

## The ethics of intimate examinations—teaching tomorrow's doctors

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The teaching of vaginal and rectal examinations poses ethical problems for students and educators, and guidelines exist to protect patients from unethical practice. Yvette Coldicott and colleagues report an exploratory survey, whose findings suggest that best practice is not always followed and that in many cases consent has not been given for procedures

The ethical integrity of doctors is under fire. Public concern after the Bristol inquiry into paediatric heart surgery,<sup>1</sup> the Alder Hey inquiry into organ retention and storage without consent,<sup>2</sup> and other cases of malpractice has put pressure on the medical profession and government to ensure that unethical practices are challenged and prevented. Alongside this, consumers of health care have higher expectations not only of the standard of services and level of care provided, but also of the manner in which care is delivered. Patients now actively participate in deciding their care. The legal framework is also changing. Articles 8 and 9 of the Human Rights Act 1998 imply that doctors should inform patients about their medical care and respect their privacy, and this is endorsed by the General Medical Council's ethical code for practice—*Duties of a Doctor*.

The problem facing doctors is that ethical values change. What was once acceptable may become unacceptable. Student doctors face special difficulty in trying to balance their learning needs with these ethical duties. Reports from Oxford and Canada have illustrated that medical training may need refining to meet the demands and expectations of modern society.<sup>3,4</sup> The need for students to learn skills such as clinical examination by practising on patients is well recognised.<sup>5</sup> Yet this often raises acute ethical dilemmas as patients may be vulnerable and obtaining informed consent can be difficult.

The conflict between educational needs and ethical requirements is especially acute in the teaching of intimate examinations. Moreover, this aspect of medical training illustrates how ethical values are shifting from utilitarianism towards more Kantian based ethics (box 1).<sup>6</sup> On the one hand, intimate examinations are not particularly risky procedures, although the patient may have some pain or discomfort, loss of privacy, and potentially psychological damage. Traditional teaching of these procedures was guided by a utilitarian ethic—that learning how to do intimate examinations would benefit future patients by improving standards of care. More recently the invasive and potentially disturbing aspect of these procedures has been recognised, and

### Summary points

It is not easy to balance ethical duties and educational requirements, particularly when ethical values change

The teaching of intimate examinations poses ethical problems for students and educators—students must learn, but patients must be protected

A survey of students in one medical school found that intimate examinations had been done by second and third year students in situations that they found disconcerting

It also found that a quarter of examinations in anaesthetised or sedated patients seem not to have adequate consent from patients

Action was taken to ensure that best practice was re-established

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so, for example, guidelines on teaching vaginal examinations require students to obtain prior informed consent.<sup>7</sup> Students are expected to practise both the procedure and the communication skills surrounding it, and formal teaching may include the use of mannequins as well as discussion of how best to obtain valid informed consent from patients.

### Exploratory study

We conducted an exploratory study in one English medical school to examine if guidelines on intimate examinations are being met. The study was prompted by a feedback session led by clinical staff and ethicists following a clinical attachment in the third year of the curriculum. Students expressed worries that they had been asked to act inappropriately. In February 2000, we sent letters to the clinical deans of all 25 medical

**Box 1: Two ethical positions**

*Utilitarianism* considers whether more people benefit from an action than are harmed by it. Harm to one individual (the patient) may be sanctioned if it is for the benefit of a larger group (other patients)

*Kant's categorical imperative* provides a counter position. Humanity should be seen as an "end in itself, never merely as a means."<sup>36</sup> Using any one person as a "means to an end"—for example, using patients as teaching "aids"—is unacceptable

**Table 1** Number (percentage) of questionnaires completed, by year of study

Year of study	Completed questionnaire
Second (n=160)	130 (81)
Third (n=161)	140 (87)
Fourth (n=131)	116 (89)
Total (n=452)	386 (85)

schools in Great Britain asking for information about current policies on intimate examinations by students. The letter asked if written policies were available and, if so, whether both staff and students received the policy document and at which stage in the curriculum they received it. Seventeen deans responded that their medical schools had a formal policy on teaching vaginal examinations; and one school had a similar policy for rectal examination.

The second phase of the study was a survey of 452 second, third, and fourth year medical students in an English medical school. First year students were excluded as they had no clinical experience, and the dispersal of fifth year students on senior attachments prohibited their inclusion in the survey.

A structured self completion questionnaire was designed in consultation with academic staff and piloted on five students. The questionnaire asked students to recollect the number of intimate (rectal and vaginal) examinations they had done throughout their undergraduate career, at what stage in their training these took place, the setting of each examination, the level of consent obtained, the degree of supervision, and the extent to which they felt uneasy about doing these procedures. With respect to consent, the questionnaire attempted to establish (for the examinations performed) whether consent was obtained by the student or the supervising doctor, or both, and for unconscious patients whether written or oral consent had been obtained. Space was provided for additional comments about these issues.

The questionnaires were anonymous and unnumbered. As a way of tracking non-response, for third and fourth year students the questionnaires were handed

out in small group teaching sessions and students were asked to sign a list on return of their questionnaire; absent students and those who had not returned a questionnaire were followed up and were given a second opportunity to participate. Timetabling arrangements meant that questionnaires for second year students had to be handed out after a lecture and we could not track non-response and absenteeism, hence the slightly lower response rates for this group (see table 1).

We entered the data on to a standard spreadsheet and examined simple descriptive statistics.

## Findings

A total of 386 students responded, providing an overall response rate of 85% (table 1).

Results are categorised by the students' year of study in February 2000 and reflect the total number of intimate examinations done by students in their medical career to date. Students from all years had done both rectal and vaginal examinations (table 2). Both the number of students doing examinations and the number of examinations done increased substantially by the fourth year, when students have to do a minimum of 10 vaginal examinations as part of their training in reproductive medicine. Fourth year students were also more likely to have personally obtained consent before doing an examination. The findings showed that only 5% of examinations reported by the fourth year group were done without explicit consent taken by the student or supervising doctor. By contrast, in a third of examinations by second year students and half of those by third years the students did not know whether consent had been obtained.

Some 702 intimate examinations were done on sedated or anaesthetised patients (table 3). In only 24% of these examinations had written consent been obtained, and a further 24% of examinations were conducted apparently without written or oral consent. Consent seemed not to have been obtained for most examinations on sedated or anaesthetised patients by junior (second and third year) students.

Additional comments from students showed that on many occasions more than one student examined the same patient, notably for the examinations done by second and third year students. Comments also suggested that many students had felt compelled to perform an examination and that they often found it difficult to express their discomfort (box 2).

## Discussion

The responses from clinical deans show that many medical schools have formal policies on teaching vaginal examinations but most have none for teaching rectal examinations. The survey of students suggests that training in intimate examinations, in at least one medical school, failed to achieve current ethical standards. It seems unlikely that this medical school is atypical.<sup>3 4</sup>

The use of retrospective, self completion questionnaires has some limitations. Anonymous distribution of the questionnaires and instructions not to reveal individual names was an attempt to preserve confidentiality and thereby reduce possible reporting and

**Table 2** Intimate examinations done by students during undergraduate course grouped according to current year of study

Year of study	No of examinations (No of students doing them)	Consent obtained (No (%))			No consent recollected (No (%))
		By student	By doctor	By student and doctor	
Second	32 (n=19)	3 (9)	16 (50)	2 (6)	11 (34)
Third	245 (n=89)	16 (7)	82 (33)	21 (9)	126 (51)
Fourth	1211 (n=98)	670 (55)	372 (31)	103 (9)	66 (5)
Total	1488 (n=206)	689 (46)	470 (32)	126 (8)	203 (14)

**Table 3** Recollection of consent obtained before examination of anaesthetised patients. Values are numbers (percentages) of examinations done throughout career

Year of study	Examinations performed on anaesthetised patients	Written consent		Oral consent only	Not known if consent was given
		For named student	For any student		
Second	11	0	0	0	11 (100)
Third	128	0	0	12 (9)	116 (91)
Fourth	563	162 (29)	6 (1)	356 (63)	39 (7)
Total	702	162 (23)	6 (1)	368 (52)	166 (24)

response biases. We could not document each examination prospectively, so the numbers of examinations recalled should be treated with some caution. However, even if these figures overestimate the numbers of examinations and those conducted without apparent consent, they give cause for concern. In some cases consent may have been obtained by a doctor but simply not witnessed by the student. However, in the absence of explicit consent, the student is liable to a legal charge of assault, so it is disturbing if any examinations are done without the student knowing whether the patient has consented to this teaching procedure.

Some of the respondents may have been aware of the ethical and legal issues surrounding intimate examinations, and some of the comments can be seen as attempts to shift responsibility to supervising staff by implying a certain amount of coercion or helplessness. Although this view may reflect the experience of many junior doctors, clearly students must also take responsibility for their conduct. These findings also suggest that some students remain unaware of their ethical and legal responsibility to obtain consent themselves or to establish that consent has been given. Supervising doctors must therefore take some responsibility for ensuring that consent is obtained and that students are aware of current ethical and legal standards. Perhaps most worrying are the comments that show that some students continue to put the need to practise techniques above the need to practise ethically.

The practice of medicine must comply with modern ethical standards. This is not easy, given shifting moral imperatives—all the more reason for ethics to be taught at medical school. Trust and respect are essential to the doctor-patient relationship, yet this study suggests that these are missing from students'

experiences of learning to do intimate examinations. Medical schools have a duty to deliver ethically informed training programmes that develop doctors' skills and are acceptable to the patient volunteers who are a necessary part of medical education.

Having established that best practice may not always be observed, a medical school working party with student and health service representation developed advice and guidelines to ensure that the situation was redressed. These guidelines have been disseminated via medical school and hospital networks, and the subject has been presented at educational meetings, including a hospital "grand round." Since the study findings, special emphasis has been put on the ethical and legal issues relevant to intimate examinations at students' introductory sessions on how to behave as a doctor.

We believe that this exercise was in itself an example of good practice for an educational establishment. Students and staff had been told of their responsibilities; concerns that they had not been fulfilled were raised; a formal investigation confirmed that there was cause for concern; and action was taken to ensure correction. We also believe that the publication of this article should be seen as another step towards achieving a proper relationship between patients and the medical profession and that medical schools throughout the United Kingdom might carry out a careful examination of current guidelines and their implementation in practice.

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### Box 2: What the students say

"Three of us were in theatre, the consultant told us to get our gloves on. There was no chance to refuse or get consent. The consultant was a scary chief" (Second year student)

"I have never felt able to refuse a consultant, even though I have really felt very unhappy about it" (Third year student)

"You are expected to obey consultants by the fourth year. You can't refuse, and as doctors have to do uncomfortable things, so you just have to start early" (Fourth year student)

"You couldn't refuse comfortably. It would be very awkward, and you'd be made to feel inadequate and stupid" (Fourth year student)

"I was told in the second year that the best way to learn to do PRs [rectal examinations] was when the patient was under anaesthetic. That way they would never know" (Fourth year student)

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## Commentary: Respecting the patient's integrity is the key

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As a teacher in obstetrics and gynaecology, I often have the opportunity to talk to students about intimate examinations and to demonstrate how I think such examinations should be performed in a learning environment. By talking to individual students, I have learned that respectful treatment of the patient by doctors and students does not always happen. Although not common in medical practice, lack of respect for patients' integrity and dignity is certainly not unknown to students. The students sometimes feel distressed but usually do not have the courage to voice their concerns. Furthermore, some claim that this problem may be more pronounced in departments outside obstetrics and gynaecology (where the intimate and ethically problematic nature of the examination is obvious to everybody involved).

Students have to learn to do clinical examinations of all kinds, and it is usually appropriate to do them on patients. In my experience, it is not difficult to obtain the patient's consent. The exception is women from particular ethnic groups, who decline clinical examination by male doctors, and thus male medical students.

Respecting the patient is the key. Patients should be notified in advance that they are attending a teaching hospital, where medical and nursing students may see them. It is the patient's right, however, to decline examination by a student. When a patient is taken into the consultation room, he or she should be asked whether a student may be present. Before the student does the examination, the patient should again be asked permission. The question needs to make it possible for the patient to decline without fear of offence. During intimate examinations, only one student should be present in the room. The same rules should apply before a group of students are taken to a patient's bed.

Consent should also be obtained before a student examines a patient under anaesthesia—preferably by the student before premedication—to allow informed consent.

Written permission for a named student seems to be a cumbersome and unnecessarily bureaucratic procedure, unless we have to obtain written consent for every procedure we do with a patient.

The teaching of students, even in delicate situations, does not need to be a balance between utilitarian and Kantian morals. An examination by a medical student does not mean that the patient has to endure an unpleasant or painful examination simply for the benefit of the student's future patients. Everybody, including patients, must have something to gain from such an experience, and very often this is possible. What patients can gain is to have their case thoroughly reviewed and discussed by a student and a senior doctor. If patients are allowed to take part in this discussion—with care being taken to use words that they can understand—they will feel well looked after. At the same time, the student will learn how to interact properly with a patient and to explain things adequately.

The patient must be treated as the student's teacher, not as a training tool. If we can succeed in this, patients will feel that they not only have helped a nice young person to learn something important but also have received much more attention than elsewhere. They will also hopefully have learned all there is to know about their ailment. Teaching can surely be arranged so as to benefit all parties involved.

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## Commentary: Teaching pelvic examination—putting the patient first

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Publication of guidelines does not necessarily lead to a change in practice, as this article shows. Students in at least one medical school are doing intimate examinations that contravene the recommendations of the Royal College of Obstetricians and Gynaecologists.<sup>1</sup> Fully informed written consent is not being obtained from all patients before examination in theatre.

We can only speculate on the reasons. An absence of planning before a training episode, failure to recognise learners' needs, poor communication between trainers and trainees, and lack of guidelines (particularly for rectal examination) may all play a part. Role modelling, known to be important in training, may also be deficient.<sup>2 3</sup>

What this study fails to tell us is whether this practice is widespread and whether local guidelines are helpful. Was this medical school one of the 17 medical schools with written policies? Are there schools where there is good practice?

What can we as medical educators learn from this? Should I, as a gynaecologist, be teaching vaginal and rectal examination to medical students at all? If so, how can I do it in a way that is valuable to learners and does no harm to patients?

Practitioners need to learn to do vaginal and rectal examinations in a sensitive and competent manner, whether they are to become primary care physicians, surgeons, physicians, emergency doctors, or gynaecologists.

cologists. Many women consider pelvic examination an unpleasant experience, and some have been traumatised by it in the past and refuse a further examination. Of these, most attribute their fear to a previous “rough” examination by a qualified doctor—perhaps one inadequately trained—and rarely to being examined by a supervised student. We owe it to such women to get it right every time and in particular the first time.<sup>4,5</sup>

There has in the past been an overemphasis on numbers of examinations done at the expense of other important aspects of competency, such as the approach to the examination and communication skills. Students need to acquire the right skills, knowledge, and attitude. Skills can initially be acquired away from patients using mannequins. Examination under anaesthesia is of doubtful validity in training students.<sup>6</sup> It adds little to mechanical learning on mannequins and fails to teach the necessary communication skills. Exceptions, for which written consent should be obtained, might include patients with specific pathology. We might also consider other models. In the United States, Australia, and the Netherlands, undergraduates and trainee doctors are taught pelvic examination skills using non-patient volunteers.<sup>6,7</sup>

The correct, empathetic attitude is more difficult to instil and requires appropriate role modelling. Students need to learn how to obtain consent for intimate examinations and to understand how patients feel about such examinations.<sup>8,9</sup> Many patients attending teaching hospital clinics will, if approached sensitively, readily consent to student examinations, but they must retain their right to refuse.<sup>9</sup> Obtaining informed consent need not, as the authors of this

article assert, be difficult; but may require specific training, perhaps using actors to provide a “safe” learning environment where students can try out strategies and receive feedback on their approach.

This paper suggests that we should not be complacent. It is a call to medical educators to examine and review practice in our own medical schools, as well as in the postgraduate arena. We must take responsibility for ensuring effective training in a safe environment for both students and patients. This may involve the development of local guidelines for both vaginal and rectal examination, as well as a change in attitude from the traditional mechanistic approach to a more holistic one.

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## A memorable patient

### The first of the fortunate

The patient was a retired professional musician in his late 60s. He smoked and drank more than was good for him and had a particular penchant for brandy. He had had a discharging sinus on his left leg from chronic osteomyelitis for as long as anybody could remember.

“I was used as a guinea pig for testing penicillin when I was young,” he told me proudly one day.

“A hazard of living in Oxford,” I joked, thinking about the many requests for recruits for scientific studies that we receive in this small, university-dominated city.

My patient’s unhealthy lifestyle began to catch up with him—peripheral vascular disease, a stroke, and then angina. An amputation was discussed but ruled out because of his poor general condition. He finally succumbed to a myocardial infarction.

Some years later, I was reading about the early development of penicillin. The case of the policeman with orbital cellulitis, documented in the groundbreaking *Lancet* report,<sup>1</sup> is well known. His condition improved dramatically when he was given the impure penicillin that had been grown in, among other things, bedpans at the Dunn School of Pathology by Florey’s team. Sadly, when the meagre trial supplies ran out the policeman relapsed and died of septicaemia.

Less well known were the five other patients, one of whom was a teenage boy with osteomyelitis of his left leg. He had developed staphylococcal septicaemia and was treated with sulphathiazole and surgical drainage to no avail. Desperately ill, he was given penicillin. It saved his life. I thought about my old patient. Could it be he?

Since my patient’s file had been returned to the health authority on his death and the computer records only started in the 1990s, I had to search elsewhere for confirmation. I visited the Dunn School and various libraries in Oxford but failed to identify the young patient. Then I learnt that Dr Norman Heatley, one of the authors of the paper, was still alive and living close to my surgery. I wrote to him, and he confirmed that my patient was indeed one of the six original trial patients.

I felt privileged to have known and treated a person who was part of probably the greatest advance in 20th century medicine.

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- 1 Abraham EP, Chain E, Fletcher CM, Gardner AD, Heatley NG, Jennings MA, et al. Further observations on penicillin. *Lancet* 1941;i:177.

We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.