Patients’ Attitudes Toward Medical Residents and the Impact on the Academic Practice

EXPLORATORY PAPER

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Introduction

An academic practice is an ambulatory clinic operating as part of a university health system. In some health systems, the clinic is the primary outpatient based facility affording residents the opportunity to gain hands-on clinical experience. Much like physician practices, academic practices provide care by specialists and primary care to patients in the community through scheduled appointments and walk-in services. The academic practice usually caters to Medicaid and uninsured residents in the community (Fiebach & Wong, 2001). One factor that distinguishes the academic practice from the physician owned practice is a larger presence of residents and supervising physicians.

The clinical experience is an integral part of the residents’ learning experience. Patients understand that all physicians must complete some type of practical training regimen to gain proficiency. Yet, patients’ reception to having residents involved in their care is not always positive. Some patients question whether residents are capable of addressing their health problems. Others make comments about the residents’ appearance, such as whether they are even old enough to practice medicine. Regardless of the types of comments or concerns expressed by the patients, those academic practice administrators find themselves trying to balance the patients’ level of comfort, working with residency program directors to provide educational and clinical experiences for the residents, and maintaining clinical operations without jeopardizing patient satisfaction.

The purpose of this paper is to explore the patients’ views on residents in the academic practice and the impact that those attitudes have on clinic operations. This paper will help practice leaders understand the patients’ reactions to residents, provide strategies for practice administrators use to address the patients’ concerns, and recognize ways to manage clinic operations in the academic practice.

Background
The residency experience is only one phase of the physician’s education and preparation for practice. This practical experience bridges the medical school experience with hands-on practice (Santen, Hemphill, McDonald, & Jo, 2004) and allows an opportunity for residents to provide continuity of care to those in the community while also enhancing their medical school learning before going out into their full-time practices. It is this experience in which physicians learn to interact with patients as well as the challenges of being a physician.

As the residents move forward in the program and become more proficient, they learn how to interact with patients and address health concerns while under the supervision of an attending physician. The resident completes the initial assessment of the patient and discusses each case with the supervising physician before prescribing a treatment plan, depending on how far the resident is in the program. The supervising physician may not accompany the resident during the resident’s initial interaction with the patient. However, the attending physician is an active part of the patient’s care team, provides guidance to the residents, and is available if the resident or patient has questions.

Discussion

The patient experience under the residents’ care is similar to care received in private practices and patient satisfaction is usually not affected by the residents’ involvement. Unlike medical students who have not yet graduated from medical school, residents have earned their medical degrees and are licensed to practice medicine while working under the supervision of an attending physician. To allow them enough time for their patient assessments, the appointment styles and templates within an academic practice are somewhat different than standard templates of physician practices. The time allotted for appointments in resident clinics is generally longer than those slots in regular practices so that the residents can discuss the patient’s treatment plan with the supervising physician. This is particularly attractive to many patients who welcome the additional time with the provider and patient satisfaction is higher when the patient feels the provider has time to listen to their concerns (Mora-Pinzon et al., 2013). Some patients prefer the
extended time with residents to address a longer list of complex issues compared to the shorter appointment slots of traditional appointments. As a result, patients actively participate in the discussion about their health with the resident than they would with the attending physician (Manninen, Henriksson, Scheja, & Silén, 2014). With longer appointment slots on the residents’ schedule, those patients enjoy the idea of spending more time with the provider without not feeling rushed during the appointment experience and feel the detailed history taking added value to the visit (Ramanayake et al., 2014). In contrast, other patients assume the reason for the extended length of time is due to the resident being inexperienced and those patients are less receptive to the resident provider and that the extended assessment time conflicts with their personal schedules and the time they plan to spend at the doctor’s office (Murata, Sakuma, Seki, & Morimoto, 2014).

Overall, there are few concerns from patients about the provider for their office visit being a resident. Although not all patients openly voice their concerns, their behavior indicates underlying opinions or concerns based on the way patients treat resident when compared to the treatment of more experienced physicians. Some of the areas in which the patients’ behaviors are different are:

1. The patient’s communication style when speaking with the resident.
2. The patient’s focus on the resident’s age or appearance.
3. The patient’s fear of care being compromised.

**First Impressions**

Patients walk into the clinic with an idea of what the doctor is supposed to look like and how the interaction with the doctor should be. Based on the expectations that patients have shared in the past, the traditional image of the physician is an older man whose experience is evident by the amount of white hair, especially from those patients who have had long standing relationships with their providers (Wilson, 2013). Some patients favor the traditional white lab
coat in the office (Moaward, 2016). This feedback is positively received by some clinic and program leadership who implement a standard dress code and require providers wear a professional white coat or business attire when in clinic setting for uniformity (Cha, et. al, 2004). Except for the identifying patches or institution names on their lab coats residents tend to fit the image of a practicing physician hoping to reduce unnecessary attention to the residents (Coppola & Reed, 2014).

When patients are informed that residents will be involved in their care, it is expected that the patient may ask questions if they need clarification on what that means. The introduction sometimes leads to comments made by the patient that shape the rest of the patient-provider interaction in an awkward way. An example of the patient making comments about how young the resident looks and how the patient has kids and grandkids older than him. The patient’s communication style becomes more informal with terms of endearment such as “dear” or “son” because they relate to the resident as one of their kids, although the resident may feel compelled to remind the patient that he is a physician and would like to be called “doctor”. How he approaches the situation could influence the patient’s satisfaction level, especially for those patients who perceive the exchange as arrogance, and disrupt the remainder of the office visit. The communication between the resident and the patient will shape the overall relationship, either by engagement and participation from the patient or diminished confidence on the part of the resident (Manninen et al., 2014).

Patients want assurance that the resident knows what he is doing and whether there will be a supervising physician present. They take comfort in knowing that there is a supervising physician who is also involved in their care and that the supervising physicians would ultimately be the person determining their treatment plans, especially if they believe the resident is disinterested in their care (Manninen et al., 2014). Thus, the patient interaction with the resident when the attending physician is not in the room may differ from the experience when the supervising physician is present in the clinic to assist. The patient might even overhear the
teaching moment between the resident and supervising physician and react by directing their questions to the attending rather than the resident, causing the resident feel as though his opinion on the care plan is being undermined.

**Impact on Operations**

It is important to note that every patient has a right to refuse care by residents (Peek, Lo, & Fernandez, 2017). However, when the patients are uncomfortable with their caregivers, the issue must be addressed quickly but appropriately to avoid chaos in the clinic or with the scheduling process. Some patients are adamant about only seeing certain types of doctors, whether it is a preference of a specific gender because of the nature of the health issue or of certain cultural background because of communication barriers. Choudhury et al. (2006) found that demographic factors such as age, gender, and ethnicity are influential factors in a patient’s view of a medical resident’s abilities. Other researchers agreed with this discovery, citing that minority patients were less likely to refuse care by a resident than White patients (Vaughn, Rickborn, & Davis, 2015). In addition, the patient’s culture and background could influence the communication style as well as the patient’s expectations from the provider (Petrilli et al., 2015).

Patients who are resistant to being treated by a resident usually do so because they assume the residents are inexperienced trainees and that the quality of care being provided will be inadequate. However, when the patient refuses to allow a resident to provide care, this disruption affects different areas. Comments or concerns about the resident’s capabilities cause resident morale to decline. As a result, the resident is unable to complete the care he started on that patient. It may also affect the patient’s treatment adherence if the patient doubts the information being provided by the resident. The disruptions also affect clinic operations with scheduling issues and patient satisfaction. These operational challenges have lasting effects beyond the time of the incident. The administrator must then decide whether to ask the supervising physician to take over the patient’s care or reschedule the patient with a different provider if no other provider is available. In academic practices where most of the appointment availability is with residents,
there are limitations for the patient to see other providers. If the patient refuses care and decides to leave, revenue is affected that day with copay refunds and inability to submit claims. The practice’s satisfaction scores are affected, which potentially impacts reimbursements.

In contrast, there are patients who welcome the opportunity to have a new provider who is unaware of his or her history and who might be more sympathetic to their health concerns, particularly if they are seeking pain meds. Many feel comfortable even sharing personal information or experiences with the residents (Ramanayake et al., 2012) and they believe the resident is more warm and welcoming (Dalia & Schiffman, 2010). And the patient sees the resident as a good listener and be more forthcoming about social behaviors such as medication compliance (Ranjan, Kumari, & Chakrawarty, 2015).

**Review of Literature**

There are editorial articles and academic literature on this topic as well as studies surrounding patients’ attitudes towards receiving care from residents. This section includes a review of literature on this topic and will address some of the factors that influence patients’ opinions on medical students and residents and their involvement in their care. The research strategy of this review was literature focused on the topic of patients’ overall opinions of residents in the clinical setting. The literature included surveys and research studies conducted by various organizations. Foundational information and literature for this paper was retrieved from academic publications, graduate medical education websites, the academic library database EBSCO and the US National Library of Medicine’s PubMed database.

**General Acceptance**

Patients’ opinions on residents’ capabilities vary by the individual’s culture as well as other influencing factors. Patients who have had positive experiences with residents in the past have generally positive views with regards to resident participation (Choudhury et al., 2006). Most patients are familiar enough with residency training programs and resident clinics that they are few questions (Santen, Hemphill, McDonald, & Jo, 2004). However, in rural areas and
community clinics where residents may not have a regular presence, the experience may be quite different (Gilmore, Avery, Tucker, & Higginbotham, 2016). Regardless of the exposure to the academic practice, it is hard to predict the patients’ reaction to the resident provider. For example, family medicine patients were asked if they would prefer residents involved in their care if given a choice to see a senior physician instead. Of the 251 patients participating in the study, 71% of the patients said yes, with nearly 62% of that group doing so because they understood the value to the residents’ practice experience (Malcolm, Wong, & Elwood-Martin, 2008). From the patients who would choose not to see a resident, more than half of that group would make the decision because of the long-term relationship they already had with their family physician (Malcolm et al., 2008, p. 571).

Researchers share a theory that the level of acceptance from patients vary depending on the specialization and other factors. Obstetrics and gynecology patients are more comfortable with female residents since the possibility of having to undress for the office visit is always a possibility (Marwan et al., 2012). In a randomized study of obstetrics and gynecology patients who were surveyed about their comfort level of having residents involved in their care, 83% of the study participants were receptive to the residents’ involvement (Coppola & Reed, 2014). However, Santen et al. (2004) mentions that patients in surgery environments are often uncomfortable if they believe they may be the first procedure for that resident, which emphasizes the confidence level demonstrated by the resident that could cast doubt on competency. On the contrary, patients in the emergency department appear to be willing to allow residents to perform their first procedures on them if given the opportunity to provide consent (Graber, Pierre, & Charlton, 2003). Finally, patients are more likely to agree to allowing the resident present for their consultation if the supervising physician asks rather than the administrator or someone else asking (Coppola & Reed, 2014).

**Negative Attitudes**
The practice has an ethical obligation to let the patient know who the members of the care team are (Martinez, 2005). Explaining to patients what an academic practice is should be part of standard communication in the clinic, allowing patients the opportunity to ask questions which could minimize skepticism (Cohen, 2011). Nevertheless, patients often have little trust in residents’ abilities when they believe the information is being hidden from them and expect lower quality and negative outcomes from residents performing procedures (Versluis & van der Linden, 2010). Some studies indicated that patients were often skeptical because no one was forthcoming about the provider being a resident and 60% of patients said they were not made aware of residents in the clinic at all (Santen et al., 2004). This was validated in a later study in which researchers found that only 82% of residents introduced themselves as a doctor instead of a resident (Santen et al., 2008). Although patients expressed their acceptance if given the information upfront, the acceptance rate declined from 95% to 57% when one organization informed patients about residents prior to the visit (Porta et al., 2012). This study proved that patients become apprehensive when faced with specific details about a resident’s role in their care.

However, the patient forms an opinion about the residents’ confidence based on their observation of communication between the resident provider, the staff, and the supervising physician. Although common for the team to discuss the care plan for the patient, how and where that information is discussed could cause the patient to doubt the resident’s competence. If the supervising provider tends to openly disagree with the resident’s assessment while in the room with the patient, that patient may question what he/she has been told by the resident. As a result, the patient might also disagree with resident because he doesn’t trust his judgment.

**Patient Satisfaction**

Few studies have addressed the issue of whether patient satisfaction is lower when the provider is a resident in training. Of the studies published on this topic, there appears to be no correlation between a decline in patient satisfaction levels and the presence of the medical
resident, even when the patient is dissatisfied with the type of procedure being conducted or anything else related to the treatment plan (Issa & Kim, 2012). Patient satisfaction appeared to be higher in resident clinics in which the time spent with physician is longer (Yancy, 2001). Yet, those patients who were not satisfied asked if there is a possibility that they can see a physician instead (Murata et al., 2014.) Patients who refuse treatment by residents when another option is available to them, insist on having a supervising physician present, cause a disruption in the clinic (Marwan et al., 2012). Several studies stated that there was a higher level of acceptance from patients in the hospital (60%) compared to the ambulatory setting, mostly because there is no expectation to continue a long-term relationship with the hospital physicians (Murata et al., 2014). More than half of the patients seen in resident clinics expressed difficulty in forming relationships with residents because they know the resident is only temporarily assigned to the clinic (Pincavage et al., 2013).

**Research Method**

To gain insight into patients’ willingness to allowing residents’ involvement in their care, an open-ended interview questionnaire was developed and disseminated to practice administrators and clinic managers where residents are routinely present at their clinic sites. Participants were asked to provide details of their observations and experiences regarding patients and residents. The study consisted of phone interviews with clinic managers, administrators, and physician leaders of various clinic specialties. Of the participants contacted, eight clinic leaders participated in the interview.

Questions 1 through 4 were foundational questions to gather information about each of the participants and their practices. All respondents were leaders in academic practices of similar sizes and structures with residents working with attending physicians. In Question 5, the participants were asked to describe the feedback received from patients regarding their encounters with residents in the clinic. From the responses, much of the routine feedback is neutral, in that many patients saw no significant difference from visits with other doctors in that clinic, stating
that the residents were polite and thorough. The overall negative feedback received was
generalized based on the patients’ brief observations. One participant recalled a patient
questioning whether the resident was familiar with the medications used to treat certain condition
because the resident asked for the spelling of her medications. Another participant shared similar
incidences in which patients questioned the resident’s knowledge since he asked more questions
than she was accustomed to and his assessment took longer than her normal office visits. Based
on the patients’ feedback in all situations, participants were asked in Question 6 to explain how
they responded to any negative comments received from patients. Nearly all responses to this
question were similar in that clinic leaders would speak with the patient to understand exactly
what their concerns were and reassure the patient that the resident was qualified to provide care.
In some occasions, they would ask the supervising physician to reassure the patient. If the patient
was still dissatisfied, that patient would be given an appointment on a different day with a
different provider.

Participants were asked in Question 7 to recall feedback they had received from residents
about their interactions with patients. The general feedback reported by the residents was that
patients challenged treatment plans and insisted they check with someone else, which was
consistent from all interview participants. Residents had mentioned that in some cases, patients
often tried to convince them to prescribe medication where the assessment did not support the
medication requested. One participant shared an experience in which a patient called the resident
“honey” and the resident promptly insisted she respect him by referring to him as “doctor”. This
exchange between the two became heated and the patient left the clinic after refused treatment.

In the final interview question, clinic leaders were asked what strategies had been
successful in managing their practices and resolving patient concerns. The participants offered
several solutions, including educating patients about residents and about the importance of
academic practices. When dealing with difficult patients, the collective responses from the
participants included: respecting patients’ wishes and never forcing them to see a provider if
they’re not comfortable; addressing patients’ concerns but not allowing the patient to speak negatively about the resident; encouraging residents to always be professional and identify themselves as “Dr. …” when they first introduce themselves to the patient; and only offering an option to see another physician if reassuring the patient is unsuccessful and the patient is threatening to leave the practice.

**Conclusion**

From the responses to the interview questions, it was apparent that some patients had negative views about residents while others had no concerns at all. Residents’ interactions with patients varied and there was no factor that contributed to the outcome of that interaction. While each clinic leader had different methods for addressing patients’ concerns in the interest of maintaining clinic operations, all agreed that balancing all facets of the clinic operations along with patient satisfaction required sensitivity and objectivity.

It is difficult to predict how patients will interact during the clinic visit. This is particularly true in a teaching facility where patients’ opinions are fueled by concerns of quality of care. As evident from the interview responses, some interactions between residents and patients result in little cause for concern with few questions or comments from patients. In other instances, the patients’ expectations differ from what is expected from the supervising physician, as does the patients’ opinions and behavior toward the resident. Regardless of the type of interaction or the patients’ opinions, clinic leaders should recognize the importance of maintaining clinic operations, including patient and resident satisfaction.

To ensure patients are given a chance to express their concerns in the least disruptive manner, administrators should be proactive about informing patients that residents will be involved in their care. Clinic staff might also let patients know when scheduling the appointment that the facility is a resident clinic. As questions or concerns arise, administrators should respond with sincerity while supporting the resident and the residency experience. They should continuously refer to the resident as “doctor” when speaking with the patient rather than using the
term “resident.” Remind patients that the residents are physicians who consult with trusted physicians in the practice on their care. And remind patients that there will be no changes to the care standards set by the practice. While there is no pre-defined approach for managing an academic practice, how the clinic leaders choose to approach the situation could determine future outcomes.
APPENDIX A

SURVEY OF ACADEMIC PRACTICE LEADERS

1. What is your practice specialty?

2. What is your role in the clinic?

3. Where do the residents see patients? How many residents see patients in your clinic at a given time?

4. What types of patients are typically scheduled with residents?

5. What feedback have you received from patients regarding residents?

6. How have you responded to concerns or negative comments about receiving care from residents?

7. What feedback have you received from residents about their interaction with patients?

8. What strategies have been successful in managing the academic practice and resolving patient concerns?
REFERENCES


