

CEJA Report 3 – I-99 Medical Students Performing Procedures on Fellow Students

INTRODUCTION

Medical students often learn basic clinical skills, such as conducting a physical examination or performing a phlebotomy, by either practicing on classmates, patients, or on trained instructors. The choice may depend on factors such as convenience, affordability, the complexity of the skill and the need for feedback, or the degree of invasiveness. In fact, undergoing basic clinical procedures may provide students with a better understanding of the patient's experience. These are not typical clinical encounters and informed consent generally is not obtained, despite the fact that the procedures may involve some risk. This report focuses on issues of informed consent in the educational setting.

CONCERNS ABOUT INFORMED CONSENT IN THE EDUCATIONAL SETTING

Respect for autonomy requires that one's right to make choices about what happens to one's body is acknowledged. This fundamental ethical precept translates into the doctrine of informed consent to medical care.¹ Several elements are required for informed consent to be valid. Traditionally, these elements have been identified as disclosure, understanding, voluntariness, and consent. Although medical students may have few problems with understanding, both the disclosure element and the voluntariness element raise concerns.

First, special disclosures may need to be made in the educational context. In the clinical context, patients often may not be asked to consent to diagnostic procedures that are minimally invasive. It is generally assumed that patients who present to a physician's office are willing to be examined, to have their blood pressure measured, and even to have samples of their urine or blood collected. The informed consent process often is initiated only when treatment options need to be evaluated in terms of their respective risks and benefits and the patients' preferences. However, unlike patients who are concerned about an ailment and wish to have their condition diagnosed and treated, students who assume the role of patients during clinical skills courses are generally expecting that no significant finding will be made. For this reason, they may not even consider the procedures in terms of risks or benefits. Nevertheless, there are potential risks and benefits that may stem from examinations in this context, albeit different ones than exist in the clinical context. Consequently, the process of informed consent and the information disclosed to students may differ from the process generally followed and the disclosure ordinarily provided in a clinical context. In particular students should consider the potential effect of the exam and knowledge of possible findings on their relationship with fellow students. Medical school facilitates close collegial relationships that often form the basis for life-long professional and personal contacts. Even "minor" revelations (e.g., someone fainting when blood is drawn) can affect how a student is regarded. Standards for ensuring the explicit and uncoerced informed consent increase as the invasiveness and intimacy of the procedure increases.

Simply emphasizing the potential clinical risks and allowing students to consent to participate in the role of patients in the context of basic clinical skills training may not be sufficient. The element of voluntariness and the forces that may undermine it deserve special scrutiny in this context. Voluntariness in medical decision making refers to an absence of manipulation or other coercive influences on one's decision regarding medical care. Influences exist along a continuum, from persuasion to coercion, and coercive influence may stem from individuals, or from situational factors.² Rather than asking in absolute terms whether individuals are free from influence, the central question is whether they are sufficiently free for their decisions to be

considered autonomous. Arguably, a course on basic clinical skills could be considered a coercive situation. Indeed, anecdotal evidence suggests that students may be uncomfortable being examined by classmates, particularly when procedures pertain to an intimate area of the body, such as breast exams, and yet feel obligated to allow their classmates to practice on them. To alleviate this discomfort, among other reasons, many training programs, in addition to using conventional patients, now use standardized patients or other specifically trained instructors for rectal, pelvic or genital exams. This may have the unintended consequence of suggesting that the procedures for which students are still used are more benign and, therefore, that the students have no reason to refuse to participate as volunteers.

Although not examined in the context of clinical training, student voluntariness has been considered in the context of students consenting to participate as subjects of human experimentation.³ Comparisons between situations where students participate as research subjects and those where students assume the role of patients provide some guidance on the special nature of student autonomy and voluntariness, and how it may affect informed consent. In both situations understanding is rarely a problem. However, in both instances, students' motivations either to participate in research or to take on the role of patients may be less altruistic or less voluntary than expected. For example, students who participate in research may receive academic credit and even be graded.⁴ Similarly, students enrolled in courses on basic skills receive credit for their work. The credit, combined with the fact that completion of the basic skills course is likely to be required, may result in compromising voluntariness.

GUIDELINES FOR OBTAINING INFORMED CONSENT IN THE EDUCATIONAL SETTING

Students should be asked specifically to consent to educational procedures. Instructors should explain to students who volunteer how the skill will be practiced, for example whether the student will be asked to remove clothing, making certain that students are not placed in situations that violate their privacy or sense of propriety. Such an effort should serve to emphasize that, as physicians, students will want to ensure that they do not unduly transgress their future patients' sense of privacy, which can vary according to cultural norms, as well as individual choice. In addition, by obtaining explicit informed consent from students before they assume the role of "patients" for fellow classmates to learn a procedure, instructors also have an opportunity to explain the consequences of a diagnostic finding. For example, if a student's blood pressure is abnormal, what follow-up measures, if any, will the student be asked to undertake? Similarly, if blood is drawn, students should be informed of whether it will be analyzed and whether findings will be reported to them. Engaging in this type of dialogue with students both will provide them with information necessary to decide whether to participate and also will allow the instructor to demonstrate first hand how informed consent may be handled with patients.

Some students may have conditions that they do not wish to reveal but that would likely be detected upon a physical examination. Unless they are presented with an explicit choice to volunteer as "patients," students may feel compelled to submit to the procedures, especially if their participation impacts the evaluation they receive from instructors. Students should not be penalized for refusing to participate. Thus instructors must refrain from evaluating students' overall performance in terms of their willingness to volunteer as "patients." It is also important to recognize that although some students may be willing to explain their choice to an instructor, others may not want their reasons to be known. Therefore, students should be given the choice in a non-coercive setting of whether to participate prior to entering the classroom and there should be no requirement that the students provide a reason for their unwillingness to participate.

CONCLUSION

Unlike patients in the clinical setting, students who volunteer to act as “patients” are not seeking to benefit from the procedures being performed on them. Nevertheless, the need to obtain their informed consent remains. While students may not need to be asked to sign consent forms, instructors should solicit volunteers in a manner that emphasizes that students have a choice whether to participate and that a choice either way will not affect their performance evaluation for the class.

RECOMMENDATIONS

The Council recommends that the following be adopted and the remainder of the report be filed:

- 1) In the context of learning basic clinical skills, medical students must be asked specifically to consent to procedures being performed by fellow students. The stringency of standards for ensuring the explicit and non-coerced informed consent increases as the invasiveness and intimacy of the procedure increase.
- 2) Instructors should explain to students how the procedures will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety. The consequences and appropriate management of a diagnostic finding, and confidentiality also should be discussed.
- 3) Students should be given the choice of whether to participate prior to entering the classroom and there should be no requirement that the students provide a reason for their unwillingness to participate.
- 4) Students should not be penalized for refusal to participate. Thus instructors must refrain from evaluating students’ overall performance in terms of their willingness to volunteer as “patients.”

REFERENCES

1. Beauchamp TL, Childress JF. Principles of Biomedical Ethics 4th ed. 1994 NY Oxford University Press
2. Beauchamp TL Informed Consent in Medical Ethics, 2nd ed. Veatch RM ed. 1997 Jones and Bartlett Publishers Boston
3. Christakis N. Do Medical Student Research Subjects Need Special Protection. IRB: A Review of Human Subjects Research. 1985;7(3):1-4.
4. Gamble HF. Students, Grades, and Informed Consent. IRB: A Review of Human Subjects Research. 1982;4(5):7-10.