University–private hospital clinical education partnerships: Opportunities, benefits and barriers for medical student clinical training in private hospitals

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Abstract

Introduction: Private hospitals in Australia have the potential to offer rich clinical training opportunities for medical students. This study aimed to identify benefits and barriers to private hospitals engaging with medical schools to provide clinical learning opportunities, as perceived by staff and visiting clinicians at private hospitals.

Methods: Visiting clinicians and staff at four private hospitals in Adelaide (South Australia) were surveyed, using open-ended questions, to determine attitudes to medical student training in private hospitals. Responses were analysed using inductive content analysis to determine dominant themes in relation to perceived benefits, perceived barriers, and factors that might facilitate clinical teaching in private hospitals.

Results: A total of 59 participants completed the survey: 38 secondary care specialists; 4 general practitioners; 6 senior administrative staff; 6 hospital volunteers, medical students or registered nurses; and 5 not specified. There were three dominant themes related to perceived benefits of teaching: the breadth and diversity of clinical exposure for students, opportunities for students to understand private and community health systems, and the high quality of learning available. There were three dominant themes related to barriers: time constraints, patient unwillingness and limitations of learning opportunities. Factors that might facilitate medical education in private hospitals included senior staff acceptance and provision of clear support structures, faculty clinical academic support, administration and facilitation.

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Conclusions: Attention to the issues raised, correction of the misunderstanding regarding patient acceptance of students and minimisation of disruption to clinical service provision should allow further development of training placements in private hospitals.

Keywords: medical education; private hospitals; community based medical education.

Background

Traditionally, public teaching hospitals have been the cornerstone of medical training in Australia. The changing nature of medical practice, shorter hospital stays, an increase in day surgery procedures and care in ambulatory settings and the private sector have all impacted the ability of medical schools to provide suitable clinical training placements when they rely predominantly on public teaching hospitals. Coinciding with these pressures is a rapid and significant increase in medical student numbers (Carmichael & McCall, 2008), adding to the demand for alternative clinical training opportunities. Therefore, medical schools are adapting their clinical training programs (specifically clinical placements) so that they include a wider range of healthcare settings (AMA, 2012), both in the community and the private healthcare sector.

The private sector can play a valuable role in medical training. A report by Phelan (2002) identified the challenges relating to clinical placement availability, including limited experience in ambulatory settings and limited training across a variety of conditions that are primarily managed in the private healthcare sector. Following on from this report, there has been a focus on investigating the possibility of training medical students in non-traditional teaching settings. Although private hospitals form a very significant part of the medical community, they are currently less involved in the clinical education of medical students than teaching hospitals. In *Promoting Quality in Clinical Placements*, Siggins Miller Consultants (2012) identified that "quality placements provide students with opportunities for skill development, socialisation into the profession, and act as a bridge between academic and workplace learning" (p. 3).

In common with many medical schools, Flinders University places students in a wide range of community settings to learn clinical medicine. The majority of such community placements are currently in general practice, through the Flinders Parallel Rural Community Curriculum (PRCC) (Worley, Silagy, Prideaux, Newble, & Jones, 2000), and in urban areas through urban general practice placements. A more recent innovation, the Onkaparinga Clinical Education Program (OCEP) (Mahoney, Walters, & Ash, 2012), provides an urban community-based medical education program based in a mix of public and private settings, with both secondary care specialists (SCSs) and general practitioners (GPs). Clinical placements in private hospitals and other private SCS healthcare settings are seen as vital components of community-based medical education and complementary to the existing strong and growing general practice-based clinical education.

This paper provides the results of a survey of visiting clinicians and staff in four private or mixed private/public hospitals in South Australia to determine attitudes of clinicians and staff to clinical teaching in private hospital settings.

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Method

Approval for this research was obtained from the Social and Behavioural Research Ethics Committee of Flinders University, project number 5814.

The chief executive officers (CEOs) of five private or mixed private and public hospitals in suburban Adelaide were asked for permission to distribute a questionnaire to their visiting clinicians and staff. Four hospital CEOs agreed to the request, two from fully private hospitals and two from mixed private and public organisations.

A simple bespoke questionnaire was designed to obtain information from each hospital's visiting clinicians and staff about their role at the hospital and current teaching activities, including whether they were currently involved in teaching and if so, where, who and what they taught. This was followed by a free-text section with three open-ended questions asking for opinions about teaching in the private hospital setting using three open-ended questions. The questions were:

- *What benefits do you see in providing clinical teaching for medical students in a private hospital/clinic setting?*
- *What barriers do you see in providing clinical teaching for medical students in a private hospital/clinic setting?*
- *What do you think would facilitate providing clinical education to medical students in private hospitals?*

Additional space was provided for optional further comments. All questionnaire responses are reported descriptively.

Hard copies of the questionnaire and collection boxes for responses were placed in each participating hospital. The estimated potential participant pool at each site ranged from 20 to 200 people, with an estimated total of 300 across the four sites. Each CEO informed participants about the questionnaire through the respective institution's preferred method of communicating to staff and clinicians rather than having the researchers approach the participants directly. The questionnaire was anonymous, although participants could identify themselves if they wished. Staff and visiting clinicians in any role in each private hospital were invited to participate, since factors other than medical clinician willingness to teach are potential barriers and enablers, and the views of nursing, administration and other support staff were deemed to be as important as medical clinician views.

The researchers used an inductive content analysis and open-coding approach (Elo & Kyngas, 2008) to analyse the responses and determine common themes for each of the three free-text questions and additional comments.

Results

Roles and teaching experiences

A total of 60 participants from four hospitals (labelled H1–H4) completed the survey. Of these, 38 were secondary care specialists; 4 were general practitioners; 6 were senior administrative staff; 7 were hospital volunteers (V), medical students (MS) or registered

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nurses (RGN); and 5 did not identify their role. Almost all (36 of 38) of the SCSs came from one hospital (H3), while five of the six senior administration staff respondents came from another hospital (H4). The GP responses came from H2 and H4 as did the RGNs.

The question about teaching experiences revealed that 88% (52) of participants had previous teaching experience, and 75% (39) were currently involved in clinical teaching. Two of the four GP respondents, one administration respondent and one RGN respondent reported providing clinical teaching; all other teaching respondents were secondary care specialists. Of the SCSs who were currently teaching, 17 taught in multiple locations, including public and private settings; 4 respondents were currently teaching in the private hospital setting; and 5 taught in private practice rooms or other private clinical facilities. Most of the respondents who teach or have taught previously were involved in teaching at more than one level in the medical training pipeline, teaching medical students (28), interns or junior medical officers (15) and registrars or fellows (22). Six SCSs, one RGN and one administration respondent reported teaching nurses.

The findings are reported for each of the four main categories of the questionnaire: "Roles and teaching experiences", "Benefits of teaching in private hospitals", "Perceived barriers to medical education in private hospitals" and "Factors that might facilitate medical education in private hospitals". Respondents provided feedback on each of these themes regardless of role.

Benefits of teaching in private hospitals

The analysis of responses revealed three dominant themes related to perceived benefits of teaching: the breadth and diversity of clinical exposure for students, opportunities for students to understand private and community health systems, and the high quality of learning available. The breadth and diversity of clinical exposure was the most common benefit identified by respondents, who referred to opportunities for students to have more interactions with patients and the benefits of one-to-one teaching and mentoring.

Some examples of respondents' comments include:

> *Excellent clinical conditions, wide range of conditions, different perspective on presentations, investigations and treatments* (SCS8H3)
>
> *Exposure to procedures they might not see at their medical school* (SCS17H3).

Many of the respondents thought the private setting could offer a high quality of learning in a supportive environment:

> *More time to spend on case studies. Community feel gives friendlier approach and not so overwhelming. Excellent range of specialities and level of experience* (GP3H4)
>
> *Further opportunity for clinical exposure [in a] relaxed and supportive setting* (GP2H4)
>
> *More one-on-one content/mentoring* (SCS5H3)

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Teaching was also seen to provide benefits for the private hospital and its clinicians, through increased expertise and academic stimulation for current staff, and a potential for increased future workforce:

> *More academic environment in hospital* (SCS22H3)
>
> *Benefits for clinicians through academic stimulation—teaching provides academic stimulation* (SCS39H4)
>
> *Educates us too!* (SCS4H3)

Perceived barriers to medical education in private hospitals

Analysis of responses to this question, again, revealed three dominant themes: time constraints, patient unwillingness and limitations of learning opportunities. Comments about time constraints reflected both personal and structural concerns, and the irregular availability of clinical supervisors:

> *I simply do not have any spare time to do so* (SCS38H3)
>
> *Ward rounds are conducted in an efficient manner. They would not have time to teach and supervise a student* (SCS33H3)

Patient unwillingness was perceived to be a concern:

> *Patients expect to be treated by their specialist, not a student* (SCS29H3)

Some respondents thought that there could be limitations to the learning opportunities, particularly because of structural constraints:

> *Availability of sufficient number of patients under a particular doctor* (SCS8H3)
>
> *The private hospital environment is not suited to medical student teaching, since medical staff come and go a lot* (SCS7H3)

A small number of respondents referred to resourcing issues, including the need for reimbursement for incurred costs and resources as well as individual time spent teaching.

Factors that might facilitate medical education in private hospitals

There were 46 respondents who made suggestions about ways to facilitate medical education in private hospitals. Responses revolved around five key themes: planning and clear structure; good communication between all parties, including university engagement with and support for hospital staff and clinicians; having a designated liaison and placement coordinator; having designated clinical supervisors; and adequate funding. Good administrative support is a feature of many of these themes. Necessary support suggested by participants included:

> *Informing all staff that students will be present* (SCS27H3)
>
> *Well-structured timetable for scheduling of teaching opportunities* (SCS5H3)
>
> *Appropriate meeting rooms. Agreed roles* (SCS37H3)

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A dedicated member of staff on site … to ensure both staff and students always have the most up-to-date info they need (Admin2H1)

Training coordinator [to] map out course (SCS23H3)

Provision of adequate funding and resources was identified as a facilitating factor, as was the need for faculty development:

Involvement of staff in training programs, guidelines and protocols, providing training for staff in teaching (GP3H4)

Other comments

Participants were able to add additional comments, and 18 respondents took this opportunity. Eleven of these additional comments were supportive and constructive, for example:

Huge capacity, i.e., exam of knee/shoulder/UMA/elbow/head/spine/airway management … pleased to give something back (SCS12H2)

*Happy to be involved in teachi*ng (SCS39H4)

I think this is worthwhile and continue to support it (Admin7H4)

Great initiative! (Admin4H2)

The remaining seven comments focused on barriers similar to those already identified, particularly time and funding, for example:

Adequate remuneration of specialists must be provided to encourage their participation (SCS16H3)

Teaching and educating takes time. Time is not kind to medical students in private hospitals (SCS33H3)

I am ambivalent re: this proposal when we are being asked to see so many patients too quickly in the public [system] (SCS37H3)

Discussion

In the Australian healthcare context, medical education has historically been seen as a function of public teaching hospitals, with the private hospital sector viewed as a place where neither clinicians nor patients accept medical students. As one respondent said, the view is that patients are "*paying for the attention of consultants"* (SCS34H3).

However, in a number of studies, the perception of private patient unwillingness has been shown to be false (for example, Arolker et al., 2010; Esguerra et al., 2014; Hudson, Weston, Farmer, Ivers, & Pearson, 2010; Mahoney & Yong, 2012; Sousa, Tajra, Coelho, Gomes, & Teixeira, 2009). Patients are frequently willing to allow medical students to be involved during their healthcare in private practice settings, both general and

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specialist practices. Providing that they have clear opportunities to give or withhold consent, patients generally accept that students need to learn and have a high regard for doctors who teach, seeing it as a sign of excellence.

Knowing that patient acceptance is unlikely to be a barrier, this study looked at attitudes of clinicians and hospital staff to the development of clinical training for medical students in private hospitals. Of the 59 respondents, 86% had previous teaching experience, with 65% of those currently involved in clinical teaching and 30% currently teaching in a private setting.

The respondents identified clear benefits for the private sector being involved in medical education. The breadth and diversity of clinical exposure that could be offered to students was highlighted by nearly half of the respondents, who recognised both the need for and value of such opportunities. Enabling students to understand private and community health systems was also seen as valuable, given that this is the environment in which many will work in the future. The high quality of learning available was also identified, along with a recognition that some learning in private and community settings is different from and complementary to that obtained in teaching hospitals. In addition, teaching and supervision of medical students is seen as part of good medical practice (Medical Board of Australia, 2009), and some respondents also identified benefits for the private hospital as an organisation through increased expertise and academic stimulation for current staff, and the potential for an increased future workforce.

Time constraint was the largest barrier identified, referred to by one-third of respondents. The next largest category of identified barriers was patient unwillingness, referred to by 25% of respondents. In light of the research into patients' attitudes, discussed above, this would appear to be a misconception on the part of respondents, and an area that medical schools should address when developing partnerships with private healthcare providers.

Excellent communication, thorough planning and a clear structure for any initiative to develop clinical learning placements were the major recommendations from respondents. Engagement of clinicians and support for hospital staff are essential, as is funding for a designated liaison and placement coordinator and clinical academic to "*take on the project and drive it and provide rewarding and effective learning environments for medical students"* (Admin3H4).

Models for medical education in private hospitals already exist. Greenslopes Private Hospital (Greenslopes Private Hospital, n.d.; Houston, 2012) has a longstanding involvement in medical education, and some of the identified benefits include the value of the training opportunities and teaching resources, attraction of the right type of visiting medical officers, good succession planning, peer review and "the patients love them" (Saunders, 2012).

It is acknowledged that change can be difficult and must be well managed. Appropriate resources are necessary for infrastructure, educational resources, support for the acquisition of teaching skills, IT and human and management resources. It is also

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clear that clinical work must not be disrupted. Students should receive induction training regarding working in the private sector, with emphasis on patient consent, and expectations regarding presentation (dress code) and punctuality. The university facilitator plays a key role in ensuring all these issues are addressed and maintaining excellent communication with all stakeholders. Clinical teachers should be invited to participate in the curriculum and timetable development if they wish, but also provided with support to minimise impact on clinical workload. Academic recognition through research opportunities and academic status are also essential.

This research adds to literature by increasing the understanding of the potential for clinical education to occur in private hospital settings in Australia.

Limitations of the research include:

- It was conducted in one capital city only, with the possibility that local factors may impact on the findings
- The presumed response rate (around 20%) is low, however the total number of true potential respondents is probably much less than the estimated 300. The true denominator is difficult to identify because the nature of Australian private practice generally includes multiple visiting medical practitioners (SCS and GP) who spend varying amounts of time in the facility, sometimes daily but sometimes only once a month. Although the total number of visiting clinicians is included in the estimated number of potential respondents, clinicians who are infrequent attenders may have missed the data collection period and may have been less interested in the survey. Information on this variable was not sought, but it may have also affected the response rate.
- The opportunities to contact potential participants were restricted by the need to use an indirect method of contact through the CEO of each hospital, which did not allow the researchers to develop an approach that may have resulted in more responses.
- The majority of responses from secondary care specialists came from one hospital, and the senior nursing and administration responses from another. This may also limit the generalisability of the findings.
- Visiting medical practitioners often visit more than one private hospital, so in some cases, the potential respondents would be the same individuals at more than one site. However, since the majority of SCS respondents were from one site only, it is unlikely that any individual responded more than once in this study.

Despite the limitations, this research offered an opportunity for SCSs, GPs and senior hospital administration and nursing personnel to offer an opinion on the topic.

Conclusion

Private hospitals, their clinicians and staff can offer numerous learning opportunities for medical students. Conversely, the involvement of a university and medical school offers the private hospital and its clinicians and staff the opportunity to engage in the culture of evidence, quality and review that goes with an academic institution.

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Attention to the identified barriers, benefits and facilitating factors identified in this research may benefit private hospitals and universities that are considering establishing clinical education partnerships. In particular, correction of the apparent common misconception about patient attitudes to medical students could support the further development of partnerships between medical schools and private hospitals.

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