‘Nipples to knees’ in the ‘Me Too’ era

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ABSTRACT

We live in an era of increased societal awareness of sexual harassment and frequent reporting by patients of inappropriate conduct. In this article, we reflect on traditional teaching of physical examination involving full exposure and intimate examinations, and whether this is still necessary, or appropriate, in clinical practice today. We discuss the balance between appropriate physical examination and inappropriate patient exposure resulting in perceived or actual harassment. We argue that ethical values and societal values change with time, and there is an onus on medical educators to reflect societal sensitivities in their teaching.

KEYWORDS: Physical examination, exposure, harassment, consent

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Physical examination is fundamental to patient assessment. A structured approach to physical examination is taught early in medical school. To ensure competency, these skills are examined during final examinations, and then refined in daily practice before further assessment at postgraduate level.

Expectations regarding level of patient exposure differ when performing physical examination under ‘examination conditions’ compared with daily clinical practice. Traditionally, it is expected that when examining cardiovascular or respiratory system, the chest is fully exposed (with the patient's consent). For example, when describing the abdominal system examination, a UK textbook suggests to ensure ‘that nothing is overlooked, expose the patient from “nipples to knees”’.[1] Marks can be lost in postgraduate exams for examining patients through clothing.[2]

Recent General Medical Council cases involving physical examination

While essential for patient assessment, physical examination can also be a tool for reassuring the patient and developing a healing rapport.[3] However, intimate examinations can also cause distress and anxiety and can be perceived negatively by patients.[3] This discomfort felt by patients may be exacerbated by cases of alleged sexual assault during physical examination in recent years, resulting in General Medical Council (GMC) disciplinary action and criminal charges.[4–6] Cases described in the media and the Medical Practitioners and Tribunals Service (MPTS) hearings describe cases of patients attending for minor ailments and undergoing inappropriate examinations.[4–6] For example, a doctor who demanded that his patients removed their clothes for breast examinations;[4] a doctor who undertook vaginal and breast examinations without consent, and which were deemed not to be clinically indicated;[6] or a doctor who recorded cases of his patients being examined without clothes on.[7] A recent hearing described a doctor who performed intimate examinations of the groins and breasts of his patients without consent, but justified these actions as being clinically indicated and appropriate.[5] The last case reflects poor understanding about how a routine cardiac examination could stray into an intimate examination through full exposure.

The GMC guidance on physical examination and intimate clinical examinations is clear. Guidance states that:

You must … where necessary, examine the patient.[8]

But also that:

Intimate examinations can be embarrassing or distressing for patients and whenever you examine a patient you should be sensitive to what they may think of as intimate. This is likely to include examinations of breasts, genitalia or rectum, but could also include any examination where it is necessary to touch or even be close to the patient … this must not deter you from carrying out intimate examinations where necessary … you should offer the patient the option of having an impartial observer present.[9]

The nature of the examination can also affect patient experience: interviews with patients and members of the public suggest that the qualities of touch and the involvement of the patient in decision making and examinations are also important.[10]

Change in societal values

Societal attitudes have changed significantly in recent years, with an increasing awareness of, and intolerance to, sexual harassment. The ‘Me Too’ movement was an international social media campaign which started in 2017. It highlighted the prevalence of sexual harassment and discrimination in current society and has empowered individuals to question cultural norms and practices.

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There is sparse literature to date examining the impact of this movement on patient attitudes.

Junior doctors' attitudes and practice

To explore the attitudes of junior doctors more fully, and to obtain opinions of junior doctors on the appropriate degree of exposure during physical examinations, we invited a group of 30 foundation year 1 and 2 doctors who had recently graduated from UK medical schools to participate in semi-structured interviews and questionnaires based on their training and practice. Interviews revealed that medical school curriculum expectations of cardiac and respiratory system examinations did not reflect those performed in routine clinical practice.

The respondents reported that they had been taught to be systematic by 'doing everything step by step' and being meticulous to 'cover everything'. They also reported that examinations in daily practice were abridged compared to during clinical examinations, and were more focused, while assessing multiple systems simultaneously.

The level of patient exposure for cardiorespiratory examinations taught at undergraduate level was felt to be well defined and consistently reported to require removal of all clothes from the waist upwards (86%). Respondents commented that they reduced the level of exposure in clinical practice despite the clearly defined and taught expectations for formal examination settings. For routine clinical practice, the majority of doctors said they would remove a patient's clothes but not their underwear (52% for cardiovascular examination and 57% for respiratory examination). Thirty per cent of doctors even reported they did not remove any clothing to examine the patient. The majority of participants (75%) felt that it was inappropriate to remove the bra of a female patient for cardiovascular or respiratory examination in routine practice. Participants felt that their curriculum requirements of full patient exposure existed to 'prove competence' and to demonstrate comprehensive training.

Multiple reasons for the reduced level of chest exposure in daily practice were raised: patient dignity, physical barriers, time pressures, patient health, patient mobility, non-essentiality, inconvenience and reliance on clinical investigations. Thus, while full exposure can be daunting for patients, it is only one of many reasons given by junior doctors for avoiding full exposure.

This finding differs from studies of medical students who revealed high degrees of embarrassment and awkwardness in learning intimate examinations.[11] Medical school curricula may need to evolve to address both students' and patients' attitudes to physical examinations, while simultaneously adhering to GMC guidance. Ethical values and societal values change with time, and there is an onus on medical educators to reflect societal sensitivities in their teaching.

Conclusion

We have written this article in response to recent GMC cases highlighting issues on ambiguous consent and inappropriate patient exposure. These cases emphasise conflict between correct consent and sensitivity to patients' needs with traditional teaching of full exposure during clinical examination. We urge heeding the clear guidance from the GMC about intimate examinations. We doubt the clinical value of removing the bra of female patients in routine cardiorespiratory examinations, and suggest that it is rarely done by senior doctors. As such, it may be time for medical schools to reconsider training accordingly to focus on a patient-centred empathetic 21st century approach to physical examination.■

References

1 Mirnezami R, Paraskeva P. Abdominal examination. In: Aziz O, Purkayastha S, Paraskeva P (eds). *Hospital surgery: Foundations in surgical practice*. Cambridge University Press; 2009:742–6.
2 Membership of the Royal Colleges of Physicians of the United Kingdom. *PACES preparation*. Federation of Royal Colleges of Physicians of the United Kingdom. www.mrcpuk.org/mrcpuk-examinations/paces/paces-preparation#Skill%20A.
3 Iida J, Nishigori H. Physical examination and the physician-patient relationship: a literature review. *MedEdPublish* 2016;5:14.
4 Dyer C. Former GP partner is jailed for 10.5 years for sexually molesting patients over two decades. *BMJ* 2019;365:l2264.
5 Medical Practitioners Tribunal Service. *Record of determinations – Medical Practitioners Tribunal: Public record: Dr Nishanth NAIR*. MPTS, 2019. www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-nishanth-nair-oct-2018
6 Medical Practitioners Tribunal Service. *Record of determinations – Medical Practitioners Tribunal: Public record: Dr Raied HARIS*. MPTS, 2019. www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-raied-haris-jan-19
7 Dyer C. Former GP partner who recorded images of female patients is found guilty of voyeurism. *BMJ* 2018;362:k3227.
8 General Medical Council. *Good medical practice*. Manchester: GMC, 2013. www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice
9 General Medical Council. *Intimate examinations and chaperones*. Manchester: GMC, 2013. www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones
10 O'Lynn C, Krautscheid L. Original research: 'How should I touch you?': a qualitative study of attitudes of intimate touch in nursing care. *Am J Nurs* 2011;111:24–31.
11 Dabson AM, Magin PJ, Heading G, Pond D. Medical students' experiences learning intimate physical examination skills: a qualitative study. *BMC Medical Education* 2014;14:39.

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