

Are Med Students Practicing on You?

It's the medical community's best-kept secret: students "practicing" on unwitting patients. Have you been a victim?

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Picture This:

You go in for surgery on your nether regions--maybe you have a growth in your prostate; maybe it's testicular cancer. You're understandably anxious, vulnerable, scared.

You're on the operating table, counting backward. Everything fades to charcoal, and you're out. Next, something you didn't bank on: A handful of medical students shuffle in, none of whom you've met. They pull on surgical gloves and gather at your . . . table.

One by one, the baby docs dig in, feeling around for your prostate gland and discussing their findings as if they were sipping pinot grigio. A scene from a Chevy Chase movie?

Try standard operating procedure at many of the 400 teaching hospitals in the United States. Students have to get their practice in somewhere, after all, and your being out cold presents the perfect opportunity. You haven't given specific consent, but it doesn't matter. You're convenient, you won't react if they hurt you--heck, you'll never even know.

Unless...

Unless you're wide awake, of course, like Melvin Stern. The recovering prostate-cancer patient from Highland, Maryland, was in his oncologist's office a few years ago, drawers at his ankles, undergoing a manual rectal exam, when the doctor turned to a med student and said, "Why don't you go ahead."

The student dug right in, caving to the intense pressure med students are placed under during training. Stern, himself a doctor, was flabbergasted--not only because the doctor hadn't asked permission, but because Stern had expressly denied the student's own request to perform the exam not 10 minutes prior.

"It was terrible," says Stern now. "I was awake. I'd said no. But the trainee went ahead anyway, and neither of them spent any time telling me why they thought it was useful. "A patient shouldn't have to meet the needs of the provider," Stern goes on. "If he decides it's appropriate to help, great. But he needs to be asked."

Ghost Surgery

At least what happened to Stern wasn't a riskier procedure like a spinal tap, at which students sometimes get their first crack at on unsuspecting patients.

It's a classic bait and switch: You think it's your doctor behind you, slipping the needle between your vertebrae. Instead, he stealthily ushers in a student, who quietly tries his hand at a procedure that, if botched, can paralyze.

Then there's ghost surgery. You might assume, quite naturally, that the surgeon you've flown across the country to see is the one who'll slice into you in the operating room. But, according to experts we spoke with, if you're in a teaching hospital, there's a chance he'll never pick up the scalpel.

Instead, it's likely to be a surgical resident or a med student honing his or her chops on your vital organs while your trusted doctor looks on. Or makes his other rounds. You'll never know who performed the surgery unless something goes wrong, you sue, and the closely held notes from your operation become public.

"I've seen so much of this kind of abuse," says Michael Greger, M.D., a general practitioner who travels the country lecturing at med schools about the inappropriateness of nonconsensual procedures. "So many take advantage of the sick, when the last thing they have on their minds is being vigilant and asking people for their credentials."

A Living Cadaver

Patient-as-practice-dummy used to happen primarily at hospitals that treated the indigent, who didn't have much voice in the matter. Since the advent of Medicaid, Medicare, and commercial insurance, though, the charity patient has largely

gone the way of the house call. As a result, students are increasingly turning to insured patients.

nt research isn't plentiful, but a 1990 study of U.S. and Canadian teaching hospitals revealed that almost half practiced on "clinic patients" (people on Medicaid or uninsured), while 20 percent used private patients--the insured.

In 1995, a study conducted at five Philadelphia-area medical schools found that only 28 percent of students view prior consent to be "very important." Perhaps this shouldn't be surprising, considering that 90 percent of these same students admitted to performing pelvic exams on unconscious women in the operating room.

Last winter, the *British Medical Journal* reported that at a single English medical school, more than half of all rectal or pelvic exams were performed on anesthetized patients--and a quarter of those were done without consent. In 2000, another study speculated that an untold number of Oxford medical-school graduates learned to perform digital rectal exams on unconscious patients.

"Do we have to choose between competency and ethics?" asks Dr. Greger. "No, we don't. Informed consent is the cornerstone of medical ethics."

At Least Take Me to Dinner First

So why, then, don't teaching hospitals simply ask in advance?

"We do," contends Jordan J. Cohen, M.D., president of the American Association of Medical Schools (AAMC), which represents medical schools and teaching hospitals in the United States and Canada.

"During the admissions process, [patients] are made aware that students and residents will be involved in their care. And they have the right to refuse."

But, opponents say, the devil is in the details.

Or lack of details. On most consent forms handed to patients, there's no specific mention of students performing surgery, doing spinal taps, or conducting invasive exams while the patient is unconscious. Dr. Cohen maintains that that wouldn't be practical. "You can't list every procedure a patient may need during hospitalization," he says.

Robin Fretwell Wilson, J.D., a University of Maryland professor specializing in health law and medical ethics, says many medical schools get around the issue by labeling students part of the patient's "care team." But no student, she says, is there to offer a second opinion or recommend treatments.

"Students doing exams for education add nothing--they're just taking advantage of people who are under anesthesia and extremely vulnerable," says Wilson, who last year testified before the Federal Trade Commission and the Department of Justice, telling officials that "violations of the duty of informed consent continue, in many places, to be routine."

If You Have to Ask

So why don't doctors just ask on a case-by-case basis?

Three reasons, explains Ari Silver-Isenstadt, M.D., a Baltimore pediatrician and coauthor of a series of studies on how med students and doctors relate to patients.

First, there's a pervasive sense of entitlement in the medical education community, he says.

Second, staff members at teaching hospitals tend to believe that patients should understand they're at a teaching facility and thus should be prepared for strangers prodding them without explanation.

And, finally, an abiding fear exists that patients, if asked, will refuse. "There's an assumption that the medical education system will collapse," says Dr. Silver-Isenstadt, who refused to examine anesthetized women as a student at the University of Pennsylvania. Dr. Silver-Isenstadt's own studies show that, when asked, about half of patients are happy to participate in student education--including unconscious rectals and awake spinals.

That's enough to ensure that medical students get all the practice they need, he contends. In response to the furor over last year's Philadelphia study--especially after newspaper reports in which several doctors admitted to unauthorized exams--most teaching hospitals are refusing to discuss the matter publicly, though many have released statements denying that it goes on within their walls.

A brave few, including the Harvard medical school and the University of Pennsylvania, have overhauled procedures and now seek specific consent from patients. The Harvard move came in part because of a grassroots campaign by its medical students.

Still, for now at least, the burden lies with patients to protect themselves. A statement released last summer by the AAMC reads, "When receiving care at a hospital, patients have a right to ask what procedures and treatments they will undergo as well as who will be involved in their care. If a patient is uncomfortable with the answer to either of these questions, the patient has the right to say 'no.' "

There's Good News and Bad News

The good news is that both Wilson and Dr. Greger agree change will come--slowly, perhaps, but undeniably. According to Dr. Greger, the people who run most medical schools--who were educated before patients' rights were considered important--are starting to retire, making way for a new, more sensitive breed of physician accustomed to a less cocky, more patient-friendly culture.

Wilson believes that patients' rights could soon become a financial issue for teaching hospitals as well: The organizations that certify them could threaten to yank accreditation if they allow certain procedures without patient consent. That would mean a devastating loss of Medicaid and Medicare funds.

In the meantime, Wilson hopes more hospitals will overhaul consent forms so patients precisely understand what they are and are not consenting to.

But even that isn't ideal. Instead, she thinks patients and med students alike would be better served if doctors would ask themselves:

What would Marcus Welby do? Dr. Welby was one of TV's most popular characters in the mid-1970s, mostly because he treated patients as people first. "He would have walked in," Wilson says, "talked to the patient honestly, and said, 'I have three medical students with me today. It would help them a lot with their education if they could palpate your mass. Is that okay?'" "That," Wilson continues, "would not cause medical education to grind to a halt."

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