Letters

Please don't touch me there: the ethics of intimate examinations

Informed consent failed to protect me

Editor—My personal experience of intimate examination dates back 23 years and illustrates how even explicit informed consent can fail to protect a patient.[1]

I was 20, a first year preclinical student, awaiting surgery for a large hiatus hernia, which had been causing supraventricular tachycardia. I was admitted to Addenbrooke's Hospital two weeks before clinical school finals. Preoperatively, somewhere between 12 and 20 people in white coats came to examine me. As I did not realise that medical students could examine patients unsupervised I assumed they were doctors.

All performed chest and abdominal examinations. Three performed breast examination (none performed otorhinolaryngological examination). All performed vaginal or rectal examination. Three performed both, which I found particularly distressing. Consent was obtained in the form of "if you don't mind, I need to," and I consented by my physical position and an embarrassed "OK."

I was upset by the examinations and felt vulnerable and unclean afterwards. After the first three examinations I wanted to go home, but I still consented. It did not cross my mind that I was in a position to refuse. You can ask, "Do you mind?"without making the patient feel that he or she is being given a clear run at saying "No." I believed that the examinations were a part of the process of my care in the mysterious world of the hospital.

Looking back, I needed an advocate to both limit the number of examinations and empower me to refuse. Without one, as a patient, the sense of vulnerability and aloneness can be enormous.

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1 Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations—teaching tomorrow's doctors [with commentaries by B-I Nesheim and J MacDougall]. *BMJ* 2003;326:97-101. (11 January.)

Consent is crucial—but don't go too far, for students' and patients' sakes

Editor—I agree that patients' consent to procedures is crucial and should be achieved whenever possible and fully, or practice becomes poor and the doors are opened for harm to be done.[1]

However, students must be educated, and with more and more students consent is becoming an increasingly serious issue. We had to catheterise a model in groups of four owing to too few patients and too many students. If the opportunity arises for me to perform a procedure at the end of an operation I am observing, should I (*a*) turn it down as I don't have consent, (*b*) hope I do get the informed chance before I qualify, or (*c*) wait to do it for real unsupervised at 2 am as a preregistration house officer?

I have assisted in a hydrocoele (I held a small retractor and cut sutures), and I gained valuable experience and did no harm—but should I have had consent? Did I need consent to watch a gynaecological operation from behind the diathermy machine? When I take a diabetic history for an assessed case presentation I am bringing no benefit to the patient, so should I be doing it?

I agree that informed consent is important and I try to obtain it whenever possible, but let's not go too far. If the point is reached where each student needs written consent to listen to every patient's pansystolic murmur radiating to the axilla, doctors will have neither the time nor inclination to teach a small firm of 15 students, and I'll have to gain my experience at 2 am.

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1 Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations—teaching tomorrow's doctors [with commentaries by B-I Nesheim and J MacDougall]. *BMJ* 2003;326:97-101. (11 January.)

What examination is not intimate?

Editor—The education and debate article by Coldicott et al is another attempt to justify the obsession with political correctness.[1] It presupposes that patients will be quite relaxed after having signed a form agreeing to be examined by medical students while under anaesthesia or in a clinic.

Patients are anxious when visiting doctors, whatever their ailment. This paper presupposes that examination by medical students is some kind of an assault and that by signing an informed consent form the patients are protected.

As medical students we are upset when we first witness any clinical situation, be it an infant crying in the arms of a paediatrician, a young patient being intubated by an anaesthetist, or a grand old lady being persuaded to walk by a physiotherapist.

This article is dangerous in that it isolates vaginal or rectal examinations as being intimate examinations. Every medical examination is intimate, which medical students soon appreciate. Examination of the fundus of the uterus is just as intimate for a gynaecologist as examining the fundus of the eye is to an ophthalmologist.

Doctors welcome people to a clinic and during the course of consultation and examination look at the pathology and not the person. Medical training is all about understanding this difference. A mole on a cheek is a beauty spot at a party but a potential melanoma in a clinic. Researchers would find that most former medical students are not overburdened by their emotions during the course of such intimate examinations.

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How medical students are being taught at University of Antwerp

Editor—Coldicott et al highlight concerns about teaching intimate examinations.[1] Our current programme for fifth year medical students could serve as a model for dealing with these legitimate problems. The project was approved by our ethics committee.

Twenty healthy volunteers were recruited as intimate examination assistants and screened for their characteristics and motivation. All gave their signed informed consent to participation. They received an introduction in anatomy, technical examination, doctor-patient interaction, and feedback training to serve as both patient and teacher. Medical staff were trained in supervising and coordinating the feedback sessions. Students were informed beforehand about the study, and technical skills were taught on manikins. A comprehensive training manual was produced.

Students performed three training sessions (urogenital-rectal, gynaecological, and breast examination). Each session consisted of two students (performer and observer), one intimate examination assistant, and one doctor. All participants were able to voice their feelings and concerns. Attention was

mainly focused on personal attitude and the students' technical and communication skills.

The programme was evaluated by structured questionnaire, personal reflection, and round table conferences. Preliminary data showed that students and assistants appreciated the training, both stating that feedback was of utmost importance for mutual understanding and appreciation. The students were grateful for working with the assistants.

Trust and respect were positive outcomes. Students reported that the training would help them in their future careers. They also felt more secure while performing intimate examinations, and paid more attention to patients' feelings, integrity, and privacy.

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1 Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations—teaching tomorrow's doctors [with commentaries by B-I Nesheim and J MacDougall]. *BMJ* 2003;326:97-101. (11 January.)

This letter was also written by Frieda Mast (general practitioner), Bert Selleslags (general practitioner), Luc Debaene (general practitioner), Wiebren Tjalma (associated professor of gynaecology), Philippe Buytaert (professor of gynaecology), and Leo Bossaert (professor of intensive care medicine), all of University of Antwerp.

Integrated approach to teaching and learning clinical skills

Editor—Coldicott et al raise several issues.[1] How do students acquire clinical skills without practising on patients? Rather than contribute to the ethical debate, we propose that alternatives be explored to support students in the development of clinical skills.

Coldicott et al recognise that technical skill is just one element of competence in vaginal examinations. The ability to communicate sensitively is crucial, and indeed each patient's definition of an intimate examination must be central. Practising on an anaesthetised patient provides no opportunity to develop communication skills and reduces vaginal examination to a purely technical task. Observing a student performing a vaginal examination provides no guarantee of what is palpated. Conventional pelvic manikins have similar limitations, but pressure sensitive manikins, fitted with electronic sensors, can provide feedback on which organs are palpated and with what force.[2 3]

We have developed an approach to teaching and learning clinical skills that links manikins with actors.[4] Students integrate their clinical skills in a safe environment, gaining confidence and competence. This graduated approach ensures that students are prepared to deal with contextual challenges of real work settings.

Clinical teaching associates (women who volunteer to undergo vaginal or rectal examination and who are trained to provide feedback on technical and communication skills) are established in medical schools in other parts of the world. Including such approaches locally within curriculums may help to avoid unacceptable situations such as those described by Coldicott et al.

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1 Coldicott Y, Pope C, Roberts C. The ethics of intimate examinations—teaching tomorrow's doctors [with commentaries by B-I Nesheim and J MacDougall]. *BMJ* 2003;326:97-101. (11 January.)
2 Pugh CM, Heinrichs WL, Dev P, Srivastava S, Krummel TM. Use of a mechanical simulator to assess pelvic examination skills. *JAMA.* 2001;286:1021-3.
3 Pugh CM, Srivastava S, Shavelson R, Walker D, Cotner T, Scarloss B, et al. The effect of simulator use on learning and self-assessment: the case of Stanford University's E-Pelvis simulator. *Stud Health Technol Inform* 2001;81:396-400.
4 Kneebone RL, Kidd J, Nestel D, Asvall S, Paraskeva P, Darzi A. An innovative model for teaching and learning clinical procedures. *Med Educ* 2002;36 628-34.

Summary of rapid responses

Editor—The 46 rapid responses to this article included four from patients, four from medical students, and 30 from practising doctors.[1]

The issue of intimate examinations without consent attracted the most powerful comment. Almost all those who mentioned it said that it was unethical and must stop. Some were incredulous, others disappointed that so little progress had been made since this issue first surfaced in the early 1980s. Two (a patient and a solicitor) said it was, or should be, a criminal offence.

No one could explain why it endured. And only a handful tried to defend it. One, a junior surgeon, wrote: "The gynaecology consultant urging medical students to examine a patient while under anaesthetic, with or without consent, is not some sort of serial pervert … After all, compared to a D&C or a vaginal hysterectomy, internal examinations do not seem particularly traumatic. And he knows that the more practice students have, the more relaxed and more competent they will be when it comes to their own future practice."

A few others, while not defending examination without consent, wondered why rectal, vaginal, and breast examinations were such a special case. All examinations can be invasive and embarrassing, but equally, breast, rectal, and vaginal examinations need not be.

One anaesthetist wrote: "The idea that gynaecological or rectal examinations are shocking is purely cultural. Breasts are not considered 'intimate' parts in many places in the world."

A general practitioner said that he would happily teach any number of medical students on his own rectum: "to me [rectal examination] is a trivial and comprehensible procedure having no more consequence than, say, an abdominal examination."

Patients were less likely to share these views. Women with first hand experience were clear that these examinations were invasive and unpleasant and should be handled with special sensitivity. The simplest of social skills would be a start.

One respondent suggested that consultants who thought intimate examinations weren't especially intimate should hand over their own body parts for weekly examination by medical students, thereby combining important training with a useful exercise in teacher-pupil bonding.

Another went further: at some stage in his training each male medical student should be placed in stirrups in a bare room and a strange woman should enter and "squeeze his balls and leave without saying a word."

So how can we resolve the special ethical pitfalls surrounding intimate examinations?

Firstly, by teaching medical students using manikins and volunteers, rather than patients.

Secondly, students and patients might be more confident (and less embarrassed) if students had a clearer and better respected place in the medical team, including being covered by the team's consent procedures. "It is understandable that if we give the student's presence no context then it may be seen only as an uncomfortable addition to an already embarrassing event," wrote a clinical lecturer.

Thirdly, we could teach intimate examinations only to postgraduates who need to know, not to undergraduates or to postgraduates who will never need those skills, says a consultant paediatrician.

Finally, perhaps we should stop doing intimate examinations altogether. "We do these examinations because we have 'always done them' and their importance is overstated," wrote one general practitioner. His Medline search suggested that vaginal and rectal examinations were poor diagnostic tests for suspected pelvic masses, pelvic infections, bowel cancer, and prostate cancer. He concluded: "Perhaps we should teach medical students how to use an ultrasound probe rather than the stethoscope. Fortunately also these cannot be worn around the neck."

Alison Tonks *associate editor*
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1 Electronic responses. The ethics of intimate examination—teaching tomorrow's doctors. bmj.com 2003. bmj.com/cgi/eletters/326/7380/97 (accessed 6 May 2003).

Shocked by attitude to MRSA

Editor—I am writing with reference to the correspondence from Howard et al.[1] My husband was in a NHS hospital for six months in 1999-2000. Visiting each day, I was afraid that the very bad standards of cleanliness and hygiene would result in his suffering an infection on top of heart disease and a stroke, quite enough for him to bear. More by luck than proper standards he did not become infected. Since then I have nursed him at home, and during this time he has developed pressure sores and leg ulcers, the