ⩾41 years (n=86)	45 (52)	27 (25)	15 (17)	20 (P<0.001)†

*Compared with women who have not had children.
†Compared with women aged ⩽40 years.

From a practical perspective we were interested in ways of identifying women who would agree to intimate examination by students of either sex. This would reduce the difficulty of the encounter and embarrassment for patient and student. We chose parity and age as easily identifiable markers, both suggested during the questionnaire design process. Older women were more likely than younger women to agree to intimate examination by students of either sex, as were women who had had children, compared with women who had not (table). Although older, parous women were more accepting of the involvement of students, the difference according to sex of the student was maintained.

Comment

Our findings support the claim of male medical students that it is more difficult for them than for female students to get experience of gynaecological examination. Some women attending this outpatient clinic were agreeable to examination by students of either sex. It may be necessary to target such women for involvement with student education.[3] It may be appropriate to use different teaching methods and settings for different aspects of teaching gynaecology: the teaching of consultation skills could be confined to the outpatient clinic, while pelvic models and volunteers could be used to teach clinical skills.

Contributors: JR had the original idea for the study and organised the distribution of questionnaires. JR and NO'F jointly designed the study, interpreted the findings, and wrote the paper. NO'F developed the questionnaire and carried out the initial analysis. Both authors act as guarantors for the paper.

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Commentary: Patients as partners in medical education

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It is important that students practise their clinical skills with patients. Learning core skills, such as pelvic examination, on plastic models alone is not enough. Practice is necessary in real life situations if the desired communication skills and attitudes are to be developed, particularly in the intimate examinations of women and men. O'Flynn and Rymer are to be congratulated on highlighting the dilemma male students face in a hospital gynaecology clinic.

Ensuring that students have access to patients is not always easy; shorter hospital stays and increasing student intakes add to the problems in finding enough patients for teaching purposes. There has been a tendency to assume that students have the right to clinical teaching involving patients and that patients have a moral obligation to participate. Yet it is difficult to find valid arguments to place such an obligation on patients.[1] The duties of a doctor to "keep professional knowledge and skills up to date" and "respect a patient's dignity and privacy" can conflict.[2]

Patients' choice is paramount. Although evidence is emerging that some patients value their role as educators,[3] some may be unwilling to participate, as O'Flynn and Rymer have shown. Ensuring that patients' choices are respected enables key objectives to be addressed. Patients must be fully informed that they have the right to refuse to take part in training of medical students. Students must learn to respect issues of consent and always seek consent from patients. Many of us are aware of students' concerns when they are asked to examine an anaesthetised patient. Has the patient given consent or not? Medical schools must have explicit mechanisms for ensuring that consent is obtained for teaching, whether it is in outpatient clinics or a general practice, on the ward or in theatre. Obtaining consent ensures patients' cooperation and encourages appropriate attitudes in our students. There must be overt, defensible recognition of the patient's rights.

At the same time we must respect students' needs and guard against disadvantage. Students are becoming equally aware of their rights. So how can we solve this dilemma? Asking patients to volunteer to become "partners in education," with acknowledgement of their role as active teachers, is essential. The professionalisation of the patient is inevitable. Patients increasingly see themselves as the "experts" on their disease and that they have specific contributions to make to the development of a student's skills and attitudes.[4] At the same time, patients benefit through sharing and reflecting on their problems with students, and they achieve satisfaction from helping.

Some medical schools already give patients active teaching roles, which can be as successful as consultant teaching.[5] Inevitably this raises issues of payment and training for patients in medical schools already struggling with limited resources. However, we must look forward. Patients' involvement in medical education is essential. They need to be acknowledged as partners in the process, for both their own and the students' sake. As a regular "patient teacher" of mine tells the students: "I do this for my grandchildren. They'll need good doctors."

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