

An ethical dilemma: informed consent, balancing patient dignity and medical student participation in sensitive examinations

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Teaching clinical examination on a patient is critical for the development of young doctors. It involves at least three people, the patient (or model), the teacher and the student, and at all times the teacher and the student need to be aware of the issues around informed consent and maintaining the dignity of the patient. Often what is written and talked about on this topic is understandably from the perspective of the teacher and increasingly, and fortunately, from that of the patient. It is seldom that we as students have a voice in this, yet how we are taught and what we are modelled is often how we behave. Understanding the experiences of students and consequences for future practice has never been more important and relevant than in the teaching of sensitive exams.

As medical students we are taught extensively about the ethics of informed consent and patient examinations. A national position statement regarding medical students and informed consent was published in the *New Zealand Medical Journal* in 2015 and our teaching is informed by this.¹ Despite outlining the expectations of seeking explicit informed consent for student involvement in sensitive examinations, enduring challenges persist as outlined by Malpas et al in this current issue of the *Journal*.² We believe one of the significant challenges students face is the incongruence of what is taught as theoretical best practice and the reality and expectations of clinical practice.^{3,4}

It is unclear why there is incongruence between medical curriculum and clinical practice with regard to consent processes.

Malpas et al recognise a difference in adherence to university policies, education and student expectations dependent on whether a clinician is affiliated with the university.² We as students also recognise a similar pattern, perhaps accounting for the disconnect between ethics teaching and the clinical consent processes relating to students and sensitive examinations. This could also go some way to explain our observed differences in consent seeking processes between individual clinicians within the clinical environment.

Informed consent for medical students to participate in sensitive examinations is paramount to patient safety, dignity and ethical best practice.¹ It is rooted in the code of patient rights with the aim to minimise patient harm and distress, while providing an opportunity for student learning.⁵ The expectation is that consent for students to observe or perform sensitive examinations should be explicit. In the case of anaesthetised patients this consent should be in writing and separate to the general operative consent which contains provision for student presence.^{1,5} It is well understood that consent should not be obtained in the presence of medical students due to the risk of coercion, however this practice is not uncommon and indeed it is our personal experience of having been present during this process in a range of clinical settings.

The article by Malpas et al² highlights the internal conflict we as students experience, balancing learning opportunities and maintaining ethical practice and professionalism. The paper shares student accounts of having conducted, being asked to conduct

or remaining present for sensitive examinations without clear and adequate informed consent despite guidelines to the contrary.^{1,2} Much of what was disclosed by the students in this study is corroborated by our own clinical experiences as 4th year students and anecdotally by our advanced learning in medicine colleagues. Having read this paper, reflecting on our own experiences, and seeking to understand why we as medical students do not speak up or take action, we recognise similar themes underpinning our complicity in unprofessional behaviour within the clinical setting.

As medical students we are not adequately empowered to speak up regarding issues of informed consent partially driven by the tension between being a compliant, effective and respected team member and the obligation to maintain patient dignity and safety. Due to the traditionally hierarchical structure of medicine and historically punitive response to disclosure of unprofessional or unethical behaviour, we fear that being seen to speak up may negatively affect our grades and future career opportunities.^{6,7} Furthermore, professional and ethical dilemmas, particularly those involving patient harm and breach of informed consent for student learning purposes may have implications for student mental health and wellbeing.⁸

Students exposed to professional dilemmas, particularly relating to patient dignity, report experiencing ongoing emotional distress for months and at times up to a year following the event, highlighting the need to reflect on opportunities for improving consent procedures.⁹ For those of us who are frequently exposed to ethically unsatisfactory consent processes we become habituated to the breach of patients' rights and dignity. This process of habituation is implicated in reducing empathy over time, and risk for compassion fatigue and burnout.^{8,9} At a time where mental health of medical professionals and students continues to be a recognised issue,¹⁰ addressing anxiety mediated through undue empathic distress is a conversation we as a profession need to be having.

It is clear the hierarchy in medicine offers several benefits, with built in redundancy

in clinical decision making acting as a safety net for decisions made by those lower down, this unidirectional flow of power is however not without its issues. As medical students we sit at the bottom of this hierarchy and we perceive ourselves as being in a position of affecting little change should we take any action—we are a minor cog in a vast machine. Recognising the challenge of overcoming perceived insignificance and disclosure offers opportunities to reflect on how clinical leaders and our medical curriculum could better prepare us for addressing these dilemmas in practice.

Changing disclosure behaviours is a leadership responsibility, and one requiring a top down approach. Relying on a process of 'breeding best practice in' from the bottom up is fallacious thinking. The reality of the clinical environment and teaching is that when 'bad habits' are modelled these are picked up and subsequently perpetuated in practice. We find much of the literature and indeed our ethical teaching puts the onus on us as students to speak up regarding concerns of consent; this is an unrealistic expectation given the culture of clinical environments. It must be recognised that without transparency of the processes and outcomes of disclosing ethical dilemmas we will remain silent and complicit in the perpetuation of ongoing unprofessional behaviour.

Disclosure requires a certain amount of moral courage⁶—not an easy feat in a system that does not actively encourage or facilitate opportunities for doing so. It is recognised that moral courage can be trained via ethical role playing⁹ and we believe experiential learning through simulation-based activities with a focus on addressing ethical dilemmas and conflict resolution should become an integral part of the medical curriculum. However, this training should take place in the setting of a systems wide change and shift in the culture of seeking informed consent for sensitive examinations.

The ethical dilemmas medical students face in relation to informed consent in the clinical environment have been detailed in a small cohort by Malpas et al.² However, we believe these challenges affect most, if not all, medical students and that the disclosures in the article reveal only the tip of the iceberg.

If we are to improve informed consent processes and address these challenges we must recognise that ethics in practice is fluid, and our practice and processes must respond to and reflect societal expectations

and acceptability.⁴ Maintaining the status quo is an unsatisfactory response in light of these significant challenges for clinicians, students and patients.

Competing interests:

Nil.

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