Learning in practice

Developing guidelines for medical students about the examination of patients under 18 years old

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When the University of Oxford developed guidelines for medical students' examination of children, three areas were particularly problematic

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Medical students are expected to examine patients as an integral part of their clinical education, raising the issue of what should be the proper conduct of students and their teachers, and what guidelines should be provided. These questions, in the specific setting of "intimate" examinations, were raised by the publication in 2003 of a survey of students in the medical school in Bristol.¹ This survey found that in a quarter of examinations the consent procedures seemed inadequate. The authors pointed to a potential conflict between the educational needs of the students and the ethical requirements of protecting individual patients, and commentary and correspondence highlighted disagreement over the right balance.²⁻³ One vital component of medical students' training involves gaining experience in examining children. We report the development in another UK medical school of guidelines for students in examining child patients and highlight three areas that were particularly problematic.

Developing the guidelines

The medical school's joint consultative committee brings together students and faculty members to discuss education and the curriculum. Student members identified a need for clear guidance on proper conduct when carrying out a physical examination of patients. A subcommittee was established to draw up draft guidelines. Its work fell into four stages:

- Identifying and articulating the main principles on which such guidelines should be based, informed by relevant previous publications⁴⁻⁸
- Producing the first draft of the guidelines
- Disseminating these draft guidelines for comment and advice to a broad range of people, both local to the medical school and nationally
- Revising the draft in the light of the comments received.

It became clear that the examination of minors (patients under 18 years old) raised specific issues, meriting specific guidelines. The two sets of guidelines, relating to adult patients and to minors, are on bmj.com.

If the parent is not present, children could feel uncomfortable being examined by a student

Four main principles were applied in developing both sets of guidelines:

- The guidelines must reflect current law
- They should respect patients: respecting both their sensitivities and their autonomy
- They should help protect students from being vulnerable to misunderstandings
- They should not impose requirements that interfere substantially with medical education.

Guidelines for examining minors

Much of the guidance is straightforward: an honest, open, and polite approach is desirable, on the basis of all the above principles. Three issues arose that were particularly problematic—unavailability of parents at time of proposed examination; consent for intimate examination; and the need for chaperones.

Availability of parents at examination

The central message of the guidelines is that examination of minors should take place only "with the valid consent of at least one parent or with the consent of the child, if aged 16 or 17 years and competent." The

Guidelines and details of contributors are on bmj.com

guidelines include further discussion of the legal approach to competence in children aged less than 16 years old.

One problem is that a parent may not be present at the time it is appropriate for medical students to examine a child. Requiring a parent to be available to give consent at the time of the examination could result in the loss of important training opportunities for medical students. Parents would expect their children to be examined as part of clinical care, but such an expectation would not necessarily include examination for educational purposes.

In the light of these considerations the guidelines state: "If the parent is present at the time of examination then the consent can be obtained at that point by the student. If the parent is not available at the time, then a medical student should only examine the patient if a parent has given prior valid consent."

This guideline places some burden on paediatric facilities, but the paediatricians and gynaecologists involved in giving advice thought a system for seeking and recording parental consent could be set up.

The guidelines also make it clear that, even with prior parental consent, if the parent is not present then a qualified health professional should be present when a student examines a patient aged under 16.

Age and consent for intimate examination

The guidelines state that medical students should never carry out either rectal or vaginal examinations on a child (a person under 18 years old). This guideline was challenged by some of the advisers on the grounds that there is no good reason to treat patients aged 16 and 17 years separately from those aged 18 years or more since statute (the Family Law Reform Act 1969) allows (competent) 16 and 17 year olds to give consent to medical treatment. It might be argued that restricting intimate examinations to those aged 18 years and over is patronising to those aged 16 and 17 years. Concern was also raised that such restriction would limit students' experience, especially in the care of pregnant women around the time of labour, where intimate examination is an integral part of assessment, and a considerable proportion of patients in labour are under 18 years old.

Despite these arguments the subcommittee decided to retain the restrictive guideline for three reasons.

- The evidence from both the medical students and gynaecologists, at least in our local area, was that excluding women under 18 years from intimate examinations by students would not interfere greatly with the learning opportunities.
- The paediatricians with whom we consulted thought that 16 and 17 year olds are not always sufficiently mature for their consent to intimate examinations to be unproblematic.
- English law considers 16 and 17 year olds differently from those aged 18 years and above: parents and doctors are under legal obligation to treat minors in their best interests, independently of consent or refusal of consent by the minor. The subcommittee thought that it would be unlikely for any court to have difficulties with a student carrying out normal physical examination with the competent consent of a 16 or 17 year old. But the legal position does give grounds for making a distinction between patients under 18 and

those over 18, and for having some concern that students may be at greater risk in the former case were a complaint over intimate examination to be made.

Chaperones

An issue with which the subcommittee struggled concerned advice about when students should be accompanied by a chaperone, defined as a third

Patient's commentary

I have concerns regarding the guidelines surrounding the issues of medical students being allowed to examine a minor without a parent being present. Even with prior consent from a parent (or if the patient is "Gillick competent"—although under 16 years, has the legal capacity to give valid consent), if the parent is not present a minor could feel uncomfortable when being examined by a student. Such circumstances could lead to misunderstandings and students being wrongly accused. The only circumstances where I believe that this could be permitted were if the patient specifically requested that they did not want a parent present.

I am the parent of a patient who is often admitted to hospital, and we are happy to accommodate student medical examination wherever possible, but I would find it extremely difficult to agree to a student carrying out an examination without my presence. The child and parent should have the opportunity to clarify their wishes, and I feel that this should be ascertained at the point of consent. This could be easily obtained when nursing staff complete the admission form with the parent by using a statement giving consent and another declining consent, with just one being signed by the parent.

Applying the term Gillick competent to a child under the age of 16 for examination by a medical student, when a parent is not present, raises concerns too. Can a child of any age be classed as Gillick competent for student examination? I would be very unhappy if a student examination was carried out without my consent or presence, especially on a child under 12. This could be open to misinterpretation and complaints from parents.

Under no circumstances should a patient under the age of 16, even Gillick competent, be examined by a group of medical students without prior consent of a parent or without their presence.

I strongly agree that medical students should never carry out intimate examinations on a child under the age of 18, for the reasons outlined in the paper. The law differentiates between a 16 or 17 year old and an 18 year old. This seems to be a fundamental distinction we all have between child and adult, both on a legal and moral standing.

The paper covers my concerns with regards to chaperone and age and sex of the student. I would be happy for a student to ask questions and carry out basic observations on a minor while the parent is present, but I would always wish for a doctor to be present for a more hands-on medical examination, even though this might restrict the important learning opportunities available to medical students.

Gill Mulford (parent)

I would always want my mum or dad to be with me when I am examined by someone training to be a doctor. I would feel OK if there was a group of students but I would still want mum or dad to be there.

I think that there should always be someone who knows what they are doing, come in with a student, when they come to look at me—I mean a doctor.

Oliver Mulford (age 10)

person (that is, additional to the patient and to the student carrying out the examination) who is of the same sex as the patient and is either a medical student or a health professional. The guidelines also state:

A relative of the patient is not a chaperone for the purposes of these recommendations... Patients will sometimes want a friend or relative (companion) present during history taking and examination. In such circumstances the patient's wishes should be respected... One purpose for the presence of a chaperone is for the protection of the student against false allegations of unprofessional behaviour and it is not appropriate for the patient's companion to fulfil this role.

The advice to medical students about who should be present when they examine child patients involved striking a balance between the protection of students from false allegations and ensuring that the chaperone requirements are not so burdensome that they interfere either with the student's education or the provision of health care.

Medical students should not examine any child patient less than 16 years old (or if the patient is incompetent, less than 18 years old) without at least one other person being present. In most situations a medical student can examine a child patient if at least one of the child's parents or a qualified health professional is present... In the case of a female child patient aged 10 years or over, a male medical student is strongly advised to carry out an examination only if a qualified health professional or female medical student is present, as chaperone, even if a parent is present. Female medical students may sometimes prefer to have a chaperone present, in addition to a parent, when examining male teenagers.

The subcommittee had to make judgments, in the absence of good data, about risks to students and balance these against imposing too burdensome a requirement and, of course, respecting patients' wishes. Subcommittee members and external advisors raised two issues.

Firstly, the choice of "10 years or over" in the guideline is somewhat arbitrary. It was thought that requiring a chaperone (in addition to a parent) when examining young children was overly protective of medical students, would not reflect the practice that would be expected once medical students qualify, and could interfere with the relationship between the medical student and parent, where a sense of trust on both sides is desirable. On the other hand, as female patients approach puberty a male student should have the protection of a chaperone even when the parent is present.

Secondly, the guidelines allow female medical students to act as chaperones for male medical students. Some advisers thought this was not appropriate, but the subcommittee thought that acting as chaperones was not too much of a burden and is a reasonable responsibility for a medical student to take on. Because of the time constraints on busy staff, a requirement that a doctor or nurse act as chaperone would be likely to restrict the important learning opportunities available for male medical students.

Conclusions

Although professional guidelines with regard to the proper conduct of doctors are increasingly detailed, guidelines for medical students are few. In some situations guidelines for doctors are appropriate to

Summary points

Medical students need experience of examining sick children as part of their training

Such examination raises many issues, including the consent procedure; the value of chaperones; and whether intimate examinations should be carried out by students

Guidelines must recognise the importance of high standards of conduct by medical students when examining patients without imposing restrictions that would interfere substantially with medical education

students—for example, those concerning confidentiality—but other guidelines for doctors do not address issues for students. By balancing various principles, our guidelines attempt to provide useful advice to students about their conduct with regard to the physical examination of children.

Contributors and sources: This article is a result of the discussions by the sub-committee that developed the guidelines for medical students at the University of Oxford on their conduct with regard to the examination of patients. The authors include medical students, a consultant paediatrician, a medical ethicist, and a consultant physician with many years' experience in medical education and student welfare.

Competing interests: None declared.

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Endpiece

The most lucrative branch of medicine

This branch of medicine had commonly been reckoned one of the most lucrative; for the subjects of it are generally found among the affluent: they are seldom without some complaint that requires assistance; and they measure their comforts too often by the quantity of medicine that is served up.

Trotter T. *A View of the Nervous Temperament Being a Practical Enquiry into the Increasing Prevalence, Prevention, and Treatment of Those Diseases Commonly Called Nervous, Biliary, Stomach and Liver Complaints; Indigestion; Low Spirits, Gout etc.* 2nd ed. London: Longman, Hurst, Rees, and Orme, 1807:231

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