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Jennifer Goedken

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# PELVIC EXAMINATIONS UNDER ANESTHESIA: AN IMPORTANT TEACHING TOOL

JENNIFER GOEDKEN, M.D.\*

When the practice of medical students performing pelvic examinations on patients under anesthesia without their express permission made the news, the public responded in outrage.<sup>1</sup> Activists saw the practice as a clear violation of patient's rights, and some groups formed a movement to put an end to it.<sup>2</sup> Admittedly, this is a practice that is age-old and universally performed.<sup>3</sup> The question that must be answered is how gynecologists and others in the medical field have found this acceptable, while the lay public does not? A thorough review of this issue requires an attempt at gaining the perspective of both the outraged public and the practicing gynecologist.

## I. IS THE PELVIC EXAM AN IMPORTANT SKILL TO TEACH MEDICAL STUDENTS?

Even the basic premise of the relevance of teaching pelvic exams has been questioned in this debate. Admittedly, most medical students will not choose a career in obstetrics and gynecology, and a budding radiologist will never use this skill in their future. Nonetheless, a pelvic examination is a basic clinical skill with which any future primary care practitioner should be proficient. Internists, pediatricians, and family practitioners are the gatekeepers of our current health system and make up a large portion of medical professionals.<sup>4</sup> These future physicians will ultimately provide general health care screening, promote healthy lifestyle choices, and help discover and treat various medical conditions found in the general population. Therefore, they should learn the skills necessary to provide screening for such deadly diseases as cervical cancer. Additionally, they should be

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\* Assistant Professor and Director of Medical Student Clerkship, Emory University, Department of Gynecology and Obstetrics; Ethics Fellow, Center for Ethics, Emory University. Atlanta, Georgia.

1. Avram Goldstein, *Practice vs. Privacy on Pelvic Exams; Med Students' Training Invasive and Needs Patient Consent, Activists Say*, WASH. POST, May 10, 2003, at A1; Audrey Warren, *Doctor Training on Unconscious Faces Scrutiny*, WALL ST. J., Mar. 12, 2003, at B1.

2. Goldstein, *supra* note 1, at A1.

3. Frank G. Lawton et al., *Patient Consent for Gynaecological Examination*, 44 BRIT. J. HOSP. MED. 326, 326 (1990).

4. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL EMPLOYMENT STATISTICS, Table 1 (May 2003), <http://www.bls.gov/news.release/pdf/ocwage.pdf> (last visited Apr. 19, 2005).

able to assess their female patient's pelvic anatomy so as to recognize a mass that may represent an ovarian tumor.

Since students do not necessarily know the course their medical future may take, it is imperative that the medical education system assure some baseline proficiency in performing exams of all organ systems, including reproductive. One would certainly question a system that graduated students without the ability to perform a routine pulmonary examination. There should be no difference in expectations for the pelvic examination.

## II. WHAT ARE REALISTIC METHODS OF TEACHING THIS SKILL?

As with any skill, there are multiple ways of teaching pelvic exams.<sup>5</sup> Pelvic mannequins provide one option, but they are woefully inadequate. They are often too stiff, represent only one anatomical type and their excessive cost does not justify the minimal educational benefits they provide. Animal models are not useful as they vary so much in size and anatomy from humans. Virtual reality techniques may be something that can be used in the future, but as of yet are not available or affordable for most medical teaching centers. Any suggestion that audiovisual devices or discussions focusing on the mechanics of a pelvic exam are effective substitutes for real patients is ridiculous. They may be an adjunct for the teaching of this skill, but they can hardly be said to be an effective way to practice it. Talking about or watching a movie about driving a car can hardly replace the skills learned by actually operating one.

Many medical schools pay standardized patients to guide students through sensitive genital exams, especially when introducing students to these procedures for the first time.<sup>6</sup> This method of instruction provides the students with an opportunity to perform this anxiety-provoking exam on a "teacher-patient" prior to performing it on a "real" patient. Standardized patients may also be used for testing the skills of students after completing certain clinical rotations. However, at a cost of fifty dollars or more per patient per hour,<sup>7</sup> the ability to use this method with frequency is very limited. Therefore, this is not a practical method that students can use to practice this skill.

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5. Michelle Martinez, *E-Pelvis Used to Teach Stanford Students*, LEARNINGTECH POST Spring 2002-03, at 2 (a Stanford University School of Medicine quarterly publication discussing new and old technology for teaching pelvic exams), [http://learningtech.stanford.edu/Vol1\\_Issue2.pdf](http://learningtech.stanford.edu/Vol1_Issue2.pdf) (last visited Apr. 19, 2005); UNIV. OF CINCINNATI DEP'T OF OBSTETRICS AND GYNECOLOGY (University of Cincinnati Medical School website discussing how the university trains its medical students to administer pelvic exams), at <http://www.med.uc.edu/obgyn/education/medical.cfm> (last visited Apr. 19, 2005).

6. Pamela Dull & Danell J. Haines, *Methods for Teaching Physical Examination Skills to Medical Students*, 35 FAM. MED. 343, 343 (2003).

7. *Id.* at 347.

Conscious patients seen in the clinic or hospital setting provide many practice opportunities for students. Much can be learned by the performance of pelvic exams on conscious patients, such as the ability to alleviate the discomfort and particular embarrassment associated with the exam, as well as some ability to discern normal and abnormal anatomy. Additionally, an assumption can be made of a conscious patient's implicit, if not explicit, consent to providing this teaching opportunity. So one may question the justification of performing a pelvic exam in a situation for which complete consent may not be clear, as in the case of patients under anesthesia. Such a question implies that there is no additional or specific value to the examination under anesthesia (EUA).

### III. DOES AN EXAM UNDER ANESTHESIA PROVIDE ANY BENEFIT?

Keep in mind that much of the female reproductive organs are internal. It is relatively easy to evaluate the labia, clitoris and vagina because they can be visualized. However, the uterus, fallopian tubes and ovaries are internal, housed within the pelvic cavity.<sup>8</sup> Therefore, they can be quite difficult to assess, particularly in a conscious patient.

While a patient is under general or regional anesthesia, there is a total relaxation of the abdominal and pelvic musculature.<sup>9</sup> This allows for a much more complete assessment of the internal pelvic organs. Even in experienced hands, certain anatomic findings may not be appreciated on the conscious patient in the clinical setting. If a patient is relatively obese or has a difficult time relaxing her abdominal and pelvic muscles during the procedure, as many women do, the uterus, tubes, and ovaries may not be well evaluated. For this reason the EUA is an essential part of the surgical procedure itself, that aids in the diagnosis and treatment of underlying reproductive diseases.

If experienced hands cannot always discern pelvic organs, it should come as no surprise that an admitted novice may not be able to correctly assess the pelvic organs on a conscious, frequently tense, and possibly obese patient. In fact, many a student has proclaimed while performing an EUA, "That was the first time I actually felt an ovary."

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8. DEITRA LEONARD LOWDERMILK & SHANNON E. PERRY, *MATERNITY AND WOMEN'S HEALTH CARE* 91-92 (8th ed. 2004).

9. See MERCK, *THE MERCK MANUAL OF HEALTH & AGING*, § 2, ch. 12 (2005) (noting that general anesthesia produces muscle relaxation), [http://www.merck.com/pubs/mmanual\\_ha/sec2/ch12/ch12c.html](http://www.merck.com/pubs/mmanual_ha/sec2/ch12/ch12c.html) (last visited Apr. 19, 2005); see also YALE NEW HAVEN HEALTH, *GENERAL ANESTHESIA FOR CHILDBIRTH* (2003), at <http://12.31.13.50/library/healthguide/en-us/support/topic.asp?hwid=tn7468> (last visited Apr. 19, 2005) (same).

## IV. IS AN EUA A HARMFUL PROCEDURE?

Regardless of the benefit proposed above, if this practice is one that causes harm to the patient, it could be deemed not worth the risk. From the standpoint of bodily injury, an EUA is probably one of the safest procedures that can be performed on a patient. It is difficult to imagine how any physical damage could result from this exam. However, it takes very little effort for a clinician to envision how, for example, the act of holding a retractor for visualization during an operation could result in the inadvertent damage of important blood vessels, nerves, or organs.<sup>10</sup> The latter is a readily accepted activity performed by medical students and other novices in many hospital settings.

However, harm can certainly encompass matters outside the realm of mere physical harm, such as the degradation of autonomy.<sup>11</sup> In this way, anything that limits full disclosure regarding a patient's medical care could be seen as affecting the patient's participation, and therefore autonomy, in the process. While a patient is conscious, doctors and medical students make assumptions as to the patient's awareness of the role of various people who oversee his or her care.<sup>12</sup> Though perhaps unfounded, even these assumptions cannot be made when a patient is unconscious. What is it that patients need to know to be respected partners in their care while they are under anesthesia?

For instance, would most people feel they need to know how many times and who may be performing such mundane procedures as monitoring their blood pressure? Do they need to know that there may be a substitution of the anesthesia staff or circulating nurse to allow bathroom or lunch breaks? Certainly, some of this information may seem superfluous. If not superfluous, then at the least it might seem unworthy of obtaining specific consent for these otherwise normal workings of an operating room. What is it about certain procedures that make their transparency seem crucial to a patient's autonomy, and for which obtaining consent seems to be warranted?

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10. See Orthopaedic Specialists, *A Patient's Guide to Compression Fixation for a Fractured Hip*, [http://www.orthogastonia.com/patient\\_ed/html\\_pages/hip/hip\\_compression.html](http://www.orthogastonia.com/patient_ed/html_pages/hip/hip_compression.html) (last visited Apr. 13, 2005) (noting nerve or blood vessel damage is possible due to the use of retractors during surgery).

11. See, e.g., Peter A. Ubel et al., *Don't Ask, Don't Tell: A Change in Medical Student Attitudes After Obstetrics/Gynecology Clerkships Toward Seeking Consent for Pelvic Examinations on an Anesthetized Patient*, 188 AM. J. OF OBSTETRICS AND GYNECOLOGY 575, 575 (2003) (discussing other harms to patients); L. Lewis Wall & Douglas Brown, *Ethical Issues Arising from the Performance of Pelvic Examinations by Medical Students on Anesthetized Patients*, 190 AM. J. OF OBSTETRICS AND GYNECOLOGY 319, 320 (2004) (same) (citing Ubel et al., *supra*).

12. See, e.g., Wall & Brown, *supra* note 13, at 321 (explaining that patients sign a consent form acknowledging that one or more surgical assistants may participate in a medical procedure).

## V. WHY ARE PELVIC EXAMS SUCH A SENSITIVE TOPIC?

This may seem to be a rhetorical question to most readers. Nonetheless, it is one worth asking. What is it about the pelvic exam that seems so much more personal than say, an exam of the lungs or heart? Genitalia are viewed as sensational to the public. This undoubtedly has something to do with their connection with sex, which has the power to invoke feelings ranging from pleasure to fear.

However, to a physician who deals with this anatomy every day as part of her job, this is not the case. To the obstetrician gynecologist, female genitalia do not, and arguably should not, be anything but routine in the same way that a plumber views a sink or drain pipes. If an obstetrician gynecologist viewed a patient's genitalia in a sexual or sensational way, it would certainly hinder the physician's ability to properly care for that patient. This would also be considered completely inappropriate and unethical. Certainly, the rare exception to the norm has been grounds for the loss of licensure and front-page news.

With regard to teaching this skill, shouldn't a responsible clinician treat the correct assessment of pelvic organs in the same routine way they treat an assessment of lung function? If, because of the personal nature of the pelvis, examination of it is relegated to something less than routine, the risk may arise of pelvic exams not being taught as well as other exam skills. Arguably, it is just such different treatment of the reproductive-related anatomy and physiology which has historically led to issues such as urinary incontinence and sexual dysfunction all but being ignored by both the public and the medical profession. Do we want the sexual mores of society to place restrictions on the ability of physicians to care for the whole patient? More germane to this discussion, do we want medical students to graduate less prepared to assess the female reproductive system than the rest of the patient?

Though perhaps not obvious at first to someone outside the medical profession, from a clinician's viewpoint the teaching of this skill is equal to all other examination skills.<sup>13</sup> Therefore, the failure to inform patients of the practice of EUA would seem no more offensive than, for instance, failure to alert patients that a student may perform a lung exam using a stethoscope on them while they are unconscious. It is doubtful that this would be seen worthy of headlines. However realistic this is, the practical reality of this position does not align with most people's feelings.

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13. *Id.* at 322 (arguing that there is “no morally relevant difference between a medical student (who is going to be actively involved in both the operation and the subsequent post-operative care of the patient) performing a pelvic examination on an anesthetized patient . . . and that student [performing general surgical tasks]”).

## VI. SHOULD CONSENT BE ACQUIRED?

Unlike the implications of many articles, the discussion above has attempted to elucidate how this practice does not lack respect for the patient. Regardless of the potential cause, the public has spoken out on the effect. At least two studies published in medical literature<sup>14</sup> and numerous other articles<sup>15</sup> support the supposition that the vast majority of patients would want to know that an EUA was being performed on them by students. More importantly perhaps, those interviewed in the studies felt that it was important to give their consent for such a procedure and not merely to be apprised.<sup>16</sup> It should be reassuring to those attempting to obtain that consent that the majority of patients would grant their consent,<sup>17</sup> suggesting that physicians should provide the patient with as much information as possible to allow them to make an informed decision.

## VII. HOW CAN WE ENSURE TRUE CONSENT?

Within the issues of obtaining true consent are the logistical challenges that have perhaps impeded the transparency of this practice thus far. First of all, teachers and students must accept the necessity of obtaining specific consent from patients for this activity. However, many will voice the assumption that patients realize these practices may be done because they have come to a “teaching hospital.”<sup>18</sup> This may be a grave misperception of the level of understanding of the lay public. In fact, in the current paradigm in which many rural, community, and private hospitals serve as teaching venues for medical school programs, this clarity is even more in question. Even if a hospital is clearly designated as the “University of X Teaching Hospital,” the number of trainees, their level of experience, and their potential participation in any one patient’s care is almost certainly unanticipated and perhaps would not be deemed acceptable. Therefore, it is crucial that any myth of true understanding, and therefore implied consent, on the part of many patients cared for at “teaching institutions” must first be dispelled.

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14. Lawton, *supra* note 3, at 329; D. Magrane et al., *Student Doctors and Women in Labor: Attitudes and Expectations*, 88 OBSTETRICS & GYNECOLOGY 298, 300-02 (1996).

15. E.g., Goldstein, *supra* note 1; Warren, *supra* note 1.

16. Ubel et al., *supra* note 11, at 575; Ari Silver-Isenstadt & Peter A. Ubel, *Erosion in Medical Students’ Attitudes About Telling Patients They Are Students*, 14 J. GEN. INTERNAL MED. 481, 483 (1999).

17. Lawton, *supra* note 3, at 329; J. Bibby et al., *Consent for Vaginal Examination by Students on Anaesthetised Patients*, LANCET (Boston, London), Nov. 12, 1988, at 1150.

18. MARYLAND HEALTH CARE COMM’N, MARYLAND HOSPITAL PERFORMANCE EVALUATION GUIDE, WHAT IS A TEACHING HOSPITAL? (2002) (defining “teaching hospital” and asserting that patients admitted to a teaching hospital can expect certain activities to occur, such as “attending physicians . . . and doctors in various stages of their training (such as residents, interns, and *medical students*) conduct teaching sessions during visits to patients [and] may . . . perform examinations”) (emphasis added), [http://hospitalguide.mhcc.state.md.us/Definitions/define\\_teaching\\_hosp.htm](http://hospitalguide.mhcc.state.md.us/Definitions/define_teaching_hosp.htm) (last visited Apr. 11, 2005).

Once doctors and medical students accept that a patient is unaware of these subtleties and deserves a full explanation, then assuring appropriate consent is key. Is some general consent form stating that students may be involved with the patient's care while in the hospital, as is commonly in use today, sufficient? Or, as implied by the very question, is a more detailed account of the actual practice of EUA necessary? Is it of particular importance because an EUA by a student does not encompass true care for the patient, but is a teaching opportunity and of no particular benefit to the individual patient? One may argue that, particularly because of the intrinsic redundancy of the activity, it is even more imperative that consent be specifically requested. For this reason, transparency in this practice is inherent to the future use of EUAs as a teaching tool.

Therefore, it seems necessary to obtain a written consent that is specific for this activity. Even so, since most patients may only glance through a potentially cumbersome consent form, it seems further enforcement of informed consent could be gained with a verbal consent. During the preoperative visit, a surgeon will have a patient read through the consent form. While the surgeon may not reiterate everything from the form, she typically will individualize the discussion of risks and benefits to highlight those most pertaining to that patient and procedure. It is at this visit that a verbal consent for an EUA may best be obtained.

#### VIII. IS LITIGATION THE ANSWER TO ENFORCEMENT?

The potential inability to enforce such consent practices is cause for concern. It is impossible for individual patients to have knowledge of activities that take place when they are under anesthesia. Also, the inherent hierarchy of the medical team could pose an obstacle to reporting a breach in policy. For instance, a medical student or a nurse may not feel comfortable "blowing the whistle" on a supervising physician who does not comply with the policy. Additionally, since this is currently an accepted practice in the operating room, those already desensitized to the issue are unlikely to consider the practice reportable.

However, the threat of litigation is not necessarily the answer. A recently enacted piece of California legislation makes unauthorized exams a misdemeanor and grounds for loss of license.<sup>19</sup> Is this likely to change current practices in operating rooms across the nation? The likelihood of reporting such failure to obtain consent will be rare, perhaps even rarer if the consequences are so severe. In addition, the punishment does not seem to fit the crime. Though appropriate consent is a serious matter, a failure to formally obtain consent from a patient by an otherwise respectful and well-intentioned physician does not seem adequate grounds for a loss of license.

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19. CAL. BUS. & PROF. CODE § 2281 (West 2003 & Supp. 2005).

A change in practice will require a true change of culture. Some may argue the threat of litigation is necessary to force that change, but the change is already afoot. Just as the doctor-patient relationship has changed dramatically over the past two decades, from one that was historically paternalistic to more of a partnership between a patient and her physician, so too medical education has evolved and continues to evolve with more emphasis on the patient and her participation in the education process. Such honest discourse is the key to assuring that patients maintain their trust in their physicians and the medical community in general. It is this trust that will allow patients, by way of their consent, to continue to provide this important teaching tool to future physicians.