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Case Study: Paul's Dilemma

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Paul is a third-year medical student in a major teaching hospital doing a clerkship in OB/GYN. Learning to do an adequate pelvic examination that produces minimal discomfort to female patients is an essential educational objective of the clerkship. One morning, after taking Mrs. Brown to the surgical suite, Paul scrubs and prepares to assist in the procedure, a D&C. After Mrs. Brown is anesthetized, the attending physician tells the junior resident and three medical students to do a pelvic examination on the patient to sharpen their clinical skills. He says that this practice will serve a basic educational need while resulting in no discomfort to Mrs. Brown and causing no harm. However, while standing in line, Paul worries about, among other issues, the principle of respect for persons, patient autonomy, and reciprocity, and considers refusing to do the practice pelvic examination.

Should Paul refuse to do the pelvic examination on Mrs. Brown?

Why or why not?

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Commentaries on Paul's Dilemma

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Pelvic Examination: An Educational Tool?

Nearly all women believe that a pelvic examination under anesthesia should not be done by trainees unless permission to do the examination has been explicitly given by the patient.[1] Yet, there is evidence that the practice of allowing students to make such examinations has not disappeared.[2] One justification for this practice is that, while medical students need to learn how to do pelvic examinations, women are reluctant to give permission for such examinations. Yet, recent data suggest that a substantial majority of women will agree to such examinations if they are asked in advance.[3,4]

This case study illustrates some of the flawed thinking that underlies examinations without permission. One of the objectives of the gynecology clerkship is to teach students how to do "an adequate pelvic examination which produces minimal discomfort to female patients." Examinations under anesthesia do not provide an opportunity to learn anything about discomfort. It may be that the best way to teach pelvic examinations is to hire women volunteers who remain awake and can react to the examination. In our institution, we hire such women and train them to teach students in real time how to do a gentle pain-free pelvic examination.

The surgeon in the vignette claims that a pelvic examination by four trainees will cause no harm to the patient. Multiple examinations by untrained individuals on an unresponsive patient pose risks of damage to the vagina, cervix, and internal organs. Such damage, should it occur, would not qualify as "no harm." Moreover, if a woman were subjected to such unconsented procedures and later were to discover that they were done, she is likely to feel violated, humiliated, or even raped— certainly not harmless outcomes.[5]

The case study does not provide a critical piece of information: did the physician ask the patient's permission ahead of time? If he requested permission and it were granted with the patient's full knowledge of the circumstances of the examinations, including specifically who would be doing them, then there is no problem. But what if he did not obtain informed consent?

Paul seems to recognize, on grounds of certain principles, the possible impropriety of doing the examination without the patient's permission. He wants to do the right thing, and initially seems not sure what the right thing is. As a medical student, he must learn how to do a thorough examination of patients, including pelvic examinations, which require access to a woman's most emotionally charged anatomic region. Surely, it is less embarrassing and less uncomfortable, physically and emotionally, for all concerned for these parts to be examined

without the patient's awareness. Yet, he knows that patients are persons whose right to self-determination ought to be respected; in fact, he read that unconsented touching is punishable as battery under the law. It takes only a few moments of reflection to conclude that the surgeon's order is most likely wrong.

Given the impropriety of what he has been asked to do, Paul recognizes his second dilemma: how far can he go in his own self defense. He knows that if he refuses to do the examination, he risks disapproval and perhaps a hostile reaction from the attending physician, with unknown potential adverse consequences to himself. He sees some ways he might be able to avoid bringing harm upon himself. He knows that others are in line ahead of him, so he can wait and see what they do. If any refuse to do the examination, he will get answers to his concerns about the surgeon's reaction and perhaps be able to decline participation comfortably. If none refuse to participate, he could reasonably do the pelvic exam behind the moral shield of numbers: if all the others are doing it, it is implausible for him to claim that they are wrong and he is right. They all have been ordered to practice a procedure by a superior who is in charge of their education at that moment. He cannot be blamed for following orders.

As he thinks about it, however, Paul sees all the doors to justifying participation by self defense swing shut. He might have been able to evade responsibility for following orders as a first- or second-year student, but he is now fully engaged in clinical activity and has assumed many of the professional obligations incumbent upon clinicians. He knows that concern for the patient takes precedence over everything else, even if he had not read the one-page statement of the Principles of Medical Ethics, which includes this principle: "A physician shall, when caring for a patient, regard responsibility to the patient as paramount."[6] Paramount means above everything else, and for Paul, everything else includes protecting himself from the possible wrath of a superior who has ordered him to do something that he realizes, once he aligns the priority of principles properly, is clearly wrong.

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A Nurse's Perspective on Paul's Dilemma

This case is interesting and important for higher education and its consideration of ethical issues. Ethical principles are at the forefront of best practices for educators, both in the classroom and in clinical settings. The Code of Ethics plays an integral part in our clinical environment.

What is the primary issue in this case? Could it be the student's concerns about the ethical principles that are involved? Or perhaps the nature of the attending physician's request of the students to perform pelvic examinations? In an analysis of the perspective of the student, Paul, there exist three principles: respect, autonomy, and reciprocity.

The principle of respect for persons involves the individual's worth or value. Paul considered the worth of his patient, Mrs. Brown, as a patient with a sense of dignity. In fact, it was so concerning to Paul that he was contemplating refusing to do the practice pelvic examination.

Secondly, Paul considered the patient's autonomy. According to Beauchamp and Childress,[1] the principle of respect for autonomy involves acknowledging a person's right to have a choice. To disrespect that right would discredit others' right of autonomy. Paul was concerned that he would jeopardize Mrs. Brown's autonomy if he performed a pelvic examination without her knowledge or consent. In his consideration of her autonomy, Paul likely reflected on his own obligation to inform the patient of whether or not an exam was performed.

The last principle that Paul considered was reciprocity. Beauchamp and Childress define reciprocity as the "act or practice of making an appropriate (often proportional) return."[1, p174] In this situation, the principle of reciprocity would be exemplified by the likelihood that Paul would improve his pelvic exam skills, which would, in turn, benefit other patients he cares

for in the future. Paul had concerns about having other opportunities to learn this skill, which cannot be discounted.

A key principle that the case does not address, however, is the principle of nonmaleficence, a duty not to cause harm on others. Since Mrs. Brown was anesthetized, the patient would have been unable to physically express herself about the way the procedure was performed. It is possible that having an intimate procedure performed without her consent could put the patient at risk for PTSD or other psychologically-based residual effects. This principle involves not only not inflicting harm but also not imposing risks of harm. Would repeated pelvic examinations by a resident and three students cause physical trauma or increased risk for infection?

Lastly, there is the question of Paul's consideration of the principle of beneficence. Beauchamp and Childress state the principle of beneficence includes the admonition that "one ought to: prevent evil or harm, remove evil or harm, do or promote good."[1, p115] Is Paul preventing a potential harmful examination? Is he considering the mercy and kindness of Mrs. Brown? If Paul considers refusing to perform the pelvic exam, would that be an act for the benefit of another? Does he have a moral obligation to act on the benefit of another?

Does Paul have an ethical duty to report the attending physician to the Chair of his department? If so, how would the attending physician treat Paul as a student in future clinical experiences? If Paul chooses to remain quiet, would that be wrong within his profession?

We cannot exclude the role of the attending physician in this case study. Although he may have thought he was allowing the students to practice a meaningful skill, he overlooked the first obligation to his patient, to do no harm. The attending physician believed that since the patient was anesthetized, she would not feel the effects of multiple pelvic exams by inexperienced medical students. He also overlooked obtaining consent from the patient prior to being anesthetized. Since this was a major teaching hospital, perhaps the attending physician thought that any procedure performed by students to enhance their learning should take precedence over the rights of the patients.

In conclusion, the student has every right to refuse to conduct the pelvic examination on Mrs. Brown. Furthermore, the attending physician should review ethical obligations he has to the patients he cares for regardless of whether he practices in a teaching hospital or a private setting.

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Student Conflicts with Learning and Patient Autonomy

The successful intersection of an individual's best medical care with society's goal of training new generations of physicians and other health care professionals has been a challenge for hundreds of years. Almost all of this tradition has utilized public patients, who agree to receive their care in a medical training facility in return for free or reduced cost of that care. In the more modern world, national health programs, special insurance programs, and local government funding have reduced the stigma of being an uninsured or underinsured patient; but teaching hospitals still depend upon both funded and non-funded patients for training and care.

A discussion of how ethical decision making plays out in a modern teaching hospital involves a brief analysis of trainees' roles. Atop the medical chain of command is the attending physician, fully trained and licensed, private or public, who takes ultimate responsibility for patient care. But, commensurate with the goals of education, a great deal of that care is delegated to resident physicians. These physicians are licensed and in specialty training programs, such as medicine or obstetrics-gynecology, to gain experience by providing supervised care, while increasing their knowledge and improving their skills. What teaching institutions should, but do not always, do is provide information about these differentiated roles to patients entering the hospital or clinic system so that they understand that resident physicians will be providing most of their direct care. The medical student role is less clear cut. Still in training to become a doctor, students are unlicensed and their and the institution's goal for them is to acquire training in the basics of good doctoring. Their participation is not necessary for the patient's care, but they do provide assistance. Most important and relevant to the case presented is that, although non-funded patients in teaching hospitals generally must accept the resident's care, they should not be required to accept a medical student's attention and the student's goals of personal learning. Funded patients have even more choice. They may ask for the attending physician to provide direct care, and decline to have even a resident physician, let alone a student or students, involved.

In this case, to put the situation in the best possible context, we will assume that Paul, as a student on the gynecology service, was assigned to care for Mrs. Brown upon her admission to the teaching hospital, so he has already taken a medical history from her and even performed a general physical examination. Therefore, completing that evaluation with a pelvic examination in the operating room (OR) would be appropriate. We will also assume that he has developed some relationship with her, that he has told her what his precise role would be in the OR, emphasizing that he is under close physician supervision, and that she would agree to his participation in the pelvic exam when specifically asked. His comprehensive participation would, thus, also fulfill his educational goals, and those of the department responsible for training him. Actually, during a pelvic examination performed under anesthesia, the musculature is very relaxed, allowing an easier exam and one free of patient discomfort so that he would get maximal benefits.

However, if for whatever reason, Mrs. Brown declines to let him examine her during the procedure, he must abide by her decision as a form of respect for her autonomy and privacy. That decision must also be respected by the resident and attending physician who will be responsible for the OR examination and the full D&C procedure.[1]

In past years and even decades, surgical trainees including residents and students routinely examined and performed pelvic and other examinations on women who were under anesthesia. The issues of informed consent, respect, and privacy were largely ignored under the perception that the practice would be excellent learning for several trainees and no harm or even discomfort to the woman. And what she did not know would, literally, not hurt her.[2] In recent years, with the dramatic rise of the number of women in medicine, greater awareness of the requirement for consent, and the development of women's health programs including sensitivity training, awareness of this practice has increased. On numerous occasions, women medical students and even nurses have complained about this practice for the reasons noted above, with at least one student calling it a "sanctioned gang rape." Most recently, this practice has been declining with many educational institutions now requiring the consent of the patient beforehand, and limiting students to only the one personally involved with the patient from the beginning. California has a law requiring this consent process.

In summary, it is very possible to combine the goals of the best care of the individual patient with the goals of a medical trainee and general medical education, assuming everyone, particularly the patient, understands what is involved. Although medical education increasingly depends upon new learning technology as well as the participation of standardized patients, real disease and its treatment are still best taught with real patients.

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