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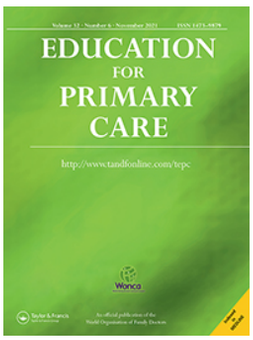

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Complaint-driven preferences & trust: patient's views on consulting GP trainees

Sarah de Bever[a], Suzanne C. van Rhijn[a], Anneke W.M. Kramer[b], Jettie Bont[a], Nynke van Dijk[a] and Mechteld R.M. Visser[a]

[a]Department of General Practice, Amsterdam Public Health Research Institute, Amsterdam UMC, University of Amsterdam, Amsterdam, The Netherlands; [b]Department of Public Health and Primary Care, Leiden University Medical Centre, Leiden, The Netherlands

ABSTRACT

Background: Work-based learning depends on patients' consent to have trainees involved in their care. However, patients can refuse trainees, which might lead to the loss of learning experiences. Improved understanding of patients' views on consulting trainees may provide useful insights to further optimise learning for trainees.

Methods: We performed a qualitative study with 28 patients in The Netherlands. Participants were recruited from GP practices, and were purposively sampled on (un)willingness to consult GP trainees. In semi-structured interviews patients' perspectives and willingness to consult a trainee were explored. Transcripts were thematically analysed using an inductive approach.

Results: Two themes explained patients' views on consulting GP trainees: *Presenting complaint-driven preferences* and *Trust in trainees' capabilities*. Patients select their doctor based on complaint-driven preferences and chose trainees if they fulfilled these preferences. For urgent, gender-specific and minor complaints, patients prefer timeliness, gender concordance or availability. Patients with more complex, long-term problems prefer to consult a trusted doctor with whom they have a longitudinal relationship. Through repeated visits and empathic behaviour trainees can become this doctor. Before patients consider consulting a trainee, they need to have trust in the trainee's capabilities. This trust is related to the basic trust patients have in the education of the trainee, their knowledge about trainees' capabilities and supervisory arrangements.

Conclusions: Patients' decision to visit a trainee is fluid. Patients will visit a trainee when their complaint-driven preferences are satisfied. Influencing trainees' fulfilment of these preferences and patients' trust in trainees can make patients more willing to consult trainees.

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Introduction

Medical trainees develop their competences while working [1]. However, a workplace does not always provide all relevant learning experiences for their future profession [2]. It is known from previous research that general practitioner (GP) trainees see fewer patients with complex, chronic conditions compared to their supervisors [3–5]. The reason for this may be related to trainees, supervisors, teams and the workplace. For example, trainees need to facilitate their own learning in the workplace [6,7]. Supervisors might withhold patients from trainees if they believe he or she is not sufficiently capable, especially when patients have complex problems [8]. Furthermore, trainees depend on the learning opportunities a workplace has to offer, and primary healthcare teams can help or hinder a trainee's learning [9,10].

An important factor that might influence which patients a trainee consults with, are patients' views on having trainees involved in their care [11,12]. Patients are not obliged to participate and can refuse to consult a trainee. Previous studies have researched patients' views on this topic. A systematic review by Vaughn et al. found that a patient's acceptance of medical student involvement is negatively correlated with the intimacy of the patient's condition and the perceived risk of an incorrect diagnosis [13]. In their review of patients' perspectives on GP trainee involvement, Bonney et al. [14] established that trust, the perceived need for continuity of care and having a 'personal doctor', influenced patients' attitudes towards trainees. Although these studies are helpful in understanding patients' views on learners, both reviews were based on questionnaires that provided only marginal insight into patients'

CONTACT Sarah de Bever s.debever@amsterdamumc.nl Department of General Practice, Amsterdam Public Health Research Institute, Amsterdam Umc, University of Amsterdam, Amsterdam, The Netherlands
Supplemental data for this article can be accessed here.

motives and thoughts. However, the understanding of patients' motives and thoughts about trainee involvement may provide insights into their willingness to accept care from trainees.

To deepen the results of previous work, further exploration was warranted. In this study, we explored patients' reasons for accepting or refusing trainees in their care, and which motives and ideas affected this decision.

Methods

Design

We employed qualitative, semi-structured interviews with patients from GP training practices. We used thematic analysis [15], with a constant comparative approach.

Context

GPs have a central role in the healthcare system in The Netherlands. Every Dutch resident is registered at a GP practice, and a person's first contact with the healthcare system is usually a GP. Appointments are made either by phone or by an online appointment system. Medical receptionists are responsible for the time and date of the appointment. Receptionists usually base their selection on a mixture of triage and patient's preferences. According to the GP speciality guidelines, patients should be informed about the practice's training status when they visit a trainee. This is usually done when patients make the appointment or through information about the trainee in the waiting area or the practice's website.

GP speciality training in The Netherlands is a three-year postgraduate programme. Trainees spend the first and third years in a GP practice, where they work under the supervision of one or two designated GP supervisors. Trainees usually manage their patients independently and discuss them with their supervisor(s) once a day.

Study participants

Patients were recruited through general practices affiliated with the GP speciality training provided by either the Amsterdam UMC (University of Amsterdam) (n = 4) or the Utrecht UMC (University of Utrecht) (n = 1). Patients were purposively sampled to gain maximum variation in willingness to consult GP trainees. Unwilling patients were those who had refused a trainee in the past, and willing patients were those who had recently visited a trainee. Unwilling patients were selected by the medical receptionist or GP, and were sent an information letter and application form. Interested patients were contacted by a member of the research team to arrange an interview at a place and time of the patients' choice Willing patients were recruited after their visit to the trainee. They were asked to participate by either a member of the research team in the practice's waiting area, or by the trainee after their consultation. These patients were interviewed either directly after their consultation or at a later time.

Data collection

Semi-structured interviews were held using a topic guide. Patients were asked if they had ever consulted a GP trainee, about their views on consulting trainees, and to reflect on their reasons for consulting or not wanting to consult trainees. Other topics were the influence of the complexity of a condition, prior experiences with trainees, knowledge about a trainee and the impact of the characteristics of a trainee (like gender or age) on a patient's decision to consult the trainee. The topic list was based on findings from our earlier study on the perspectives of professionals working in general practice [16], additional literature [14,17–19] and discussions within the research team. The topic list can be found in Appendix I. The interviews were conducted by SvR, MV and SdB. All interviews were audio-taped and transcribed verbatim. Data on demographics were collected using a questionnaire.

Data analysis

Data analysis consisted of familiarisation, coding, generating initial themes, reviewing these themes and finally defining the themes [15]. Data collection and analysis were performed iteratively. After each interview a short discussion was held to review the topic list. The first eleven transcripts were inductively coded by two researchers (SdB and SvR), after which they constructed the initial code scheme. Two more transcripts were coded by these researchers to check the initial coding scheme. The resulting code scheme was discussed with a third researcher (MV). After achieving consensus, SdB coded four more transcripts. The new codes and initial themes were checked through re-reading and a discussion between SdB and SvR. Meanwhile, new interviews were conducted to deepen understanding. These interviews were coded by SdB with the existing coding scheme, which was checked for accuracy by MV.

After 20 interviews, a discussion between JB, AK, MV and SdB was held, during which it was concluded that the sample lacked patients with a lower educational

level. Since this is a factor that might affect patients' attitude towards consulting trainees [20,21], we purposively sampled for these patients by recruiting patients from a GP practice in a deprived area. This practice has a large population with a low educational level, therefore the likelihood to interview a patient with a low educational level was high. Educational level was assessed using the questionnaire on demographics. Eight more interviews were held and analysed using our coding scheme, which did not result in any further modifications. Finally, the themes were discussed by the whole research group to establish the final themes and their relations. Data analysis was supported by MAXQDA Plus 2018.1 software. During the coding process, a number of memos were written to support the analysis.

Reflexivity

The research team consisted of a GP trainee (SdB), a cognitive psychologist (MV), a medical educationalist and medical doctor (NvD), one GP and clinical researcher (JB) and one GP and educational researcher (AK) and a research assistant/educationalist (SvR). The diversity of this team ranged from people working in GP practices (SdB, JB, AK) to people more distant from practices (MV, NvD, SvR) and with educational research experience (MV, NvD, AK, SvR) ensured a broad range of perspectives on the data.

Results

We held 28 interviews, each lasting 6–31 minutes. Twelve patients were considered as 'unwilling' and 16 as 'willing' to consult with trainees. Their demographic data are presented in Table 1.

Our results indicated that the factors affecting patients' decision to consult a trainee were not about the qualities of a trainee. Most of our patients had positive perceptions about trainees, and considered they had up-to-date knowledge or were thorough. Despite this, they could be unwilling to visit a trainee.

Table 1. Demographic data for patients who were unwilling to visit a trainee and those who were willing to visit a trainee.

	Unwilling (n = 13)	Willing (n = 15)
Age in years (median)	61	35
Gender (M/F)	3/10	4/11
Education		
Primary school	1	1
Pre-vocational education	1	1
Vocational education	2	5
Higher education	8	8
Missing	1	0

Interviewer: *You said you had experiences with trainees, and those were?*

> *Kind, friendly, professional. They helped me very well, let me put it that way. But that's not why I avoid consulting them. No, not because they still have to learn and I don't want that. No, it's definitely not that.* (Participant 7)

We found that patients' willingness to visit a trainee could be best explained by the preferences patients had related to their complaint and the trust patients had in trainees' capabilities. In the following paragraphs we will elaborate on these themes and how they influenced patients' ideas on trainees as caregivers.

Presenting complaint-driven preferences

For this study we define a presenting complaint as the reason why a patient visits a GP. This can be related to a symptom, like a sore throat, or to a specific disease, such as a review of diabetes. Every complaint is related to specific preferences regarding *timeliness, availability, gender concordance* or *having a longitudinal, personal relationship with the doctor*. Patients attending with a minor ailment prioritise the *timeliness* of their appointment. If a complaint is urgent, *availability* is prioritised. Patients with sexual health problems tended to prefer *gender concordance* when choosing a doctor.

> *It depends on the urgency. For urgent matters you have to consult the substitute, whoever that may be. For matters that can wait, if the preferred doctor is on a skiing holiday, you wait until he is back.* (Participant 2)

> *I find a female doctor a little more pleasant [to consult], but that's personal. Because she understands better how females and hormones work and what troubles you have if you're going through menopause.* (Participant 15)

For more complex, multi-morbidity, chronic or psychosocial conditions, patients preferred consulting a doctor with whom they have an established, longitudinal relationship. This relationship is based on repeated visits to a single doctor, after which this doctor is presumed to have knowledge about the patient, his/her complaints and his/her socio-cultural background. Patients presumed that through this knowledge the doctor can provide personal care, tailored to their specific needs. Moreover, patients trusted these doctors because they had this knowledge.

> *I have a couple of complaints and the doctor [GP] knows them well and knows me well. That's why I really prefer talking to her about it [complaints], and less with the trainee.* (Participant 4)

Consulting the trainee

Patients' willingness to consult a trainee was fluid, and depended on the extent to which a trainee can fulfil their complaint-driven preferences. For example, the following patient visited a trainee because she wanted a female doctor who was available quickly:

> *Today I wanted to consult a female doctor, and the only available one was the trainee.* (Participant 24)

Though availability and timeliness are usually easily fulfilled preferences, the preference for a longitudinal, personal relationship was more difficult to fulfil for trainees. Participants considered that trainees were not always familiar with patients' contexts and histories and were considered less suitable to consult than their personal doctors.

> *She [GP] knows everything about me and my family, and she remembers a lot. With the GP trainee you do not have this, they will look into your file to see the reasons why I visited the last couple of times. And they will ask me questions about that visit or this new visit. That is just a professional but, how do I put this, more distant. I do not have any bond with the trainee of course.* (Participant 7)

Patients can form relationships with trainees as illustrated by the following quote in which a patient wished to have the trainee as their regular GP.

> *I am very satisfied about this trainee. If she would work here as a regular GP, I would choose her. Yes. (Participant 15)*

To form a bond between trainee and patient, repeated visits and empathic behaviour were important. Repeated visits offered the opportunity for patients to get to know the trainee and his or her way of working. For the trainee, they offered the opportunity to actively work on the relationship.

> *If you knew the trainee better, because you consulted her twice when you couldn't consult your own GP, then I also might choose her [the trainee].* (Participant 3)

Repeated visits were possible if patients wanted to return to see a trainee. Patients tended to do so when the initial contact with the trainee was pleasant.

> *Yes, this is the first experience that really stuck with me. I did experience it [visiting the trainee] as pleasant. (Participant 17)*

Patients described visits as pleasant when they felt at ease with the trainee. This feeling can be enhanced by the use of empathic behaviour. Trainees needed to listen carefully and pay personal attention to the patient. Patients wanted trainees to explain their findings and make suitable treatment plans. If trainees did this, patients were more likely to return for a repeat visit to the trainee.

> *I knew that this young man, because I consulted him once, that he paid attention to me, that he looked after me. And that is important to me.* (Participant 25)

> *That she [the trainee] listened very well to my story and searched carefully for a solution. Yes. She made her considerations clear to me. Yes. I was satisfied. That is why I returned to her. (Participant 17)*

Trust in capabilities

Participants considered another prerequisite to consulting with a trainee was having trust in the trainees' capabilities. Some patients found consulting with trainees was more risky due to their training status.

> *For some things, it's important that they're [trainees] properly examined. When someone is still in training, perhaps they are less able to make a connection with something that could be very severe.* (Participant 19)

Patients' previous experiences with trainees influenced their trust in a trainee's capabilities. Patients who had had negative experiences with a trainee were less trustful in trainees' capabilities and less willing to consult them.

> *I've had bad experiences with people who are still in training. When I was a new patient in this practice, I always consulted a lady who was still in training. Every time, she gave me an unpleasant feeling . . . I had the feeling that she wasn't experienced enough to help me . . . Then I decided not, to no longer consult trainees, because I didn't have any good experiences with them.* (Participant 27)

Despite the perceived risk of consulting with trainees, most patients usually had enough trust in trainees' capabilities to consult with them as long as they fulfilled their complaint-driven preferences. Patients usually trusted that GP trainees were properly skilled because they trusted that the (Dutch) educational system had trained them to a sufficient standard, or that their GP practice had established that the trainee was capable.

> *Because he's already come this far, I think he [the trainee] is skilled enough to do his job. I hope he's been assessed well enough during his training to let him work here.* (Participant 22)

Consulting the trainee

Trust in trainees depended on patients' prior experiences with trainees, their perceived risk of a misdiagnosis, and their trust in the Dutch educational

system and the GP practice. Patients' trust can be enhanced by providing information about achieved competences and trainees capabilities, as explained in the following quote:

> *When I came to make an appointment for the IUD they told me that my GP was on holiday. But the trainee was available, and that she was also very good at it. I thought 'Well fine'. (Participant 13)*

Another method to enhance patient trust was providing knowledge about the supervisory system. When patients knew the supervisor was close at hand, they tended to be less hesitant to consult a trainee.

> *No, that does not matter to me. I know that the trainee can call for help when she can't figure it out or is in doubt. (Participant 18)*

Discussion

Patients' decisions to visit a trainee were fluid. The choice of patients was based on their complaint-driven preferences and they would consult with a trainee when he or she satisfied these preferences. For urgent, gender-specific or minor complaints patients prefer availability, gender concordance or timeliness. Patients with more complex complaints preferred to consult a known doctor with whom they had an established relationship. Our finding that patients choose their doctor based on their complaint-driven preferences is not a new one. Previous studies found that patients with chronic illnesses or psychosocial problems preferred to consult their personal doctor and had a less strong preference when attending with minor ailments [18,22]. The same preferences were important when patients chose between different qualified GPs [23,24]. This was understandable considering the benefits such as continuity of care which patients experienced when consulting their 'personal' doctor. These preferences had a large impact on patients' willingness to consult a trainee, and had consequences for trainees' learning experiences. Patients' preference for their personal doctor were, at least partly, the reason why trainees saw fewer patients with multimorbidity, chronic or psychosocial conditions compared to their supervisors [3]. Our findings indicated that trainees could satisfy patients' preferences. Timeliness and availability were easily fulfilled by trainees and our results showed that trainees can become personal doctors. Repeated visits and empathic behaviour were the cornerstones to form a bond between trainee and patient. This is already known for established GPs. A review by Ridd et al described that being interested, listening well and being empathic were the foundations for a good patient-doctor relationship [25]. We add to this, that trainees can use these recommendations to bond with their patients. Moreover, another study by our research group investigating the view of professionals on trainees' patient mix indicated that trainees could become the preferred doctor of patients with long-term conditions. Repeated visits and the trainee's behaviour were important in establishing the relationship [16]

The influence of trust on patients' willingness to see a trainee is another important finding. Patients needed to trust trainees before they would consider consulting with them. Previous negative experiences and a high perceived risk for misdiagnosis diminished patients' trust and their willingness to consult with the trainee. Drevs and colleagues found a strong negative relationship between patients' anxiety about a wrong diagnosis (and thus negatively influencing their trust) and their willingness to allow a medical student to participate in their care [17]. We add to this knowledge that in general, most patients had sufficient trust in trainees. This trust was based on the trust patients place in the training of GPs or the trust they had in their GP practice. This finding was echoed by Bonney et al who found a positive relation between the trust patients have in the system (educational system or GP practice) and their willingness to visit a trainee [26]. We found that patients' trust can be influenced by enhancing their knowledge about trainees' capabilities or the supervisory arrangements. This is a finding confirmed by previous studies [27,28] and is likely linked to the reassuring effect of this knowledge on patients' anxiety when visiting a trainee.

Implications for workplace learning & research

Patient's consent is crucial for workplace learning but sometimes difficult to get. Our results offered some guidance on how trainees can influence patient consent. Our most important recommendation is that trainees should form bonds with their patients. To do so, repeated visits and empathic behaviour were important. We recommend that trainees and supervisors are taught about this, and are encouraged to discuss it in their learning conversations. Topics to consider are the manner in which the trainee approaches the patient, listening and communication skills and how the trainee ensures repeated consultations with patients. Supervisors should review the patient allocation process with their medical receptionists and discuss how to establish repeated consultations with the trainee. Medical receptionists

should be informed about trainee's competences and skills and use this knowledge to adequately inform patients. Supervisors could openly discuss trainee's competences when undertaking house visits or provide consultations together with a trainee. By doing so, they transfer the trust patient place in them to the trainee [16].

Although this study offers insights into how to improve trainees' patient mix, further research is required to examine this in more detail. Our findings pertain to the doctor–patient relationship, which is an important aspect in primary care but perhaps less so in other contexts. It would be interesting to establish whether this aspect is an influencing factor in other settings.

Limitations

Our selection method could have introduced bias. Unwilling patients were recruited after selection by the GP or receptionist. GPs or receptionist could have chosen patients they knew would have 'good' reasons to refuse a trainee and did not invite patients with reasons that were unfavourable for the GP or the practice. It is possible that only patients with socially desirable reasons to refuse a trainee responded to our invitation, and that patients with more embarrassing reasons did not. In the case of willing patients, we asked the trainee to invite them to participate and it is possible that trainees only invited satisfied patients. We tried to minimise this risk by inviting patients who were still in the waiting area before being asked by the trainee GP to participate.

This study was based on what patients wanted to share with us during interviews. It is possible that patients could have answered in a socially desirable manner questions concerning more sensitive topics – such as a trainee's capabilities or reasons to refuse to consult a trainee – or because they did not want to criticise their regular doctor. We minimised this risk by having a person without a medical background (SvR) conduct all but one interviews with 'unwilling' patients.

We conducted our research within the setting of general practice in The Netherlands. This setting has marked differences from other medical specialties, such as longstanding doctor–patient relationships and holistic care. The educational setting is different compared to other specialties or other GP training programmes. The GP training programme in The Netherlands has longstanding one-to-one supervisory relationships and GP trainees spend a whole year in one GP practice. Our findings might not be transferrable to other settings.

Conclusion

We studied what affected patients' decision on consulting with GP trainees. Patients decided to consult which doctor based on the type of complaint they had and their corresponding preferences for timeliness, access, gender concordance or having a longitudinal, personal relationship. Whether a trainee can fulfil these preferences influences a patient's willingness to consult the trainee. Though trainees can easily fulfil the preference for timeliness and access, the preference for a personal relationship is difficult to fulfil. With repeated visits and empathic behaviour trainees can become the patient's preferred doctor. Patients need to have trust in a trainee's capabilities before they will consider consulting the trainee. Patient's trust is affected by their trust in the educational system, their knowledge about trainees capabilities, or their knowledge about the supervisory arrangements. Increasing patients' willingness to consult a trainee is through enhancing patients' trust in the trainee and strengthening the bond between trainee and patient.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical Review

The ethical review board of the Netherlands Association for Medical Education gave permission for the study (file number: 630).

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ORCID

Sarah de Bever http://orcid.org/0000-0002-5113-0396

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